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

Request to change banking details 2026

Discovery Health Medical Scheme

Purpose of the form

The form accommodates banking detail changes for Discovery Health Medical Scheme.

How to complete this form

1. Fill in the form in black ink and print clearly or complete the form digitally. You can view the list of approved digital signature providers on **www.discovery.co.za**, under Medical Aid > Find documents and certificates > Application forms. All relevant sections must be signed by the main applicant. The main applicant must sign and date any changes.
2. Read and sign section four and five.
3. Where you need to choose between different options, mark your selection with a (√)

How to submit this form

Email the completed form to **bankingdetails@discovery.co.za**.

Supporting documents required

These are listed under each type of account. Attach the relevant documents only and return them with the completed form. We can only change your banking details if you have completed the form, accepted the terms and conditions and submitted all the required supporting documents.

Main member/ policyholder account	If you are updating your own banking details, you do not need to submit supporting documents, as we will verify the banking details with the bank. If we are unable to verify the details, we will need the following documents: • Proof of the account (bank statement or bank letter not older than three months) • A copy of your ID, passport or driver's license
Third party account	• Proof of the account (bank statement or bank letter not older than three months) • A copy of the third party's (accountholder) ID, passport or drivers license
Joint account	• Proof of the account (bank statement or bank letter not older than three months) • A copy of the ID, passport or driver's license of each of the joint owners
Trust account	• Proof of the account (bank statement or bank letter not older than three months) • A copy of the ID, passport or driver's license of each of the trustees of the account • A copy of the trust's certificate of registration • A copy of the trust letter, showing the trustees. The resolution must be dated, signed by an authorised person on behalf of the trust and it must contain the membership or policy number(s). The letter must give authority that the trust account can be debited for the policy or membership details specified in the letter
Company account	• Proof of the account (bank statement or bank letter not older than three months) • A copy of the ID, passport or driver's license of each signatory or person who has authority to sign on behalf of the company • A letter of authority that includes the details of all the persons of authority and the policy or membership details the authority applies to. The letter or authority must be signed and dated and give authority that the company account can be debited for the policy or membership details specified in the letter • A copy of the company's certificate of registration

Section 1 - Details of main member/policyholder

Please complete all the information in this section.

Title | Initials

Surname

First name(s)

ID or passport number | Date of birth (D D M M Y Y Y Y)

Telephone (H) | Telephone (W)

Cellphone

Email

Note: This email address will be used for a once-off communication regarding the banking details update. We will not save the email address you give us on this form to your profile. If you have authority to act on behalf of the main member, you can specify the relevant email address that we need to communicate to. You must also submit proof that you are allowed to act on behalf of the main member (example, Letter of Authority or Letter of Executorship). This form is available on the Discovery website at **www.discovery.co.za** in the "Update banking details" section. Using the website ensures a quicker, easier change process.

Section 2 - Debit order banking details update for Discovery Health Medical Scheme

Membership number

Please mark the tick box if you would like us to use the debit order banking details for claims and Medical Savings Account refund purposes.

Bank account details - please note that we cannot accept credit card details for debit order collections.

This is the account we will use to collect contributions, it will also be used to process contribution refunds.

Account owner Main member Third party Company Joint account Trust

Bank name

Branch name Branch code - -

Account number Type of account Cheque Savings

Title Initials

Surname

First name

Date of birth D D M M Y Y Y Y ID or passport number

In addition to the above, please also complete the details below for company or trust accounts.

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

Company or trust

Registration number

Account holder residential address (if the account holder is a company, please state the company address)

Unit/Suite number Complex name

Street number Street name

Suburb

City Code

Account holder email address

(if the account holder is a company, please state the company email address)

Account holder contact number

(if the account holder is a company, please state the company contact number)

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

Section 3 - Terms and conditions for Discovery Health Medical Scheme

The main member and third party account holder who sign this agreement (referred to as “you”) authorise Discovery Health Medical Scheme to deduct the policy contributions from the debit order account.

Authorisation to use the bank account

You must accept these terms and conditions. The third-party debit order account holders must give Discovery Health Medical Scheme written notice if they want to cancel this authorisation.

Payment instructions

The bank listed in this agreement will treat all payment instructions issued in terms of this authorisation as if you personally issued the instructions.

You may cancel this payment instruction. However, such cancellation will not cancel the agreement. You will not be entitled to any refund of amounts withdrawn while the payment instruction was in force.

Payment obligations

You must pay any bank charges for this debit order authorisation or instruction. You will have to pay claims, losses and damages if there are not enough funds in the account, if the account details are incorrect or if the account is held in the name of any other person not included in this Agreement.

Changes to your rights and responsibilities

Discovery Health Medical Scheme, authorised to withdraw money from your account, may not cede (give up or transfer) or assign any of their rights to any other third party without your written permission.

