Application to add dependants 2026

Discovery Health Medical Scheme

Who we are

Discovery Health Medical Scheme, (referred to as the "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 provide. 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**, **www.discovery.co.za**, PO Box 784262, Sandton, 2146, 1 Discovery Place, Sandton, 2196.

Purpose of the form
This document is an application form to add dependants to your membership. We need the information that we ask for in this application form so that the Scheme can process your dependants application to your membership. It will help to administer your membership and to administer the Scheme.

This application form has terms and conditions that apply to your membership see section 11. Please make sure you read and understand these terms and conditions. This document is valid for 90 days from the date that you sign it. The footnote on each page shows 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.z**a, 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.
- Read and understand the terms and conditions for membership (section 11) and the Scheme Rules. The full set of Scheme Rules is available on **www.discovery.co.za/medical-aid/scheme-rules**.
- This form lets you and your dependants give us information about your 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 9 and 11. You must sign section 5 if you have a KeyCare plan.
- 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:

- We will contact you if any details are missing or if we need more information for underwriting purposes to process your application.
- You and your financial adviser (if you have one) will receive a notification or 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.
- If standard terms of acceptance apply (no waiting periods or late-joiner penalties), we will activate your membership and send you (or your financial adviser if you have one) a welcome letter. If non-standard terms apply, we will send you a counter-offer letter showing those terms (waiting periods or late-joiner penalties).
- If you would like to accept the counter-offer, you can sign and return the letter to activate your membership. Once we receive your signed acceptance, we will send you or your financial adviser 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 speak to your financial adviser.

When you sign this application, you confirm that you have read and understood the terms and conditions (section 11 of this form) for membership, which is available on request.

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

1. Main member details

Membership number

ID or passport number

Member's surname

Member's name

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

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

Title | Initials

Surname

First name(s)

Previous or maiden name

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

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

Telephone (H) Telephone (W)

Cellphone

Email

Addition of spouse to an existing membership

- If a spouse is being added to an existing membership because of a legal and registered marriage within the last three months, you must attach an official certificate to this application form to avoid underwriting
- If the spouse is being added to an existing membership more than three months after the marriage, full underwriting will apply

3. Adding your dependants (if applying for cover)

Only complete this section if you are adding a dependant.

Dependant 1

Title | Initials

Surname

First names (according to identity document)

ID or passport number

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

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

You do not need to fill this form about your race. 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 give us legal proof of the relationship.)

If over 18 years provide cellphone number

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

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 (according to identity document)

ID or passport number

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

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

You do not need to fill this form about your race. 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 give us legal proof of the relationship.)

If over 18 years provide cellphone number

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

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 (according to identity document)

ID or passport number

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

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

You do not need to fill this form about your race. 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 give us legal proof of the relationship.)

If over 18 years provide cellphone number

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

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** .

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

Please make sure 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 Petro Nel

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 the main member and spouse before deductions. If you have selected a KeyCare plan, income verification will be done 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 done by the Scheme and Administrator who will verify the income amount declared below with a third-party service provider (credit bureau), when considering your membership application. If there is 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 11.7 of the terms and conditions of membership (section 11). 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 the registered South African medical schemes that 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 your dependants on a medical scheme Yes No

If your dependants who are applying for the cover belonged to 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	

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 Yes No

7.1.2. Are currently or were members of a South African medical scheme for at least the past 24 months Yes No

If you answered **yes** to both questions in **7.1**, please answer the questions in **section 7.2**.

If you answered **no** to either question in **7.1**, please answer 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 or having regular, ongoing treatment for 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 or investigations costing more than R2,000 in the next 12 months? Yes ☐ No ☐

If you answered **yes** to all questions in **7.1**,you **do not have to complete section 8**.

During a three month general waiting period, if applicable, we will only cover claims relating to Prescribed Minimum Benefits according to the Scheme's rules. Information about dependant/s previous medical history and dependant/s details that are held by the previous medical scheme will not be automatically transferred to Discovery Health Medical Scheme.

8. 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.

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

8.1 Tumours, growths, cancerous, non-cancerous and disorders of the skin and breast **Yes** ☐ **No** ☐

Example: skin lesions, eczema, psoriasis, breast disease, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, lump in breast, abnormal mammogram result, abscess, any autoimmune conditions or other skin conditions, and any congenital conditions.

