

Discovery
Health Medical Scheme

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01.01.2024

Gender	M	☐	F	☐	Date of birth										
Race	African	☐	Coloured	☐	Indian/Asian	☐	White	☐	Other	☐	Do not want to disclose	☐			
<i>You do not have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.</i>															
Occupation															
Tax Number															
Gross monthly earnings	R									.					
ID or passport number															
Telephone (H)										Telephone (W)					
Cellphone															
Email															

Physical address while in South Africa

Suite/unit number		Complex name														
Street number		Street name														
Suburb												Postal code				

Postal address (post collected from post box, suite or private bag)

Same as residential address Yes ☐ No ☐

If you do not complete a postal address, we will use your physical address for post.

☐ PO Box	☐ Private Bag	Box number														
☐ Suite	☐ PostNet Suite	Number														
Suburb												Postal code				

2. About your spouse or partner (only complete if applying for cover)

Title		Initials													
Surname															
First name (as per identity document)															
Gender	M	☐	F	☐	Date of birth										
Race	African	☐	Coloured	☐	Indian/Asian	☐	White	☐	Other	☐	Do not want to disclose	☐			
<i>You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.</i>															
Marital status	Married	☐	Single	☐	Divorced	☐	Widowed	☐							
ID or passport number															
Telephone (H)										Telephone (W)					
Cellphone															
Email															

3. About your dependants (only complete if they are also applying for cover)

Dependant 1

Title		Initials													
Surname															
First names (according to identity document)															
Gender	M	☐	F	☐	Date of birth										
Race	African	☐	Coloured	☐	Indian/Asian	☐	White	☐	Other	☐	Do not want to disclose	☐			

You do not have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data

and it will be used for statistical purposes.

ID or passport number

Relationship to main member

(For example mother or child. Where your child is not your biological child, please state your relationship, for example adopted child or foster child. Please give us legal proof of the relationship.)

If your dependant is 21 years and older, are they:

Married Yes ☐ No ☐

Financially dependant on you? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐

Does your dependant's spouse earn an income? Yes ☐ No ☐

How much does your dependant earn each month? R .

How much does your dependant's spouse earn per month? R .

Dependant 2

Title Initials

Surname

First names (according to identity document)

Gender M ☐ F ☐ Date of birth

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Do not want to disclose ☐

You do not have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

ID or passport number

Relationship to main member

(For example mother or child. Where your child is not your biological child, please state your relationship, for example adopted child or foster child. Please give us legal proof of the relationship.)

If your dependant is 21 years and older, are they:

Married Yes ☐ No ☐

Financially dependant on you? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐

Does your dependant's spouse earn an income? Yes ☐ No ☐

How much does your dependant earn each month? R .

How much does your dependant's spouse earn per month? R .

Dependant 3

Title Initials

Surname

First names (according to identity document)

Gender M ☐ F ☐ Date of birth

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Do not want to disclose ☐

You do not have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

ID or passport number

Relationship to main member

(For example mother or child. Where your child is not your biological child, please state your relationship, for example adopted child or foster child. Please give us legal proof of the relationship.)

If your dependant is 21 years and older, are they:

Married Yes ☐ No ☐

Financially dependant on you? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐

Does your dependant's spouse earn an income? Yes ☐ No ☐

How much does your dependant earn each month? R .

How much does your dependant's spouse earn per month? R .

Are you applying for more than 3 Dependants? Yes ☐ No ☐

Note: If you are applying for more than 3 dependants, please add the details on a separate page.

4. Your financial adviser's details

Do you want an adviser? Yes ☐ No ☐

If you would like an adviser, a Discovery Connect Distribution Services adviser will be in contact with you via email to confirm the appointment of an adviser.

Please complete this section if you already have a financial adviser

Financial adviser's name		Code	
Intermediary house		Code	
Financial adviser's telephone number (W)		Lead number	
Email			
Bank reference number (if applicable)		(Mandatory for all ABSA and FNB financial advisers)	

Declaration

I declare that I have read, understood and agree to the broker declaration on www.discovery.co.za/portal/rules.

