# Applying to become a member of Discovery Health Medical Scheme in 2025

Discovery Health Medical Scheme

### Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes and is the medical scheme that you are applying to become a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

### Contact us

Tel (members): **0860 99 88 77**, Tel (health partners): **0860 44 55 66**, www.discovery.co.za, PO Box 784262, Sandton, 2146, 1 Discovery Place, Sandton, 2196.

### Purpose of the form

Thank you for deciding to apply to join the Discovery Health Medical Scheme. This document is an application form for membership.
The information requested in this application form is required to enable the Scheme to process your membership application and to help in the administration of your membership as well to better administer the affairs of the Scheme.
This application form also contains terms and conditions applicable to your membership (Section 13). Please make sure you read and understand these terms and conditions as well as our Privacy Statement providing information on how we will be processing your personal information. This document is valid for 90 days from date of signing it. Make reference to the footnote that indicates the expiry date of the form. Download the latest version of all forms from www.discovery.co.za, under Medical Aid > Find documents and certificates.

### What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally. You can view the list of approved digital signature providers on www.discovery.co.za, under Medical Aid > Find documents and certificates > Application forms.
- All relevant sections must be signed by the main applicant. The main applicant must sign and date any changes.
- Read and understand the terms and conditions for membership (Section 13) and the Scheme Rules. The full set of Scheme Rules is available on request at www.discovery.co.za/medical-aid/scheme-rules.
- Sign section 6 (if applying to become a KeyCare member), 8, 12 and 14.
- Provision is made in this form for you and your dependants to provide information relating to your race. This information is required by the Council for Medical Scheme for statistical purposes only. You are not compelled to provide this information.
- Email the completed and signed form to **application@discovery.co.za**.
- Please attach a copy of each applicant's identity document. We also accept valid passports and birth certificates for children.

### Once you submit your application form, here is what will happen:

You will be contacted if any details are missing or if more information is required for underwriting purposes and to process your application.

- You will receive a notification and you (and your financial adviser, if you have chosen one) will receive an email to let you know when your application is considered to have been fully and completely made. This date may differ from the date on which you sign the application form.
- If standard terms of acceptance are offered (no waiting periods or late-joiner penalties), your membership will be activated.
- For any non-standard terms, a counter-offer letter will be issued, which will indicate any conditions applicable to your membership (waiting periods and/or late-joiner penalties). Your membership will only be activated if you agreed to the new terms.
- We will send your Welcome notification via WhatsApp and an Encrypted email, if you appointed a financial adviser, the Welcome email will be sent to them via Encrypted email.

If you do not hear from the Scheme within seven days after submitting your application form, please contact us on **0860 100 345** or your financial adviser.

**When you sign this application, you confirm that you have read and understood the terms and conditions (Section 13 of this form) for membership as well as the Privacy statement and agree to them.**

## 1. About yourself (main applicant)

When do you want your cover to start? D **0** D **1** M M Y Y Y Y

Title | Initials

Surname

First names (as per identity document)

ID or passport number

Gender M F Date of birth D D M M Y Y Y Y

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

*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.*

Occupation

Tax Number | Gross monthly earnings **R** . 

Telephone (H) | Telephone (W)

Cellphone

Email

**Physical address**

Unit/Suite number | Complex name

Street number | Street name

Suburb

City | 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 | Post code

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

Title | Initials

Surname

First name (as per identity document)

ID or passport number

Gender M ☐ F ☐ Date of birth D D M M Y Y Y Y

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

*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.*

Marital status Married ☐ Single ☐ Divorced ☐ Widowed ☐

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 (as per identity document)

ID or passport number

Gender M ☐ F ☐ Date of birth D D M M Y Y Y Y

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

*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.*

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 attach proof of this relationship to this application.)

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 (as per identity document)

ID or passport number

Gender M ☐ F ☐ Date of birth D D M M Y Y Y Y

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

*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.*

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 attach proof of this relationship to this application.)

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 (as per identity document)

ID or passport number

Gender M ☐ F ☐ Date of birth D D M M Y Y Y Y

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

*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.*

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 attach proof of this relationship to this application.)

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 ☐

**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:**

4.1. 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.
4.2. I am appointed by the main applicant to provide advice about this application.
4.3. 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.
4.4. 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.

4.5. 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.**

## 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 ☐ | *Active Smart ☐ | Essential Delta ☐ | KeyCare Start Regional ☐ |
| | | | Coastal ☐ | | Coastal ☐ | |

*Subject to Council for Medical Schemes Approval

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 Saving 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, Pretoria, Johannesburg, 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 | | | |
| Spouse or partner | | | |
| Dependant 1** | | | |
| Dependant 2** | | | |
| Dependant 3** | | | |

** 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.

Employer's authorised signatory

Name

Designation

7.2. **Only complete this section if you own your own business and your business will be paying your contribution:**

Name of your business

Registration number | VAT number

Telephone | Fax

## 8. Your banking details

### 8.1. Your contributions

If you will be paying your contributions in full, please complete this section:

**Please note**: We cannot accept credit card account details and only South African banking details are accepted.

If we are debiting a third party account, the main member must sign next to the account holder.

