Broker House Name: Aon South Africa (Pty) Ltd
Broker House Code: 1004785125
Broker Code: 1020031108

Applying to join Discovery Health Medical Scheme as part of an employer group in 2026

(with limited underwriting)

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. It 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**; Postal address: PO Box 784262, Sandton, 2146; Physical address: 1 Discovery Place, Sandton, 2196; Website: **www.discovery.co.za**.

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 the administration of your membership as well as to better administer the affairs of the Scheme. This application form also contains terms and conditions applicable to your membership (see 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

- You can fill in the form in writing, printing clearly and using black ink, or 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.
- The main applicant must sign all the relevant sections. The main applicant must sign and date any changes.
- Please attach a copy of each applicant's identity document. We accept valid passports and birth certificates for children.
- Read and understand the terms and conditions for membership (section 13) and the Scheme Rules. The full set of Scheme Rules is available at **www.discovery.co.za/medical-aid/scheme-rules**.
- This form lets you give us information about you and your dependants' race. This information is needed by the Council for Medical Schemes only for statistical purposes. You do not have to fill in this information.
- You must sign sections 7, 10 and 11.
- Email the completed and signed form to **application@discovery.co.za**.

Once you send us your application form, here is what will happen:

- We will contact you if any details are missing or if we need more information for underwriting purposes and to process your application.
- You will get a notification and you (and your financial adviser, if you have one) will get an email to let you know when your application is considered to be complete. This date may differ from the date on which you sign the application form.
- We will send your welcome notification by **WhatsApp.** We will send the welcome letter to you and to your financial adviser (if you have one) by **encrypted email.**
- If **standard terms** of acceptance are offered (no waiting periods or late-joiner penalties), we will activate your membership.
- If there are **non-standard terms**, we will send you a **counter-offer letter showing the terms that apply** showing the terms that apply to your membership (waiting periods or late-joiner penalties). We will only activate your membership once you agree to the new terms.

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

When you sign this application, you confirm that you have read and understood the terms and conditions for membership (section 13 of this form), as well as the privacy statement, and that you 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 in 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

This information is not mandatory. The Council for Medical Schemes collects this information 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 PO 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

City | Postal code

2. About your spouse or partner (only complete if you're also applying for cover for them)

Title | Initials

Surname

First names (as in 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

This information is not mandatory. The Council for Medical Schemes collects this information for statistical purposes.

Marital status Married Single Divorced Widowed

Telephone (H) | Telephone (W)

Cellphone

Email

3. About your dependants (only complete if you're applying for cover for them)

Dependant 1

Title Initials

Surname

First names (as in 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

This information is not mandatory. The Council for Medical Schemes collects this information 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 over 18 years provide cellphone number

If your dependant is 21 years or older:

Are they married? Yes No

Are they financially dependent on you? Yes No

Do they earn an income? Yes No

Does their spouse earn an income? Yes No

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

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

Dependant 2

Title Initials

Surname

First names (as in 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

This information is not mandatory. The Council for Medical Schemes collects this information 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 over 18 years provide cellphone number

If your dependant is 21 years or older:

Are they married? Yes No

Are they financially dependent on you? Yes No

Do they earn an income? Yes No

Does their spouse earn an income? Yes No

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

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

Dependant 3

Title Initials

Surname

First names (as in 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

This information is not mandatory. The Council for Medical Schemes collects this information 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 over 18 years provide cellphone number

If your dependant is 21 years or older:

Are they married Yes No

Are they financially dependent on you? Yes No

Do they earn an income? Yes No

Does their spouse earn an income? Yes No

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

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

Are you applying for more than three dependants? Yes No

Note: If you are applying for more than three 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 – to be completed by your financial adviser, if you have one

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 give advice about this application.

4.3. I have a valid contract with Discovery Health Medical Scheme and I have told the client about the commission that Discovery Health Medical Scheme pays me.

4.4. I am responsible for giving the main applicant:
- My name, physical address, postal address and the telephone number
- Impartial advice that is in the main applicant's best interest.