I declare that:

- I am an accredited financial adviser in terms of the Medical Schemes Act and licensed by the Financial Sector Conduct Authority in terms of the Financial Advisory and Intermediary Services Act at the date of signing this application form.
- I am appointed by the main applicant to provide advice about this application.
- I have a valid contract with Discovery Health Medical Scheme and I have made the client aware of the commission payable by Discovery Health Medical Scheme.
- I am responsible for providing the main applicant with:
 - my name, physical address, postal address and the telephone number
 - impartial advice that is in his or her best interest.
- I am accountable for any advice given to the main applicant about completion of this application form and joining Discovery Healthcare Fund.

Signature of financial adviser



Signature of main applicant



Please only sign if information is true, complete and correct.

Discovery Ltd. registration number: 1999/007789/06. Companies in the Group are authorised Financial Services Providers.

5. Please select your health plan

Executive Plan	Comprehensive Series	Priority Series	Saver Series	Smart Series	Core Series	KeyCare Series
Executive ☐	Classic ☐	Classic ☐	Classic ☐	Classic ☐	Classic ☐	KeyCare Plus ☐
	Classic Smart ☐	Essential ☐	Classic Delta ☐	Essential ☐	Classic Delta ☐	KeyCare Core ☐
			Essential ☐	Essential Dynamic ☐	Essential ☐	KeyCare Start ☐
			Essential Delta ☐		Essential Delta ☐	KeyCare Start Regional ☐
			Coastal ☐		Coastal ☐	

I would like to select that my health plan complies with the requirements of Shariah

Yes ☐ No ☐

How would you like us to refund claims from the Medical Savings Account if your plan has one?

Discovery Health Rate ☐ Cost ☐

Discovery Health Rate is the medical scheme rate subject to funds available.

Cost is the full amount of the claim subject to funds available.

You have the right to ask for help in selecting a health plan that suits your needs. Whether you have requested help or made the decision on your own, by signing this application, you confirm that you are familiar with the conditions and benefits of the plan you select.

When you make a claim that is eligible for payment, the Scheme will use the money available in your Medical Savings Account (MSA) to pay for it. Your MSA is a combination of your annual MSA allocation, which is the amount of money you receive at the start of each year, and your accumulated MSA, which is the money that you didn't spend in previous years and that carried over to the current year.

6. If you choose a KeyCare plan

Please complete this section if you selected a KeyCare plan.

Income is defined as guaranteed gross monthly earnings of the main member and the spouse before deductions. If you have selected a KeyCare plan, Income Verification will be conducted for the lower income bands.

IMPORTANT NOTICE

Declaring income lower than your actual income is fraud. This may lead to the termination of your membership and criminal charges may be brought against you. If your income is not declared, your income verification status will default to the highest income band. It is your responsibility to give accurate income information, otherwise the Scheme may not be in a position to pay back the excess amount you paid.

	Main member	Spouse or partner
Gross earnings over the last 12 months	R	R
Gross monthly earnings	R	R

By signing this application form, you give your permission for us to verify your declared income using all relevant internal and external sources, indicated in 13.4 of the terms and conditions of membership (Section 13).

I declare that this income declaration is true and accurate.

Signature of main applicant



Please only sign if information is true, complete and correct.

Please complete this if you have selected the KeyCare Plus, KeyCare Start or KeyCare Start Regional Plan.

- For KeyCare Plus please select a GP on the KeyCare GP Network.
- For KeyCare Start please select a GP on the KeyCare Start GP Network.
- For KeyCare Start Regional please select a GP on the KeyCare Start Regional GP Network.
- If you have selected the KeyCare Start Regional Plan, which offers comprehensive and affordable cover in and around Polokwane, Tzaneen, Mbombela, Trichardt, Bellville and George, please make sure that you stay or work in one of these locations so that the full benefit suite is available to you.

	Name	GP name	Practice number								
Main applicant			<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								
Spouse or partner			<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								
Dependant 1**			<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								
Dependant 2**			<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								
Dependant 3**			<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								

** Please make sure that the dependant information you give above is the same as the dependant information in section 3 of this form. Please provide the details on a separate page if you are applying for more than 3 dependants.

7. Your employment details (only complete if your employer pays the contributions on your behalf)

7.1. If your employer is paying your full contribution or a part of it and we need to debit their account, please complete this section:

Name of employer Employer and billing number

Employee number Date of employment

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

(or PERSAL number for government employees. Please attach a clear copy of your salary slip.)