Name of bank

Branch name | Branch code - -

Account number | Type of account Cheque Savings Other

Account holder

I agree to inform the Scheme in writing of any changes that may occur.

Account holder's physical address (own/3rd party/trust/company)

Unit/Suite number | Complex name

Street number | Street name

Suburb

City | Post code

Account holder contact details

Account holder email address

If we are debiting from a third party bank account, the main member must insert the ID or passport number of the third party.

ID or passport number

If the third party bank account is a Joint account Company account or Trust account

As part of Payment Association of South Africa (PASA) debit order mandate requirements you are required to supply the account holders residential address, email address and contact number. Please note that the details you supply will only be used for the PASA debit order mandate requirement and will not be used to update the contact details we have on system, if you wish to update any contact details please visit **www.discovery.co.za**.

We will debit the account on the first working day of the month. If the membership is not activated in time for the debit order collection and there is an amount outstanding Discovery Health will collect that amount in the interim, upon activation . Once your account is paid up to date, you may change your debit order date to a variable debit order date by contacting us on 0860 99 88 77.

### 8.2. Your claims refund

Can we use the same account we deduct contributions from to refund your claims? Yes No

If you do not want to use the same banking details for your contributions and claims refunds, please give us the details you would like to use.

**Please note:** We cannot accept credit card account details. We no longer issue cheques. If no details are provided it will impact your claims payment. If we are paying a third party bank account, the main member must insert the ID or passport number of the third party.

Name of bank

Branch name | Branch code - -

Account number | Type of account Cheque Savings Other

Account holder

If we are paying a third party bank account, the main member must insert the ID or passport number of the third party.

ID or passport number

If the third party bank account is a Joint account Company account or Trust account

Please provide proof of bank account. Refer to Annexure A at the back of the application form for the proof of bank account required.

By signing this application, you agree that once claims have been refunded into the bank account you have chosen, the Scheme will not be responsible in any way for the amounts refunded.

You understand that you may not transfer, assign, pledge or cede the payment or receipt of any benefit by or from the Scheme to any person and if you do or attempt to do so, the Scheme may withhold, suspend or discontinue the payment of such benefit.

Signature of account holder

Signature of main applicant

**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. However it is still the applicant's obligation to disclose any and all relevant information as required above.**

**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. However, it is still your obligation to disclose any and all relevant information as required. 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/investigated 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.

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 disorder, 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". If you answered 'Yes', please provide full details in the sections provided.**

### 11.1 Tumours, growths, cancerous, non-cancerous and disorders of the skin and breast

**Yes** ☐ **No** ☐

Example: 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, 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 to fall pregnant or trying to conceive or difficulty falling pregnant?** 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, coeliac disease, obesity, overweight, unintentional weight loss, incontinence, abdominal pain, colo-rectal symptoms/conditions Crohn's disease, ulcerative colitis, diverticulitis, Irritable bowel syndrome (IBS), Hemorrhoids, long standing constipation/diarrhea, 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, ventilator, oxygen therapy, CPAP 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, injury and muscle pain)

Yes ☐ No ☐

Example: arthritis (any form), ongoing/intermittent joint or muscular pain, ankylosing spondylitis, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, gout, physical disability, prosthesis and internal insertion of surgical implants, 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 (loss of bladder control or inability to empty the 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 conditions** Yes ☐ 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 conditions** Yes ☐ No ☐

Example: cataract, intra-ocular pressure, visual disturbances, night blindness, 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 conditions** Yes ☐ 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 conditions** Yes ☐ No ☐

Example: prostate disorders, urogenital defects, varicocele, abnormal PSA tests (prostate specific antigen), 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 ever been diagnosed with or received treatment for, any condition/symptoms or any allergic reactions or side-effects, 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 |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

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

When you engage with Discovery Health Medical Scheme, you are entrusting us 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, beneficiaries and life assureds, where applicable. To view and read our Privacy Statement, please follow this link: **https://www.discovery.co.za/medical-aid/about-discovery-health-medical-scheme** and scroll to, "YOUR PRIVACY IS IMPORTANT TO US" click on the **Privacy Statement link.**

Signature of applicant

Date D D M M Y Y Y Y

⚠ The applicant must sign and date any changes
Please only sign if you have read and understand this statement

**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.

## 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 as 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.
- I (main applicant) consent to my spouse and/or adult dependant, that is part of this application process, acting on my behalf and providing personal information, including health information, to Discovery Health for the purpose of my application to join Discovery Health Medical Scheme.
- we may be able to retrieve certain previous medical information we have for you and your dependants (if applicable) from previous memberships, however it is still the applicant's obligation to disclose any and all relevant information as required above.

13.4. ***Giving and getting information***

**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. It is still all applicant's obligation to disclose any and all relevant information as required above.

**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:
a) 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.
b) 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.

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.

13.5. ***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.

13.6. ***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

⚠ **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.
- Acknowlegement 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

## 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 use
  - 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.