# Application to add dependants 2024

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 you are 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 add your dependant/s to your Discovery Health Medical Scheme. This document is an application form to add dependants to your membership. The information requested in this application form is required to enable the Scheme to process your dependants application to your membership and to help in the administration of your membership as well better administer the affairs of the Scheme.

This application form also contains terms and conditions applicable to your membership (Section 10). Please make sure you read and understand these terms and conditions. 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 10) and the Scheme Rules. The full set of Scheme Rules is available on www.discovery.co.za/medical-aid/scheme-rules.
- 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.
- Sign section 5 (if you have a KeyCare plan), 9 and 11.
- Email the completed and signed form to **application@discovery.co.za.**
- Please attach a copy of each dependant's identity document. We also accept valid passports and birth certificates for children.

Once you send us 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 and your financial adviser (if you have chosen one) will receive a SMS or 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 and you (or your financial adviser if you appointed one) will receive a welcome letter. 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).
- You may accept the offer by signing and returning this letter to activate your membership. Once we receive your acceptance and you or your financial adviser will receive a welcome letter.

If you do not hear from the Scheme 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 10 of this form) for membership, which is available on request.**

Cover start date D 0 D 1 M M Y Y Y Y

## 1. Main member details

Membership number

ID or passport number

Member's name

Member's surname

## 2. Adding a spouse or partner (if applying for cover)

Only complete this section if you are adding a spouse or partner.

Title Initials

First name(s)

Surname

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

Race African Coloured Indian/Asian White Other

*You are not compelled to provide this information. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.*

Do not want to disclose race

ID or passport number

Marital status Married Single Divorced Widowed

Date of marriage to main applicant (where applicable). Please attach a copy of an official certificate. D D M M Y Y Y Y

Previous or maiden name

Telephone (H) Telephone (W)

Cellphone

Email

**Addition of spouse to an existing membership**

If addition of spouse or partner to an existing membership is:

- As a result of a legal and registered marriage within the last three months, an official certificate must accompany this application form to avoid underwriting.
- For a spouse married for a period of more than three months, full underwriting will apply.

## 3. About your dependants (if applying for cover)

**Dependant 1**

Title Initials

Surname

First names (according to identity document)

Gender M F

Race African Coloured Indian/Asian White Other

*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.*

Do not want to disclose race

Date of birth D D M M Y Y Y Y

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 How much does your dependant earn each month? **R** . 

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

Race African Coloured Indian/Asian White Other

*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.*

Do not want to disclose race

Date of birth D D M M Y Y Y Y

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 How much does your dependant earn each month **R** .

Does your dependant's spouse earn an income? ☐ Yes ☐ No How much does your dependant's spouse earn each month **R** .

**Dependant 3**

Title Initials

Surname

First names (according to identity document)

Gender M F

Race African Coloured Indian/Asian White Other

*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.*

Do not want to disclose race

Date of birth D D M M Y Y Y Y

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 How much does your dependant earn each month? **R** .

Does your dependant's spouse earn an income? ☐ Yes ☐ No How much does your dependant's spouse earn each month? **R** .

## 4. Your employer warranty (additions to employer groups need to be signed by the HR or payroll contact)

Please ensure your employer completes this warranty if you are part of an employer group.

4.1. We warrant that the member detailed in section 1 of this application form is an employee of our organisation.

4.2. The Discovery Health Medical Scheme may bill us for the amount due for this dependant in the same way as it does for our other employees with the Discovery Health Medical Scheme.

| | |
|---|---|
| Authorised signatory | |
| Name | |
| Designation | |

## 5. If you have a KeyCare Plan.

**Please complete this section if you selected a KeyCare plan.**

Income is defined as guaranteed gross monthly earnings of main member and 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.

Income verification will be conducted by the Scheme and Administrator who will verify the income amount declared below with a third party service provider i.e. credit bureau, when considering your membership application. Should there be an inconsistency between the income declared and the verification by the third-party service provider, we may request that an additional form be completed and additional supporting documentation be supplied in order to verify your income.

| | Main member | Spouse or Partner |
|---|---|---|
| Total earnings over the last 12 months | R | R |
| Total 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 10). I declare that this income declaration is true and accurate.

Signature of main applicant

Date D D M M Y Y Y Y

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

- 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

| | 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.