Patient name	Symptoms/medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment within the last 12 months

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 of first diagnosis or first	Date of last symptoms,	Medicine used for this condition and	Date of last treatment within the

		sign of symptoms	consultations and/ or hospitalisation within the last 12 months	dose	last 12 months

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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment taken within the last 12 months

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

Patient name	Symptoms/medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment taken within the last 12 months

8.5 Mental health Yes ☐ No ☐

Example: mood disorders (like depression and 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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment taken within the last 12 months

8.6 Metabolic or endocrine conditions Yes ☐ No ☐

Example: overweight, obesity, 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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment taken within the last 12 months

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, coeliac disease, obesity, overweight, unintentional weight loss, incontinence, abdominal pain, colo-rectal symptoms/conditions, Crohn's disease, ulcerative colitis, diverticulitis, Irritable Bowel Syndrome (IBS), Hemorrhoids, long standing constipation/diarrhea, ascites (fluid in the abdomen), any autoimmune conditions, and any congenital conditions.

Patient name	Symptoms/medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment taken within the last 12 months

8.8 Brain and nerve conditions **Yes** ☐ **No** ☐

Example: ventilator, oxygen therapy, CPAP, 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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment taken within the last 12 months

8.9 Breathing and respiratory conditions **Yes** ☐ **No** ☐

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

Patient name	Symptoms/medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment taken within the last 12 months

8.10 Musculoskeletal (back, bone, injury and muscle pain) **Yes** ☐ **No** ☐

Example: arthritis (any form), ongoing/intermittent joint or muscular pain, ankylosing spondylitis, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, gout, physical disability, prosthesis and internal insertion of surgical implants, amputation, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment taken within the last 12 months

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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment taken within the last 12 months

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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment taken within the last 12 months

8.13 Eye conditions **Yes** ☐ **No** ☐

Example: intra-ocular pressure, visual disturbances, night blindness, 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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment taken within the last 12 months

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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment taken within the last 12 months

8.15 Male urogenital conditions **Yes** ☐ **No** ☐

Example: prostate disorders, urogenital defects, varicocele, abnormal PSA tests (prostate specific antigen), undescended testes, phimosis, urinary incontinence, retention, infertility, any autoimmune conditions, and any congenital conditions.

Patient name	Symptoms/medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment taken within the last 12 months

8.16 Are any of your dependents expecting surgery or planning hospitalization 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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment taken within the last 12 months

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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment taken within the last 12 months

8.18 Have any of your dependants ever been diagnosed with or received treatment for, any condition/symptoms or any allergic reactions or side-effects, not mentioned in the questions above in the last 12 months before this application? **Yes** ☐ **No** ☐

Patient name	Symptoms/medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment taken within the last 12 months

HIV and AIDS

If any 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 any 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 your 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 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.

10. Debit order mandate

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

- I 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 acknowledgment 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: 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

11. Terms and conditions of 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.

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. They may change from time to time. You may ask us for a copy of these rules at any time or view these rules on **www.discovery.co.za**.
When you sign this application, you confirm that you have read and understood these terms and conditions and you agree that you and those you apply for will be bound by these and Scheme Rules.
Where applicable you also acknowledge and confirm that you, your financial adviser, or your employer, may communicate with us on this application and your membership of the Scheme.

You give permission that the Scheme or Administrator can share your medical information and other relevant Personal Information about you and your dependant/s with your chosen financial adviser. The information will be shared so that he or she can help us if necessary while we process your membership application.
Please speak to your financial adviser or the Administrator if there is anything you do not understand.

11.2. **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.

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/partner and any dependant(s) over 18 to act for them in any matter relating to this application.
- You have consent from your spouse and/or adult dependant, who is part of this application process, to act on their behalf and provide personal information, including health information, to Discovery Health for the purpose of your application to add your dependant/s to join Discovery Health Medical Scheme.
- and Discovery Health may be able to retrieve certain previous medical information they have for my dependants (if applicable) from previous memberships.

11.4. **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.

11.5. **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.

11.6. **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.

11.7. **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.

11.8. **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.

11.9. **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 your membership being cancelled for this reason.

11.10. **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 your membership has to be monitored for the first 12 months, the Scheme may request additional medical history when we receive 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.

11.11. **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 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 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 amend monthly contributions and benefits from time to time with prior notification.

11.12. **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.

11.13. **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 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.

Signature of main applicant

Date D D M M Y Y Y Y

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

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: _____ **Membership number**: _____

Medical Scheme: _____

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)C • 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: _____