4.5. I am accountable for any advice I give to the main applicant about completing this application form and joining Discovery Healthcare Fund.

Signature of financial adviser

Broker House Name: Aon South Africa (Pty) Ltd
Broker House Code: 1004785125
Broker Code: 1020031108

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 Saver Series	Smart Series	Core Series	KeyCare Series
Executive	Classic	Classic	Classic	*Classic Smart	Classic	Classic	KeyCare Plus
	Classic Smart	Essential	Classic Delta	*Essential Smart	Essential	Classic Delta	KeyCare Core
			Essential		Essential Dynamic	Essential	KeyCare Start
			Essential Delta		Active Smart	Essential Delta	KeyCare Start Regional
			Coastal			Coastal	

**Available from 1 January 2026 subject to approval by the Council for Medical Schemes*

You have the right to ask for help in choosing a health plan that suits your needs. Whether you have had help or made the decision on your own, by signing this application you confirm that you understand the conditions and benefits of the plan you choose.

I would like to select that my health plan complies with the requirements of Shariah. Yes ☐ No ☐

How would you like us to refund claims from the Medical Savings Account if your plan has one? Discovery Health Rate ☐ Cost ☐

Discovery Health Rate is the medical scheme rate as long as you have funds available. **Cost** is the full amount of the claim as long as you have funds available.

When you make a claim that is qualifies 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 has carried over to the current year.

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 add the details on a separate page if you are applying for more than three dependants.

6. About your employer

Please ask your employer to complete this section.

Name of employer: **LANCET LABORATORIES PTY LTD**

Employer or billing number: **3737013**

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: **Lancet**

Branch number: **Branch 01**

Employer warranty

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

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

6.2. The 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 with the Discovery Health Medical Scheme.

Employer's authorised signatory:

Name: **Seleena Govender**

Designation: **HR REPRESENTATIVE**

7. Your banking details (claim refunds)

Please note: We cannot accept credit card account details. We no longer issue cheques. If you do not give any details, it will affect your claims payment. If we are paying a third-party bank account, the main member must enter the ID or passport number of the third party.

Bank name:

Account number:

Type of account: Savings ☐ Cheque/Transmission/Transaction ☐

Account holder:

If third-party bank details, please enter the third-party ID or passport number:

If the third-party bank account is a: Joint account ☐ Company account ☐ Trust account ☐

Please provide proof of bank account. Annexure A to this form explains which types of proof of bank account are needed.

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 and authorise Discovery Health to contact the account holder provided above to verify payments made or received, if necessary.

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. If you do or attempt to do so, the Scheme may withhold, suspend or discontinue the payment of the benefit.

Signature of account holder		Date	D D M M Y Y Y Y
Signature of main applicant		Date	D D M M Y Y Y Y

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

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

Please give us the details of all the registered South African medical schemes that you and your dependants who are being added belonged to previously. We will use this information to decide if we need to apply late-joiner penalty fees. We may also sue the information on the membership certificate to decide if we can apply the waiting periods. However, it is still your obligation to disclose the relevant information that we have asked for.

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

If you and your dependants who are applying for the cover belonged to different medical schemes, please fill in the information 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 ☐	
				Yes ☐ No ☐	

9. Your health questions

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)

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 (which includes whether to impose a waiting period on your membership) and any other relevant uses.

Please note that the Council for Medical Schemes has oversight over any irregular use of your or your dependant's health information.

Please also note that the Medical Schemes Act restricts the ability of the Scheme to impose waiting periods. A condition specific waiting period cannot be imposed on you or any of your dependants relating to any condition that you disclose in this application except if you or your dependant received or were recommended any medical advice, diagnosis, care or treatment in respect of such a condition within a 12-month period ending on the date on which this application is considered to be fully and properly made.

Information disclosed by you relating to health conditions prior to the preceding 12 months can serve as a basis for the Scheme requiring that you undergo a medical examination, at the Scheme's cost. Should that medical examination reveal a current health condition, waiting periods may be applied in respect of such current condition.

