Application to change the main member on Discovery Health Medical Scheme 2026

Discovery Health Medical Scheme

Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme 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**; PO Box 784262, Sandton, 2146;
1 Discovery Place, Sandton, 2196.

Purpose of the form

This document is an application form to change the main member on an existing Discovery Health Medical Scheme membership. It also contains some rules for membership. Please make sure you read and understand the rules. The full set of Scheme Rules is available on **www.discovery.co.za/medical-aid/scheme-rules**.

What you must do

- Fill in the form in black ink and print clearly or complete the form digitally. You can view the list of approved digital signature providers on **www.discovery.co.za**, under Medical Aid > Find documents and certificates > Application forms.
  All relevant sections must be signed by the main applicant. The main applicant must sign and date any changes.
- Read and understand the rules for membership (section 10).
- Sign section 4, 5, 7, 8, 9 & 11.
- Submit your documents by using the 'Get Help' tool on **www.discovery.co.za** under Medical Aid > Get Help > Submit a document.
- This form must be submitted together with a copy of your ID or passport and your banking statement that is not older than 3 months.

When you sign this application, you confirm that you have read and understood the rules for membership and agree to them.

1. About the new main member

Effective date of the new main member D D M M Y Y Y Y

Membership number

Title Initials

Surname

First name(s)

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 have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Marital status Married Single Divorced Widowed

Telephone (H) Telephone (W)

Cellphone

Email

Postal address (Post collected from post box, suite or private bag)

P O Box Private Bag Box number

Suite PostNet Suite Number

Suburb

City Postal code

Physical address

Unit/Suite number | Complex name

Street number | Street name

Suburb

City | Postal code

2. Details of previous main member

If you need to change the main member due to the death of the previous main member, please attach a certified copy of the death certificate.

Title | Initials

Surname

First name(s)

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 have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Martial status Married | Single | Divorced | Widowed

Telephone (H) | Telephone (W)

Cellphone

Email

We need to get the following information according to Section 18 of the Income Tax Act 1962:

Are you financially dependent on the new main member? Yes | No

Please specify your nett income **R** .

Are you disabled? Yes | No | Are you a full-time student? Yes | No

3. About your employer (applicable to new main member)

Employer name | Date of employment D D M M Y Y Y Y

Employee number

Branch name | Branch number

4. If you have a KeyCare Plan

Income verification will be conducted for the lower income bands. Income is considered as: The higher of the main member's or registered spouse or partner's earnings, commission and rewards from employment; interest from investments; income from leasing of assets or property; distributions received from a trust, pension and/or provident fund; receipt of any financial assistance in terms of any statutory social assistance programme.

IMPORTANT NOTICE:
Declaring income lower than your actual income constitutes fraud. This will lead to the immediate termination of your membership and criminal charges may be brought against you. If your income is not declared, your income verification status will default to the highest income band. It is your responsibility to provide accurate income information otherwise the Scheme may not be in a position to refund the excess amount paid by you. By signing this application form, you give your permission for us to verify your declared income using all relevant internal and external sources.

	Main member	Spouse or partner
Total earning over the last 12 months	**R** .	**R** .
Occupation		

I declare that this income declaration is true and accurate.

Signature of new main member

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

If you are applying to KeyCare Plus/KeyCare Core and the highest earner earns less R191 892 or KeyCare Start/KeyCare Start Regional and the highest earner earns less R291 012, please supply supporting documentation.

If you are applying in your private capacity, then please provide the following supporting documentation as proof of income:

- Last 3 months' (90 consecutive days) bank statements; and
- If employed, your last 3 months' payslips and commission schedules, or most recent tax year's IRP5 certificate
- If student, proof of enrolment at academic institution
- If self-employed, most current financial statements
- If pensioner, proof of annuity and/or employer pension and/or State Older Person's Grant
- If unemployed, UIF certificate.

If you are applying through an employer group, then please provide the following supporting documentation as proof of income:

- Last month's payslip
- Letter of engagement from employer

5. Your banking details

5.1. Your contributions

If you will be paying your contributions in full, please complete this section:

Please note: We cannot accept credit card account details and only South African banking details are accepted.