Branch name Branch number

Employer warranty

Please ensure your employer completes this warranty if this application form is not submitted with an employer application form:

7.1.1 We warrant that the main applicant detailed in section 1 is an employee of our organisation.

7.1.2 Discovery Health Medical Scheme may bill us for the amount due for this member in the same way as it does for our other employees
Health Medical Scheme.

Authorised signatory

Name

Designation

Name of your business			
Registration number		Vat number	
Telephone		Fax	

Signature of main member



Please only sign if information is true, complete and correct.

9. Previous medical scheme details (please give us proof in the form of a membership certificate)

Please give us the details of all registered South African medical schemes that you and your dependants being added previously belonged to. **We will use this information to determine if we need to apply any late-joiner penalty fees. We may also use the information on the membership certificate to determine if we can apply waiting periods.**

Were all your dependants on the same medical scheme Yes ☐ No ☐

If you and your dependants applying for cover belonged to different medical schemes, please complete them below:

Name	Scheme name	Start date	End date if already resigned	Are they still a member?	Reason for leaving
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	

10. Moving from another medical scheme

Please make sure that you have completed section 9.

10.1. I confirm that all people named on this application:

10.1.1. have not had a break in membership of more than 90 days since resigning from the previous South African medical scheme, and

Yes ☐ No ☐

10.1.2. are currently or have been members of a South African medical scheme for at least the past 24 months

Yes ☐ No ☐

If you answered yes to the above questions, please answer the questions in 10.2.

If you answer no to any question in 10.1, you must complete all the medical questions in section 11.

10.2. For any person named on this application form:

10.2.1. Have they been admitted to hospital in the 12 months before this application?

Yes ☐ No ☐

10.2.2. Are they currently taking regular, ongoing medicine and/or treatment of a medical condition or symptom?

Yes ☐ No ☐

10.2.3. Are they planning to or reasonably expecting to be hospitalised (including for pregnancy) or expecting to receive dental or medical treatment/investigations costing more than R2 000 in the next 12 months?

Yes ☐ No ☐

If you answered yes to any questions in 10.2, we will apply a three-month general waiting period to your application and you do not have to complete Section 11.

During these three months, we will only cover claims relating to Prescribed Minimum Benefits according to the Scheme's rules. If you feel that a three-month general waiting period should not be applied and you want to give us more information, please complete section 11.

11. Your health questions

We may be able to retrieve certain previous medical information we have for you and your dependants (if applicable) from previous memberships. By signing this, you agree that we may utilise this information for the purposes noted below.

Signature

Information on symptoms, conditions or disorders (must be completed for the main applicant, spouse/partner and all dependants and must include information on conditions even if covered or not on previous memberships)

Have **you or any dependant/s** in this application **ever** experienced, been treated for, or are you currently suffering from any of the following symptoms, conditions or disorders? We have listed some examples of conditions, symptoms or disorders under each question. These are only examples and not the full list of conditions, symptoms or disorders. Please include congenital abnormalities.

We use this information only for lawful purposes, for example, enabling us and our administrator to process your application and to optimally administer your membership, to verify whether the information you provide on this application form is true and complete, to provide you with customized information relevant to your health status, to develop disease management programs for specific conditions, to review and enhance Scheme benefits, to improve Scheme's financial modeling, to assist the Scheme to better assess and mitigate its risk and other beneficial uses. A condition specific waiting period will only be imposed on your membership if you or your dependant received or were recommended any medical advice, diagnosis, care or treatment within a 12-month period ending on the date on which this application is considered to be fully and properly made.

You must tell us in writing if any of the information you gave, in your application for membership, changes between the day you sign this document and the day your membership starts. This includes information about your health and the health of those you apply for.

Please take note that if you or any of your dependants have any symptom or condition not listed in the questions below, you should highlight and provide full details of this symptom or condition in response to question 11.18 below.

Indication of existing medical conditions on this application does not automatically enroll you/your dependants onto the Scheme's Disease Management programme. For more information with regards to the Schemes disease management enrollment visit www.discovery.co.za.

Please answer ALL questions by ticking “Yes” or “No”.