Below we require you to advise us about whether **you or any dependant/s** specified in this application **at any time** have 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.

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.

Please also note that you must tell us in writing if any of the information you gave, in **this** 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 further that any indication of existing medical conditions on this application does not automatically enrol 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.

9.1 Do you or any dependants have any heart or 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, vericose veins

Patient name	Symptoms/Medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine or surgical procedure/intervention used for this condition and dosage	Date of last treatment within the last 12 months

9.2 Do you or any dependants have any 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, overweight, obesity, metabolic disorders, Conn’s syndrome, any autoimmune conditions, any congenital conditions

Patient name	Symptoms/Medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine or surgical procedure/intervention used for this condition and dosage	Date of last treatment within the last 12 months

9.3 Do you or any dependants have any tumours or growths (cancerous and non-cancerous) or 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 or any other abnormal cancer-screening or diagnostic test result/s or other skin conditions

Patient name	Symptoms/Medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine or surgical procedure/intervention used for this condition and dosage	Date of last treatment within the last 12 months

9.4 Are you or any of your dependants pregnant or trying to conceive or having difficulty falling pregnant or having treatment or investigation to fall pregnant? Yes ☐ No ☐

Patient name	Symptoms/Medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine or surgical procedure/intervention used for this condition and dosage	Date of last treatment within the last 12 months

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

Patient name	Symptoms/Medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine or surgical procedure/intervention used for this condition and dosage	Date of last treatment within the last 12 months

9.6 Have you or any dependants had any symptoms or had any medical advice from a medical professional about a symptom or condition not yet diagnosed, or ever been diagnosed with, or received treatment for, any condition, symptoms or allergic reactions or side-effects not mentioned in the questions above, in the last 12 months?

Yes ☐ No ☐

Patient name	Symptoms/Medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine or surgical procedure/intervention used for this condition and dosage	Date of last treatment within the last 12 months

HIV and AIDS

If you or any of your dependants are , you or they must call us on **0860 99 88 77** within seven working days of the date we activate your Discovery Health Medical Scheme membership. We treat this information in the strictest confidence. If you or any of your dependants are , it is in your interest to register on the HIVCare Programme. Discovery Health Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set period before Discovery Health Medical Scheme starts paying for any general or specific medical conditions. A 12-month condition-specific waiting period or a 3-month general waiting period may apply to this condition or any related condition. If you do not let us know about your or your dependant's HIV status within 7 days of your membership being active, we may end your Discovery Health Medical Scheme membership.

10. 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 go to: **https://www.discovery.co.za/medical-aid/about-discovery-health-medical-scheme**. Under, **Your privacy is important to us**, click on **Privacy Statement**.

Signature of main 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.

11. Terms and conditions of Discovery Health Medical Scheme memberships

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.

May the Scheme and its Administrator send you direct electronic marketing (related to the business of the Scheme) from time to time? No, thank you ☐ Yes, I agree ☐

11.1. ***Scheme rules for membership***

The rules of the Scheme record your rights and responsibilities for your membership. The rules may change from time to time. You may ask us for a copy of these rules at any time or view these rules at **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 by the Scheme rules.
Where applicable, you also acknowledge and confirm that you, your financial adviser or your employer may communicate with us about 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 dependants with your chosen financial adviser. The information will be shared so that they 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.

11.2. ***Who you are applying for***

You may apply to join the Scheme on your own or together with other people – your spouse or partner and people who are financially dependant on you as defined in the Scheme rules, as referred to above. For anyone to be treated as financially dependant 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 will be called the principal member or main member in our future communications to you.

11.3. ***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 or partner and any dependants over the age of 18 to act for them in any matter relating to this application.
- You consent to your spouse or adult dependant, who is part of this application process acting on your behalf and providing personal information, including health information, to Discovery Health for the purpose of your application to join Discovery Health Medical Scheme.
- Discovery Health may be able to retrieve certain previous medical information we have for you, your spouse or partner and your dependants (if applicable) from previous memberships. However ,you must still disclose any and all relevant information as asked for above.