If we are debiting a third party account, the main member must sign next to the account holder

Bank name

Branch name | Branch code - -

Account number | Type of account Cheque Savings

Account holder

Account holder's physical address (own/3rd party/trust/company)

Unit/Suite number | Complex name

Street number | Street name

City | Postal code

Account holder contact details

Account holder email address

If we are debiting from a third party bank account, the main member must insert the ID or passport number of the third party.

ID or passport number

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

As part of Payment Association of South Africa (PASA) debit order mandate requirements 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 requirement and will not be used to update the contact details we have on system, if you wish to update any contact details please visit **www.discovery.co.za**.

We will debit your account on the first working day of the month. If the membership is not activated in time for the debit order collection and there is an amount outstanding Discovery Health will collect that amount in the interim, upon activation . Once your account is paid up to date, you may change your debit order date to a variable debit order date by contacting us on **0860 99 88 77**.

5.2. Your claims and claims and medical savings account refund

Can we use the same account we deduct contributions from to refund your claims and medical savings account? Yes No

If you do not want to use the same banking details for your contributions and claims refunds, please give us the details you would like to use.

Please note: We cannot accept credit card account details. We no longer issue cheques. If no details are provided it will impact your claims payment. If we are paying a third party bank account, the main member must insert the ID or passport number of the third party.

Bank name

Branch name | Branch code - -

Account number | Type of account Cheque Savings

Account holder

If we are paying a third party bank account, the main member must insert the ID or passport number of the third party.

ID or passport number

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

please provide proof of bank account.

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/policy holder 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 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 holder (bank statement or bank letter not older than three months)
- A copy of the third party's (account holder) ID, passport or driver's license

Joint account

- Proof of the account holder (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 holder (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 authorized 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 specified policy or membership details specified in the letter

Company account

- Proof of the account holder (bank statement or bank letter not older than 3 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 including the details of all the persons of authority and the policy or membership details the authority applies to. The letter of authority must be signed and dated and give authority that the company account can be debited for the specified policy or membership details specified in the letter
- A copy of the company's certificate of registration

If you are completing the application form on behalf of the main member, please include proof that you have obtained the necessary authority (example, Letter of Authority or Letter of Executorship)

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.

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

Signature of account holder

Signature of new main member

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

6. Your financial adviser's details

Please choose one of the following options: I choose to remain with the current intermediary from the employer of previous main member ☐

I would like to choose a new intermediary ☐

Should you not wish to appoint an intermediary, please accept the intermediary waiver below

Intermediary waiver: I select to continue without financial advice from any financial adviser and understand that this decision will have no impact on my monthly contribution

Accept intermediary waiver ☐

Please complete the section below with the new intermediary details, if the second option is selected above

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)

7. Authorisation

I, am duly authorised to appoint the financial adviser and intermediary house mentioned above, I also give the Discovery companies consent to share with my appointed adviser all policy information, including personal and underwriting information necessary to ensure the efficient administration, assessing of claims and to ensure that Discovery complies with all relevant legislation on an ongoing basis. I understand and accept that this consent can be revoked at any time failing which Discovery shall be entitled to continue sharing such information with the appointed individuals until termination of such policy.

Signature of new main member

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

8. Our Privacy Statement – How we will process and disclose your personal information and communicate with you

When you engage with Discovery Health and Discovery Health Medical Scheme, you are entrusting both 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 and beneficiaries, where applicable. You can view and read our Privacy Statement on **www.discovery.co.za** > Medical aid > About **Discovery Health Medical Scheme**.

Signature of the new main member

Date D D M M Y Y Y Y

9. Discovery Health Medical Scheme rules for 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.

Discovery Group refers to Discovery Limited, registration number 1999/007789/06, including all subsidiaries of the group. Subsidiaries in the Group are authorised financial services providers.

9.1. *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 rules and you agree that you and those you apply for will be bound by them.

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

9.2. *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.

9.3. *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.

9.4. *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 and older for more information about themselves.