## 6. 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 ☐ | |

## 7. Moving from another medical scheme

**Please make sure that you have completed section 6**.

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

7.1.1 have not had a break in membership of more than 90 days since resigning from the previous South African medical scheme, and Yes ☐ No ☐

7.1.2. 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 7.2.

If you answer no to any question in 7.1, you must complete all the medical questions in section 8.

7.2. For any person named on this application form:

7.2.1. Have they been admitted to hospital in the 12 months before this application? Yes ☐ No ☐

7.2.2. Are they currently taking regular, ongoing medicine and/or treatment of a medical condition or symptom? Yes ☐ No ☐

7.2.3. 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 no to all questions in **7.2,** we will not apply any waiting periods and you **do not have to complete section 8.**

If you answered yes to any questions in 7.2, we will apply a three-month general waiting period to your application and you **do not have to complete Section 8.**

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 8. During these three months, we will only cover claims relating to Prescribed Minimum Benefits according to the Scheme's rules. Information regarding your previous medical history and your details that are held by your previous medical scheme will not be automatically transferred to Discovery Health Medical Scheme.

## 8. Your health questions

We may be able to retrieve certain previous medical information for you and your dependants (if applicable), we have from previous policies. By signing this, you agree that we may utilize 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)**

Do **you or any dependants** in this application have any of the following symptoms or conditions, or have you ever had them or received treatment for them? We listed some examples of the conditions and symptoms under each question; these are only examples, it is not a full list. When you answer, please include congenital conditions (inborn abnormalities).

We only use this information for lawful purposes. We use the information so we can:

- Process your application.
- Administer your membership in the best way.
- Verify if the information you give us on this application form is true and complete.

- Give you customised information that is relevant to your health status.
- Develop disease management programmes for specific conditions.
- Review and improve the medical scheme benefits.
- Improve the Scheme's financial modelling.
- Better assess and lower our risk.

A condition-specific waiting period on your membership if you or your dependant received a diagnosis or any medical advice, care or treatment for the condition or symptoms, or if it was recommended. This is if it was within the 12 months before you applied. The 12-month period ends on the date on which we consider this application as 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 8.18 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".**

### 8.1 Tumours, growth 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, lump in breast, abnormal mammogram result, abnormal PSA (prostate specific antigen) result, abscess, any autoimmune conditions or other skin conditions, and any congenital conditions.

| Patient name | Symptoms/Medical diagnosis | Date first diagnosed/ symptoms | Date of last symptoms, consultations and/or hospitalisation | Medicine used for this condition and dosage | Date of last treatment taken |
|---|---|---|---|---|---|
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### 8.2 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, peripheral vascular disease ,deep vein thrombosis, pulmonary embolus, any autoimmune conditions, and any congenital conditions, varicose veins.

| Patient name | Symptoms/Medical diagnosis | Date first diagnosed/ symptoms | Date of last symptoms, consultations and/or hospitalisation | Medicine used for this condition and dosage | Date of last treatment taken |
|---|---|---|---|---|---|
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### 8.3 Gynaecological and Obstetric conditions

**Yes** ☐ **No** ☐

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

| Patient name | Symptoms/Medical diagnosis | Date first diagnosed/ symptoms | Date of last symptoms, consultations and/or hospitalisation | Medicine used for this condition and dosage | Date of last treatment taken |
|---|---|---|---|---|---|
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**8.4 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, consultations and/or hospitalisation | Medicine used for this condition and dosage | Date of last treatment taken |
|---|---|---|---|---|---|
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**8.5 Mental health** Yes ☐ No ☐

Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (i.e. 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, and any other psychological conditions, any autoimmune conditions, and any congenital conditions.

| Patient name | Symptoms/Medical diagnosis | Date first diagnosed/ symptoms | Date of last symptoms, consultations and/or hospitalisation | Medicine used for this condition and dosage | Date of last treatment taken |
|---|---|---|---|---|---|
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**8.6 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, and any congenital conditions.

| Patient name | Symptoms/Medical diagnosis | Date first diagnosed/ symptoms | Date of last symptoms, consultations and/or hospitalisation | Medicine used for this condition and dosage | Date of last treatment taken |
|---|---|---|---|---|---|
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**8.7. Abdominal conditions** Yes ☐ No ☐