11.4. ***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 or older for more information about themselves. All the applicants still have to disclose all relevant information as asked for 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 we need 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) get your personal information from other relevant sources, including medical practitioners, contracted service providers, financial advisers, credit bureaus or industry regulatory bodies ('relevant sources'). They may process this information to consider your membership application, to conduct underwriting or risk assessments, to consider a claim for medical expenses, to profile and analyse risk or to investigate fraud, waste 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 memberships

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.

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 days before the date of application.

In accordance with the Medical Schemes Act, we ask you to make sure that you disclose true and complete information to the Scheme. It is always better to disclose too much than too little.

Giving 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 your membership being cancelled for this reason.

11.5. ***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 let you know if any waiting periods apply. Please speak to your financial adviser or the Administrator about any waiting periods that apply 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 make sure contributions are paid on time
As the main member of the Scheme, you are responsible for making sure 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 change monthly contributions and benefits from time to time with prior notification.

11.6. ***Repaying money owed to the Scheme***
The Scheme has the right to collect from you any amount that you owe at any time.
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 choose, 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 ends, 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 by the reference number 'DISCSETTLE'.

Signature of main applicant ______ Date D D M M Y Y Y Y

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

This form is only a complete application when it contains all the information we need to fully process your application. We take the date on which we receive the complete application as the application date, and not the date on which you sign the form.

12. Debit order mandate

This signed Authority and Mandate refers to the application on the signed date (`the Agreement').

- Warrant that the account information provided is either in my name or that I have the authority to use this account for debit order purposes and that the information given by me in this Authority and Mandate is true and correct.
- I 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 in terms of this application. This is on condition that the sum of these payment instructions will never be higher than my obligations set out in the Agreement, which will start on the date that cover starts as requested on the application form and will continue until I end this Authority and Mandate. I can end this Authority and Mandate by giving Discovery Health at least 20 ordinary working days' written notice or, immediately, by instructing 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 afterwards on the same day 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.
- I 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.
- I undertake to tell 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 because I have given the incorrect banking details here, or if the bank account is in the name of another person or entity, or because I did not tell Discovery Health about a change in banking details, or if the bank account does not have enough funds to meet my obligations in terms of the Agreement.
- I know and understand that the withdrawals I authorise here will be processed through a computerised system offered 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 on the Agreement so I can identify this membership.
- I acknowledge that although this Authority and Mandate may be ended by me, that will not necessarily end this Agreement. If it is ended, I am not entitled to any refund of any premiums or amounts due that were withdrawn by Discovery Health while this Authority and Mandate was in force, if the premiums or amounts were legally owing to Discovery Health in terms of the Agreement.
- I acknowledge that by signing this Authority and Mandate I am bound by the payment terms applicable to this Agreement.
- I acknowledge that this Authority and Mandate may be assigned to a third party if this Agreement is also assigned to a third party.

Reference number

This Agreement reference number: System generated reference number

Abbreviated name

Abbreviated name as registered with the bank: DISCPREM

Deduction amount: As in your activation of membership letter

Deduction date: As in section 1 of your membership application form

Payment start date: As in section 1 of your membership application form

Account holder name			
Signature of applicant		Date	D D M M Y Y Y Y

The applicant must sign and date any changes.
Please only sign if information is true, complete and correct.

This form is only a complete application when it contains all the information we need to fully process your application. We take the date on which we receive the complete application as the application date, and not the date on which you sign the form.

13. Annexure A: Third-party bank details

Banking details for a third party

A third party can be anyone, such as your spouse, aunt, uncle, friend, parent or adult child. Please attach the relevant proof of bank account if you give a third-party's bank account details for claim refunds or contribution debit orders.