You may not hand over any of your responsibilities in terms of this contract to any other third-party without the authorised party's written permission.

You can view and read our Privacy Statement on **www.discovery.co.za** > Medical aid > About Discovery Health Medical Scheme.

Section 4 - Debit order mandate

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

I, the undersigned:

- Warrant that the account information I have provided above is an account in my name and that the information furnished by me/us in this Authority and Mandate is true and correct.
- Authorise Discovery Health Medical Scheme to issue and deliver payment instructions to my bank, recorded above, for the collection by Discovery Health Medical Scheme from the bank account (or any other bank or branch to which I may transfer my account) any amounts due under or in terms of this application on condition that the sum of such payment instructions will never exceed my obligations as framed in the Agreement, which shall commence on the date that cover starts as requested on the application form and shall continue until this Authority and Mandate is terminated by me by giving Discovery Health Medical Scheme no less than 20 ordinary working days written notice thereof or immediately in the event that I instruct my bank to withdraw this Authority and Mandate.
- If the membership or change in account details is not activated in time for the debit order collection and there is an amount outstanding, Discovery Health Medical Scheme can collect that amount in the interim. If I change the date of the debit order after activation, I confirm that the payment instructions must be issued and delivered on the day that I have nominated ("payment day") and thereafter on the same day in each successive month. If the payment day falls on a Sunday or recognised South African public holiday, the payment day will automatically be the next working day.
- Acknowledge that my bank will treat each payment instruction to pay contributions or amounts due under this Agreement to Discovery Health Medical Scheme as if each payment instruction came from me personally as the account holder.
- Undertake to advise Discovery Health Medical Scheme in writing of any changes to my account details and acknowledge that Discovery Health Medical Scheme will not be held responsible or liable for any claim, loss or harm that I or any third party may suffer as a result of me providing incorrect banking details herein or if the bank account is in the name of another person or entity or as a result of my failure to notify Discovery Health Medical Scheme of a change in banking details or if the bank account has insufficient funds to meet my obligations under or in terms of the Agreement.
- Know and understand that the withdrawals hereby authorised will be processed through a computerised system provided by South African banks. The details of each withdrawal from my bank account will be printed on my bank statement and must show the reference number of the membership inserted in the Agreement so as to enable me to identify this membership.
- Acknowledge that although this Authority and Mandate may be terminated by me, such termination does not necessarily terminate this Agreement. In the event of such termination, I am not entitled to any refund of any contributions or amounts due that was withdrawn by Discovery Health Medical Scheme whilst this Authority and Mandate was in force if such contributions or amounts were legally owed to Discovery Health Medical Scheme in terms of the Agreement.
- Acknowledge that by signing this Authority and Mandate, I am bound by the payment terms applicable to this Agreement.
- Acknowledgment that this Authority may be assigned to a third party if this agreement is also assigned to a third party.

Reference number:

This Agreement reference number: Your membership number

Abbreviated name:

Abbreviated name as registered with the bank: DISCPREM

Deduction amount: as per your signed contract

Deduction date: as per your signed contract

Payment start date: as per your signed contract

Signature of account holder

Date D D M M Y Y Y Y

Section 5 - Medical claims and Medical Saving Account refunds - banking details update for Discovery Health Medical Scheme

Membership number

Please note that you do not have to complete the medical claims refund section if you have indicated in the debit order account section that the same details should be used for claims and Medical Savings Account refunds purposes.

Account owner Main member Third party Company Joint account Trust

Bank name

Branch name Branch code - -

Account number Type of account Cheque Savings

Title | Initials

Surname

First name

Date of birth (D D M M Y Y Y Y) | ID or passport number

In addition to the above, please also complete the details below for company or trust accounts.

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

Company or trust

Registration number

Signature of account holder

Please only sign if you have read and understood this statement.

In addition to the above terms, the main member or their proxy and bank account holder must agree to the following

1. I confirm that I have the right to give Discovery Health Medical Scheme the authority to debit such account on a monthly basis. Furthermore, I will be liable for any claims, losses or damages of whatsoever nature arising out of debits made by Discovery Health Medical Scheme to the account as listed above should this account have insufficient funds, be incorrect or be held in the name of any other person.
2. I hereby authorise Discovery Health Medical Scheme to verify the banking details as provided above for the purposes of setting up the debit order, if needed.
3. I confirm that the account listed above complies with the Financial Intelligence Centre Act ("FICA").
4. I confirm that if I miss a contribution collection date, I authorise that Discovery Health Medical Scheme may deduct a double debit of my contributions the following month.

I, (full name(s) and surname according to your identity document), as the main member, give Discovery Health Medical Scheme permission to change my banking details.

Signed at (town or city) | Date (D D M M Y Y Y Y)

Signature of main member

Please only sign if you have read and understood this statement.