11.1 Tumours, growths and disorders of the skin

Yes ☐ No ☐

Example: abnormal pap smear results, skin lesions, eczema, psoriasis, breast disease, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abscess, abnormal mammogram result, abnormal PSA (prostate specific antigen), any autoimmune conditions, any congenital conditions, any other abnormal cancer-screening or diagnostic test result/s or other skin conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.2. Heart and circulation conditions

Yes ☐ No ☐

Example: chest pain, palpitations, shortness of breath, coronary heart disease, angina, heart attack, arrhythmia, high blood pressure (hypertension), cardiomyopathy, valvular heart disease or heart valve replacement, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker, any autoimmune conditions, any congenital conditions, peripheral vascular disease, deep vein thrombosis, pulmonary embolus, and varicose veins.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.3. Gynaecological and obstetrics conditions

Yes ☐ No ☐

Example: abnormal pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility, ectopic pregnancy, missed period, ovarian cyst, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.4. Are you or any of your dependants pregnant or undergoing treatment/investigation for pregnancy?

Yes☐No☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.5. Mental health

Yes☐No☐

Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (like narcolepsy), eating disorders, Alzheimer’s disease, dementia, attention deficit-hyperactivity disorder, drug and/or alcohol abuse or rehabilitation, suicide attempt, post traumatic stress disorders, counselling, any autoimmune conditions, any congenital conditions and any other psychological conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.6. Metabolic or endocrine conditions

Yes☐No☐

Example: diabetes mellitus (high blood sugar), diabetes insipidus, thyroid disease, Addison’s disease, Cushing’s syndrome, metabolic syndrome, parathyroid disease, Paget’s disease, osteoporosis, growth deficiency, metabolic disorders, Conn’s syndrome, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.7. Abdominal conditions

Yes☐No☐

Example: hepatitis, cirrhosis, portal hypertension, liver disease, liver failure, pancreatitis, cystic fibrosis, gall bladder/stones, GORD (reflux), heartburn, oesophageal disease, hernias, gastritis, ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis, Irritable bowel syndrome (IBS), Hemorrhoids, long standing constipation/diarrhea, ongoing abdominal pain, ascites (fluid in the abdomen) any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.8. Brain and nerve conditions

Yes ☐ No ☐

Example: stroke, epilepsy, seizures, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, other chronic headaches, cerebral palsy, Parkinson’s disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, brain shunt (VP shunt), intellectual disability, CVA, bleeding on the brain, constipation, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.9. Breathing and respiratory conditions

Yes ☐ No ☐

Example: asthma, chronic obstructive pulmonary disease, bronchiectasis, tuberculosis, bronchitis or emphysema, cystic fibrosis, sarcoidosis, pneumonia, interstitial lung disease/chronic cough > 3months, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.10. Musculoskeletal (back, bone and muscle pain)

Yes ☐ No ☐

Example: arthritis (any form), ongoing/intermittent joint or muscular pain, ankylosing spondylitis, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, neurogenic bladder, gout, injury, physical disability, prosthesis, amputation, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.11. Kidney or urinary conditions including current or past dialysis

Yes ☐ No ☐

Example: kidney and/or renal failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, neurogenic bladder, bladder infections, other bladder or kidney problems, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.12. Blood conditionsYes ☐ No ☐

Example: deep vein thrombosis, anaemia, polycythaemia vera, blood clotting disorders/diseases, leukaemia, lymphoma, pulmonary embolus, haemophilia, haemochromatosis and other bleeding disorders, any autoimmune conditions, any congenital conditions, varicose veins.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.13. Eye conditionsYes ☐ No ☐

Example: cataract, keratoconus (cross linkage), corneal ulcer, uveitis, glaucoma, squint, ptosis, retinopathy, macular degeneration, cornea transplant, eye surgery, blurred vision, eye infections, blindness (partial or full), retinal detachment, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.14. Ear, nose and throat (ENT) and dentistry conditionsYes ☐ No ☐

Example: otitis media (middle ear infection), otitis externa (ear canal infection), hearing problems, hearing aid, cochlear implant, tonsillitis, adenoiditis, vertigo, deafness, sinus problem, nasal surgery, dental treatment or dental surgery, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.15. Male urogenital conditionsYes ☐ No ☐