Documents we need for a third-party bank account

- 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 people who have authority to sign on behalf of the company
- A letter of authority. The letter must:
  - State that the account can be used
  - State the membership details (including the membership or policy numbers) for which the bank account will be used
  - Include the details of the signatory
  - Be dated and signed by an authorised person on behalf of the company.
- A copy of the company's certificate of registration
- A copy of the main member's ID, passport or driving licence.

Documents we need for a trust account

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

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

AON

Benefits of appointing
Aon South Africa Healthcare as your intermediary

Across Aon, we are united in our passion to provide you with the insights and support to make Better Decisions around all aspects of your holistic wellbeing, medical scheme, gap cover and primary care insurance. We have a team of professional, fully accredited advisors to assist you with all your medical schemes, Gap cover and Primary care enquiries.

Our philosophy is to:

Guide:
our members in selecting the medical scheme, Gap cover insurance or Primary care options aligned to their needs.

Educate:
our members with ongoing training throughout the year, end of year medical schemes and Gap cover benefits and rate changes.

Protect:
the rights of members by applying the Medical Scheme Act and scheme rules when resolving disputes with the medical schemes on behalf of the members.

Catalogue of services and technological platform accessible to our members

- **Microsites:** Provides you with access to voice recorded Induction, Year-end launch highlight presentations, brochures, COVID-19 updates, various application forms.
- **Aon Resolution Centre:** Professional assistance with your Medical scheme, Gap cover or Primary care claim resolution, comparison or benefit explanation.
- **Year-end renewal communications:** Access to the following:
  - Alert - Provides high level summary of benefits and rates changes launched by medical scheme, Gap cover insurance as well as Primary care providers.
  - Member letter - Provides comprehensive information in relation to the benefits and rates changes implemented by Medical scheme, Gap cover or Primary care provider.
  - Guidance letter - Aon generates guidance letters for members that are under or over insured. The purpose of the guidance letter is to guide a member on selecting an appropriate option aligned to his/her needs.
  - **Client Assistance Programme** - We are delighted to offer you access to a range of essential services at absolutely no charge. The Aon Client Wellbeing Programme is a telephonic, online, and structured e-mail support program (excluding in-person or video sessions). The following services are available through our third- party service provider, LifeAssist:
    - Structured Telephonic Counselling
    - Telephonic Trauma Support
    - Financial Wellbeing Coaching
    - Legal Advisory Services
    - Health and Wellness Services (professional advice from a dietician and a biokineticist)
- **General Updates:**
  - Ad-hoc updates pertaining to Medical schemes industry and providers specific updates.

Cost of appointing Aon

We are pleased to inform you that there is no additional fee charged by Aon when you appoint Aon Healthcare as your Healthcare intermediary. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme whether you have appointed Aon as broker or not. This monthly commission is 3% of the contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Section 65 of the Medical Schemes Act, 131 of 1998, plus value added tax (VAT). In terms of Primary Care Insurance products, we earn maximum 3%. Gap Cover Insurance products, we earn commission on a sliding scale from 5% up to 20% depending on policy holder's monthly contributions.

For more information, contact Aon South Africa:
0860 100 404 | arc@aon.co.za | www.aon.co.za

Connect with us

We focus on communication and engagement, across insurance retirement and health, to advise and deliver solutions that create great client impact. We partner with our client and seek solutions for their most important people and HR challenges. We have an established presence on social media to engage with our audiences on all matters related to risk and people.

For more information from Aon Employee Benefits on healthcare, retirement benefits and a wide range of topics feel free to go to **www.aon.co.za**

http://www.facebook.com/Aonhealthcare
Click "Like" on our page (Aon healthcare)

http://twitter.com/Aon_SouthAfrica
Click "follow" on our profile

Aon Employee Benefits – Healthcare

Aon South Africa Pty Ltd, an Authorised Financial Service Provider, FSP # 20555.

http://www.aon.co.za/disclaimer
On all services provided, Aon's Terms & Conditions of Business, as amended from time to time, are applicable and can be found at http://www.aon.co.za/terms-of-trade or will be sent to you upon request.

