

## 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 a member of.

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

## Contact us

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

## Purpose of the form

Thank you for deciding to register your newborn baby on your Discovery Health Medical Scheme membership. This document is an application form to register your biological newborn or newly adopted baby on your Discovery Health Medical Scheme membership. This form is applicable for new born babies up until the age of three months. 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](http://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 access a list of the approved digital signatures from [www.discovery.co.za](http://www.discovery.co.za), under Medical Aid > Find documents and certificates > Application forms.
- All relevant sections must be signed by the main member. The main member must sign and date any changes.
- Provision is made in this form to provide information relating to your race. This information is required by the Council for Medical Schemes for statistical purposes only. You are not compelled to provide this information.
- Email the completed and signed form to [application@discovery.co.za](mailto:application@discovery.co.za).
- Please attach a copy of the birth certificate for your newborn baby.

When you sign this application, you also accept our terms and conditions for membership on [www.discovery.co.za](http://www.discovery.co.za).

If you have any questions, please let us or your financial adviser know. Once we have assessed your application, we will let you know of the outcome of your application and what will happen next.

## Please note:

For us to accept your newborn baby without any conditions you must register your newborn or newly adopted baby within 90 days of his or her birth or adoption and cover must start from date of birth or adoption. You will have to pay increased contributions from the first day of the month following the month of birth or adoption, and benefits will accumulate from the date of birth or adoption. If you are applying after 90 days from birth or adoption of your baby or you want cover to start on any other day after the date of birth, we may apply certain conditions to your baby's membership with the Scheme. You will need to complete a different application called "Application to add a dependants 2025." Download the latest version of all forms from [www.discovery.co.za](http://www.discovery.co.za), under Medical Aid > Find documents and certificates.

### 1. Main member details

|                       |                      |                   |                      |
|-----------------------|----------------------|-------------------|----------------------|
| Title                 | <input type="text"/> | Initials          | <input type="text"/> |
| First name(s)         | <input type="text"/> |                   |                      |
| Surname               | <input type="text"/> |                   |                      |
| Date of birth         | <input type="text"/> |                   |                      |
| ID or passport number | <input type="text"/> | Membership number | <input type="text"/> |

### 2. Newborn's details

|                       |                                  |                                   |   |
|-----------------------|----------------------------------|-----------------------------------|---|
| 2.1. Surname          | <input type="text"/>             |                                   |   |
| First name(s)         | <input type="text"/>             |                                   |   |
| ID or passport number | <input type="text"/>             |                                   |   |
| Gender                | M <input type="checkbox"/>       | F <input type="checkbox"/>        | Date of birth <input type="text"/>  |
| Race                  | African <input type="checkbox"/> | Coloured <input type="checkbox"/> | Indian/Asian <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Do not want to disclose race <input type="checkbox"/> |

*You are not compelled to provide the information on race. The Scheme is required, by the Council for Medical Schemes, to request this*

information. It will be used for statistical purposes only.

Is the newborn your biological child? Yes  No

Is the newborn adopted? Yes  No

If the newborn is adopted, please supply legal proof of adoption.

2.2. Surname

First name(s)

ID or passport number

Gender M  F  Date of birth

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

You are not compelled to provide the information on race. The Scheme is required, by the Council for Medical Schemes, to request this information. It will be used for statistical purposes only.

Is the newborn your biological child? Yes  No

Is the newborn adopted? Yes  No

If the newborn is adopted, please supply legal proof of adoption.

2.3. Surname

First name(s)

ID or passport number

Gender M  F  Date of birth

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

You are not compelled to provide the information on race. The Scheme is required, by the Council for Medical Schemes, to request this information. It will be used for statistical purposes only.

Is the newborn your biological child? Yes  No

Is the newborn adopted? Yes  No

If the newborn is adopted, please supply legal proof of adoption.

**3. Please only select a GP if you have a KeyCare Plus or KeyCare Start Plan**

If you are on KeyCare Plus or KeyCare Start Plan, you need to choose a GP from the KeyCare GP Network for your newborn as it may be different from the GP(s) you or your dependants previously chose. Please fill in the details of the GP you have chosen for your newborn below.

| Newborn name**       | GP name              | Practice number      |
|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

\*\*Please make sure that the information you give above is the same as the information in section 2 of this form.

**Please note:** you can only access day-to-day cover and chronic benefits through the KeyCare general practitioner(s) you chose above.

#### 4. Declaration

I,  (first name and surname), the main member, request that the newborn(s) on this form be added to my health plan as a registered dependant(s). I also confirm that all the information given here is true and correct to the best of my knowledge and belief.

Signed at (town or city)

on 

|   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

Signature of main member

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



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

#### 5. Approval from employer (Please complete only if applicable to your employer group)

Name

SIGNATURE/COMPANY STAMP

Designation

Date 

|   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|



Contact us on: 0860 100 404, P.O. Box 78367, Sandton, 2146, [www.aon.co.za](http://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   |
|---|--|---|--|
| <ul style="list-style-type: none"> <li>• Name and Surname</li> <li>• Membership number</li> <li>• Date of birth</li> <li>• ID number</li> <li>• Postal Address</li> <li>• Physical address</li> <li>• E-mail Address</li> <li>• Telephone numbers</li> <li>• Cellular Number</li> <li>• Number of dependents</li> </ul> | <ul style="list-style-type: none"> <li>• Plan type</li> <li>• Medical Savings Account (MSA)</li> <li>• Balance Medical Scheme benefits</li> <li>• Spent for the year Accumulated</li> <li>• Medical scheme Savings Account Medical Savings Carry over from previous year</li> <li>• MSA reimbursement, Scheme Rate or cost</li> <li>• Self-payment Gap</li> <li>• Above Threshold Benefit</li> <li>• Waiting period details</li> <li>• Late joiner penalty indicator</li> <li>• Wellness benefits</li> </ul> | <ul style="list-style-type: none"> <li>• Total</li> <li>• Contribution</li> <li>• Contribution breakdown</li> </ul> | <ul style="list-style-type: none"> <li>• Chronic Indicator/ confirmation (Yes/No)</li> <li>• In Hospital Indicator/ confirmation (Yes/No)C</li> <li>• Confirmation of claims paid and from what benefit</li> <li>• Claims transaction history</li> <li>• Procedures done in doctor's rooms paid from Hospital Benefit</li> </ul> |

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:** \_\_\_\_\_