Example: prostate disorders, urogenital defects, varicocele, undescended testes, phimosis, urinary incontinence, retention, infertility, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.16. Are you or any of your dependants expecting to have medical investigations or surgery or planning hospitalisation or treatment in the next 12 months or have you been admitted to hospital/seen in casualty in the last 12 months? Yes ☐ No ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.17. Have you or any of your dependants received or not yet received medical advice or treatment for symptoms, not yet diagnosed by a medical professional, in the last 12 months before this application? Yes ☐ No ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.18. Have you or any of your dependants been diagnosed with or received treatment for, any condition/symptom not mentioned in the questions above, in the last 12 months before this application? Yes ☐ No ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

HIV and AIDS

If you, or one or more of your dependants, are HIV-positive, you or they must call us on **0860 99 88 77** within seven working days from the date we activate your Discovery Health Medical Scheme membership. We treat this information in the strictest confidence. If you, or one or more of your dependants are HIV-positive, it is in your interest to register on the HIV Care Programme. Discovery Health Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before Discovery Health Medical Scheme starts paying for any general or specific medical conditions. A 12-month condition specific waiting period or a three-month general waiting period may therefore apply to this condition or any related condition. If you do not let us know about you or your dependant's HIV status within 7 days of your membership being active, we may end your Discovery Health Medical Scheme membership.

12. Our Privacy Statement – How we will process and disclose your personal information and communicate with you

When you engage with Discovery Health and Discovery Health Medical Scheme, you are entrusting both with your personal information. We are committed to protecting your right to privacy and keeping your information safe. Our Privacy Statement tells you how we collect, use and share your personal information, including personal information about your spouse, employees, dependants and beneficiaries, where applicable. You can view and read our Privacy Statement on www.discovery.co.za > Medical aid > About **Discovery Health Medical Scheme**.

Signature of main member

Date

The main applicant must sign and date any changes.



Please only sign if you have read and understand this statement

13. Terms and Conditions applicable to Discovery Health Medical Scheme membership

Definitions

The Scheme refers to Discovery Health Medical Scheme, registration number 1125, registered with the Council for Medical Schemes.

Administrator refers to Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider, the administrator and managed care organisation for Discovery Health Medical Scheme and a subsidiary of the Discovery Group.

Do you agree that we may send you direct electronic marketing from time to time

No, thank you ☐ Yes, I agree ☐

13.1. Scheme rules for membership

The rules of the Scheme record your rights and responsibilities for your membership. They may change from time to time. You may ask us for a copy of these rules at any time or view these rules on www.discovery.co.za.

When you sign this application, you confirm that you have read and understood these terms and conditions and you agree that you and those you apply for will be bound by these and Scheme Rules.

Where applicable you also acknowledge and confirm that you, your financial adviser, or your employer, may communicate with us on this application and your membership of the Scheme.

You give permission that the Scheme or Administrator can share your medical information and other relevant Personal Information about you and your dependant/s with your chosen financial adviser. The information will be shared so that he or she can help us if necessary while we process your membership application.

Please speak to your financial adviser or the Administrator if there is anything you do not understand.

13.2. Who you are applying for

You may apply to join the Scheme on your own or together with other people – your spouse, your partner and people who are financially dependent on you as defined in the Scheme rules, as referred to above. For anyone to be treated as financially dependent for this application, you must have a responsibility to provide financially for that dependant. The Scheme or Administrator might ask you to give us proof of financial or legal responsibility.

You may be called the principal member or main member in our future communications to you.

13.3. Acting for others

You confirm you have the right to act for others.

By signing this document, you confirm that:

- you have the right to apply for membership and to act for those you apply for in any matter relating to this application.
- you have received permission from your spouse/partner and any dependant(s) over 18 to act for them in any matter relating to this application.

You must give true, correct and complete information.

To consider your application for membership, the Scheme must learn more about you and those you apply for.

Information about you and those you apply for must be true, correct and complete. This includes the details you give in this application form and in future dealings with us. It is important that you tell us about any medical condition, symptom or illness relating to you or those you apply for, even if you do not consider it relevant to your application. We may ask those you apply for who are 18 and older for more information about themselves.