Privacy Notice

Disclaimer:

The Benefits and contributions are subject to approval by the council for medical schemes. Although care is taken to represent the rates and benefits correctly, errors and omissions could occur. In case of any conflict, the rules of the affected medical scheme prevail. Any decisions regarding your medical scheme portfolio should be made in conjunction with your Aon Employee Benefits consultant or manager. While Aon has taken reasonable steps to ensure that the information contained in this report is relevant, accurate and current, no warranties of any kind, whether express or implied, including but not limited to the accuracy, completeness, relevance or fitness for a particular purpose are given and Aon expressly disclaims any liability for any loss or damage that may arise from the use of this report. This report is confidential and intended solely for the use of the individual or entity to whom it is addressed. If you received this report in error, you should not disseminate, distribute or copy this report and you should notify Aon if you are not the intended recipient and destroy the report. The report is copyright of Aon SA (Pty) Ltd. You may not, except with our express written permission, distribute or commercially exploit the report. Aon hereby authorizes you to copy the report for non-commercial use within your organization only.

POPIA

Protection of Personal Information Act 4 of 2013 (POPIA), Medical Schemes are requesting a signed Broker Appointment letter to make certain information available to Aon South Africa (Pty) Ltd.

Contact us on: 0860 100 404, P.O. Box 78367, Sandton, 2146, www.aon.co.za
FSP number: 20555; CMS number: ORG895
Follow our website link for further information on Aon's processing of your personal information

Acknowledgement of appointment

I acknowledge and appoint Aon South Africa (Pty) Ltd as my financial advisor for all matters related to my medical scheme membership.

My ID: ____________________ and membership number: ____________________

Signed at (Town or City): ____________________ on yy/mm/dd: ____________________

I have been informed that there is no additional fee charged by Aon for providing you with healthcare intermediary services. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme. This monthly commission is 3% of the monthly contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Section 65 of the Medical Schemes Act, 131 of 1998, plus Value Added Tax (VAT).

Permission to process my personal information as well as personal information of all dependents included on my membership application form and I consent to Aon South Africa (Pty) Ltd accessing information listed on the table below.

I give consent for the disclosure of information about me.

Membership number: ____________________ ID or passport number: ____________________

Title: __________ Initials: __________ Surname: ____________________

First name(s) (as per identity document): ________________________

The following information should be made available to my appointed financial advisor as is necessary:

Personal examples	Benefit examples	Financial examples	Medical examples
* Name and Surname * Membership number * Date of birth * ID number * Postal Address * Physical address * E-mail Address * Telephone numbers * Cellular Number * Number of dependents	* Plan type * Medical Savings Account (MSA) * Balance Medical Scheme benefits * Spent for the year Accumulated * Medical scheme Savings Account * Medical Savings Carry over from previous year * MSA reimbursement, Scheme Rate or cost * Self-payment Gap * Above Threshold Benefit * Waiting period details * Late joiner penalty indicator * Wellness benefits	* Total Contribution * Contribution breakdown	* Chronic Indicator/ confirmation (Yes/No) * In Hospital Indicator/ confirmation (Yes/No) * Confirmation of claims paid and from what benefit * Claims transaction history * Procedures done in doctor's rooms paid from Hospital Benefit

By signing this letter of appointment , I confirm that I have fully read and understood the contents of this document and provide my express consent for Aon South Africa (Pty) Ltd ("Aon") to process my Personal Information including but not limited to special personal information, as well as that of my beneficiaries and where necessary including my minor children (as defined in the Protection of Personal Information Act no 4 of 2013) for the purposes set out herein and which Personal Information may be shared and or disclosed with any party including but not limited to service providers who Aon (in it's reasonable discretion) has an obligation or requirement to share or disclose my Personal Information and that of my beneficiaries and where necessary my minor children in compliance with its obligations in law or contract.

Signed at (Town or City): ______________________ on yy/mm/dd: _____________________

Signature: ____________________

Broker House Name: Aon South Africa (Pty) Ltd
Broker House Code: 1004785125
Broker Code: 1020031108