Example: hepatitis, cirrhosis, portal hypertension, alcoholic 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, and any congenital conditions.

| Patient name | Symptoms/Medical diagnosis | Date first diagnosed/ symptoms | Date of last symptoms, consultations and/or hospitalisation | Medicine used for this condition and dosage | Date of last treatment taken |
|---|---|---|---|---|---|
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### 8.8 Brain and nerve conditions

Yes ☐ No ☐

Example: stroke, epilepsy, seizures, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, Parkinson's disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, brain shunt (VP shunt used to drain fluid from the brain),Intellectual disability, CVA, bleeding on the brain, any autoimmune conditions, any congenital conditions and down's syndrome.

| Patient name | Symptoms/Medical diagnosis | Date first diagnosed/ symptoms | Date of last symptoms, consultations and/or hospitalisation | Medicine used for this condition and dosage | Date of last treatment taken |
|---|---|---|---|---|---|
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### 8.9 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, and any congenital conditions.

| Patient name | Symptoms/Medical diagnosis | Date first diagnosed/ symptoms | Date of last symptoms, consultations and/or hospitalisation | Medicine used for this condition and dosage | Date of last treatment taken |
|---|---|---|---|---|---|
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### 8.10 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, 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, consultations and/or hospitalisation | Medicine used for this condition and dosage | Date of last treatment taken |
|---|---|---|---|---|---|
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### 8.11 Kidney or urinary conditions including current or past dialysis

Yes ☐ No ☐

Example: kidney 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, and any congenital conditions.

| Patient name | Symptoms/Medical diagnosis | Date first diagnosed/ symptoms | Date of last symptoms, consultations and/or hospitalisation | Medicine used for this condition and dosage | Date of last treatment taken |
|---|---|---|---|---|---|
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### 8.12 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, and any congenital conditions, varicose veins.

| Patient name | Symptoms/Medical diagnosis | Date first diagnosed/ symptoms | Date of last symptoms, consultations and/or hospitalisation | Medicine used for this condition and dosage | Date of last treatment taken |
|---|---|---|---|---|---|
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### 8.13 Eye conditions

Yes ☐ No ☐

Example: cataract, keratoconus, 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, and any congenital conditions.

| Patient name | Symptoms/Medical diagnosis | Date first diagnosed/ symptoms | Date of last symptoms, consultations and/or hospitalisation | Medicine used for this condition and dosage | Date of last treatment taken |
|---|---|---|---|---|---|
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### 8.14 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, and any congenital conditions.

| Patient name | Symptoms/Medical diagnosis | Date first diagnosed/ symptoms | Date of last symptoms, consultations and/or hospitalisation | Medicine used for this condition and dosage | Date of last treatment taken |
|---|---|---|---|---|---|
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### 8.15 Male urogenital conditions

Yes ☐ No ☐

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

| Patient name | Symptoms/Medical diagnosis | Date first diagnosed/ symptoms | Date of last symptoms, consultations and/or hospitalisation | Medicine used for this condition and dosage | Date of last treatment taken |
|---|---|---|---|---|---|
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**8.16 Are any of your dependants expecting surgery or planning hospitalisation or treatment in the next 12 months or have they been admitted to hospital in the last 12 months?** Yes ☐ No ☐

| Patient name | Symptoms/Medical diagnosis | Date first diagnosed/ symptoms | Date of last symptoms, consultations and/or hospitalisation | Medicine used for this condition and dosage | Date of last treatment taken |
|---|---|---|---|---|---|
| | | | | | |
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**8.17 Have 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, consultations and/or hospitalisation | Medicine used for this condition and dosage | Date of last treatment taken |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**8.18 Have any of your dependants been diagnosed with or received treatment for, any condition 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, consultations and/or hospitalisation | Medicine used for this condition and dosage | Date of last treatment taken |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**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.

## 9. 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 main member

Date D D M M Y Y Y Y

**The main applicant must sign and date any changes.**

⚠ **Please only sign if you have read and understand this statement**

## 10. 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 ☐

10.1. **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.

10.2. **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.

10.3. **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:
  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.

  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.

10.4. **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.

10.5. **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

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

## 11. 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.
- Acknowledgment 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 signature

Date D D M M Y Y Y Y

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