Your legal address

The Scheme or Administrator will send documents to you at the address you indicated as the communication channel you prefer to be contacted on. If it is necessary to send you any legal notices or summonses, our legal team will serve these at the physical address you have given, or at any other address you have given us. It is your responsibility to make sure we have the correct address for you.

The Scheme and Administrator may record telephone calls

The Scheme and Administrator may record telephone conversations with you and with those you apply for.

The recordings and all information we get during the recordings will be processed and kept as required by law.

The Scheme and Administrator may get information about you from other relevant sources

The Scheme and Administrator may (at any time and on an ongoing basis) obtain your personal information from other relevant sources, including medical practitioners, contracted service providers, financial advisers, credit bureaus or industry regulatory bodies ("relevant sources") and further process such information to consider your membership application, to conduct underwriting or risk assessments, or to consider a claim for medical expenses, to profile and analyse risk or to investigate fraud, waste and/or abuse (including by medical practitioners, contracted service providers or financial advisers). We may (at any time and on an ongoing basis) verify with the relevant sources that your personal information is true, correct and complete.

You give your permission that the Scheme and Administrator may get any information that is relevant to your application from your employer.

Tell the Scheme or Administrator immediately if your information changes

You, your employer or your financial adviser must tell the Scheme or Administrator in writing if any of the information you gave, in your application for membership, changes between the day you sign this document and the day your membership starts. This includes information about your health and the health of those you apply for. We need advance notice of any administrative changes such as cancellation of membership, as we do not accept backdated changes.

When the Scheme may cancel your membership/s

The Scheme may cancel any membership if you and those you apply for:

- do not give us information that later turns out to be relevant to this application.
- give us any information that is not true, correct and complete.

- do not tell us about any relevant changes (including about your health and the health of those you apply for) between the day you sign this document and the day cover starts.

Providing false information may lead to criminal charges being brought against you. You will have to pay any amount owing to the Scheme as a result of this cancellation.

Monitor for possible non-disclosure.

To exclude the possibility of non-disclosure of material information, for the first 12 months we will monitor membership in the following cases:

- Claims of new beneficiaries with less than 24 months continuous medical scheme membership and with less than 90 days break, immediately prior to date of application.
- When an application is made for membership or admission for a person who was not a beneficiary of a medical scheme for a period of at least 90 (ninety) days preceding the date of application.

In accordance with the Medical Schemes Act, we implore new applicants to disclose true and complete information to the Scheme. It is always better to disclose too much than too little.

Please note that if membership is subject to the above-mentioned 12-month monitor period, the Scheme may request additional medical history upon receiving a claim and/or a request for authorisation. In this case, the Scheme will only confirm benefits once it is satisfied with the additional information received.

13.4. About becoming a member

The Scheme might not pay for certain expenses immediately after you become a member

The Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before the Scheme starts paying for any general or specific medical conditions. We will advise if any waiting periods apply. Please speak to your financial adviser or the Administrator with regard to any waiting periods applicable to your membership and the memberships of those you apply for.

Resign from current medical schemes when accepted

It is illegal to be a member of more than one medical scheme at the same time. You and those you apply for must resign from your current medical schemes when you receive notice from the Scheme by letter, email or SMS telling you that you and those you apply for have been accepted.

You must ensure contributions are paid on time

As the main member of the Scheme, you are responsible for ensuring that your contributions and the contributions of those you apply for are paid on time every month to avoid suspension of benefits. The Scheme has the right to amend monthly contributions and benefits from time to time with prior notification.

13.5. Repaying money owed to the Scheme

The Scheme has the right at any time to collect from you any amount that you owe. We will notify you if there is any amount that you owe to the Scheme.

You must repay any medical savings owing if you leave the Scheme

When you become a member, depending on the plan you chose, you may have money available in advance to use for medical expenses during the year. This money is allocated to an account called the 'Medical Savings Account'. If you leave the Scheme before the year is up, you must repay the portion of medical savings you have used that is more than you have paid back to the Scheme over the year.

By signing this form, you agree that any money you owe to the Scheme may be deducted from any future claim payment amounts that are due to be paid to you. You will be able to identify the debit order for the money owing to the Scheme on your bank statement, the reference number DISCSETTLE will be used.

Signature of main applicant

Date

D	D	M	M	Y	Y	Y	Y
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Please only sign if information is true, complete and correct.

14. Debit order mandate

This signed authority and mandate refers to the application on the signed date ("the Agreement")

I, the undersigned:

- Warrant that the account information I have provided above is an account in my name and that the information furnished by me/us in this Authority and Mandate is true and correct.
- Authorise Discovery Health to issue and deliver payment instructions to my bank, recorded above, for the collection by Discovery Health from the bank account (or any other bank or branch to which I may transfer my account) any amounts due under or in terms of this application on condition that the sum of such payment instructions will never exceed my obligations as framed in the agreement which shall commence on the date that cover starts as requested on the application form and shall continue until this Authority and Mandate is terminated by me by giving Discovery Health no less than 20 ordinary working days written notice thereof or immediately in the event that I instruct my bank to withdraw this Authority and Mandate.
- If the membership or change in account details is not activated in time for the debit order collection and there is an amount outstanding Discovery Health can collect that amount in the interim. If I change the date of the debit order after activation, I confirm that the payment instructions must be issued and delivered on the day that I have nominated ("payment day") and thereafter on the same day in each and every successive month. If the payment day falls on a Sunday or recognised South African public holiday, the payment day will automatically be the next working day;

- Acknowledge that my bank will treat each payment instruction to pay premiums or amounts due under this Agreement to Discovery Health as if each payment instruction came from me personally as the account holder.
- Undertake to advise Discovery Health in writing of any changes to my account details and acknowledge that Discovery Health will not be held responsible or liable for any claim, loss or harm that I or any third party may suffer as a result of me providing incorrect banking details herein or if the bank account is in the name of another person or entity or as a result of my failure to notify Discovery Health of a change in banking details or if the bank account has insufficient funds to meet my obligations under or in terms of the Agreement.
- Know and understand that the withdrawals hereby authorized will be processed through a computerized system provided by South African banks. The details of each withdrawal from my bank account will be printed on my bank statement and must show the reference number of the membership inserted in the Agreement so as to enable me to identify this membership.
- Acknowledge that although this Authority and Mandate may be terminated by me, such termination does not necessarily terminate this Agreement. In the event of such termination, I am not entitled to any refund of any premiums or amounts due that was withdrawn by Discovery Health whilst this Authority and Mandate was in force if such premiums or amounts were legally owing to Discovery Health in terms of the Agreement.
- Acknowledge that by signing this Authority and Mandate I am bound by the payment terms applicable to this Agreement.
- Acknowledgement that this Authority may be assigned to a third party if this agreement is also assigned to a third party.

Reference number

This Agreement reference number: Your membership number

Abbreviated name

Abbreviated name as registered with the bank: DISCPREM

Deduction amount: as per your activation of membership letter

Deduction date: as per section 1 of your membership application form

Payment start date: as per section 1 of your membership application form

Account holder name

Account holder signature

Date of signature

D	D	M	M	Y	Y	Y	Y
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15. Third Party Bank Details - Annexure A

Banking details for a third party

Please attach the relevant proof of bank account if you give a third party's bank account details for claim refunds and / contribution debit orders

Documents we need for a third-party bank account

(A third party can be anyone, such as your spouse, aunt, uncle, friend, father or son.)

- Proof of the account (bank statement or bank letter not older than three months)
- A copy of the third party's (account holder) ID, passport or driving licence
- A copy of the main member's ID, passport or driving licence

Documents we need for a joint bank account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of each of the joint owners.

Documents we need for a company account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of the persons who have authority to sign on behalf of the company
- A letter of authority. The letter must:
 - State that the account can be used
 - State the membership details (including the membership or policy numbers) for which the bank account will be used
 - Include the details of the signatory
 - Be dated and signed by an authorised person on behalf of the company
- A copy of the company's certificate of registration.
- A copy of the main member's ID, passport or driving licence

Documents we need for a trust account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of each of the trustees of the account
- A copy of the certificate of registration of the trust
- A copy of the trust resolution. The resolution must:
 - Show the trustees
 - Be dated and signed by an authorised person on behalf of the trust
 - Contain the membership or policy numbers
- A copy of the main member's ID, passport or driving licence

If you are completing the request on behalf of the main member, please include proof that you have the necessary authority to do so, for example, a letter of authority or a letter of executorship.