Your legal address

The Scheme or Administrator will send documents to you at the address you indicated as the communication channel you prefer to be contacted on. If it is necessary to send you any legal notices or summonses, our legal team will serve these at the physical address you have given, or at any other address you have given us. It is your responsibility to make sure we have the correct address for you.

The Scheme and Administrator may record telephone calls

The Scheme and Administrator may record telephone conversations with you and with those you apply for.

The recordings and all information we get during the recordings will be processed and kept as required by law.

The Scheme and Administrator may get information about you from other relevant sources

The Scheme and Administrator may (at any time and on an ongoing basis) obtain your personal information from other relevant sources, including medical practitioners, contracted service providers, financial advisers, credit bureaus, entities that are part of Discovery Group 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. We may (at any time and on an ongoing basis) verify with the relevant sources that your personal information is true, correct and complete.

You give your permission that the Scheme and Administrator may get any information that is relevant to your application from your employer.

Tell the Scheme or Administrator immediately if your information changes

You, your employer or your financial adviser must tell the Scheme or Administrator in writing if any of the information you gave, in your application for membership, changes between the day you sign this document and the day your membership starts. This includes information about your health and the health of those you apply for. We need advance notice of any administrative changes such as cancellation of membership, as we do not accept backdated changes.

When the Scheme may cancel your membership/s

The Scheme may cancel any membership if you and those you apply for:

- do not give us information that later turns out to be relevant to this application.
- give us any information that is not true, correct and complete.
- do not tell us about any relevant changes (including about your health and the health of those you apply for) between the day you sign this document and the day cover starts.

Providing false information may lead to criminal charges being brought against you.

You will have to pay any amount owing to the Scheme as a result of this cancellation.

9.5. ***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 advise if any waiting periods apply. Please speak to your financial adviser or the Administrator with regard to any waiting periods applicable to your membership and the memberships of those you apply for.

Resign from current medical schemes when accepted

It is illegal to be a member of more than one medical scheme at the same time. You and those you apply for must resign from your current medical schemes when you receive notice from the Scheme by letter, email or SMS telling you that you and those you apply for have been accepted.

You must ensure contributions are paid on time

As the main member of the Scheme, you are responsible for ensuring that your contributions and the contributions of those you apply for are paid on time every month to avoid suspension of benefits. The Scheme has the right to amend monthly contributions and benefits from time to time with prior notification.

9.6. ***Repaying money owed to the Scheme***

The Scheme has the right at any time to collect from you any amount that you owe.

We will notify you if there is any amount that you owe to the Scheme.

You must repay any medical savings owing if you leave the Scheme.

When you become a member, depending on the plan you chose, you may have money available in advance to use for medical expenses during the year. This money is allocated to an account called the 'Medical Savings Account'. If you leave the Scheme before the year is up, you must repay the portion of medical savings you have used that is more than you have paid back to the Scheme over the year.

By signing this form, you agree that any money you owe to the Scheme may be deducted from any future claim payment amounts that are due to be paid to you.

You will be able to identify the debit order for the money owing to the Scheme on your bank statement, the reference number DISCSETTLE will be used.

10. Debit order mandate

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 and every successive month. If the payment day falls on a Sunday or recognised South African public holiday, the payment day will automatically be the next working day;
- Acknowledge that my bank will treat each payment instruction to pay premiums or amounts due under this Agreement to Discovery Health 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 authorized will be processed through a computerized system provided by South African banks. The details of each withdrawal from my bank account will be printed on my bank statement and must show the reference number of the membership inserted in the Agreement so as to enable me to identify this membership.
- Acknowledge that although this Authority and Mandate may be terminated by me, such termination does not necessarily terminate this Agreement. In the event of such termination, I am not entitled to any refund of any premiums or amounts due that was withdrawn by Discovery Health Medical Scheme whilst this Authority and Mandate was in force if such premiums or amounts were legally owing 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

Account holder signature _____ Date D D M M Y Y Y Y

In addition to the above terms, the policyholder 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.
2. 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.
3. I hereby authorise Discovery Health Medical Scheme to verify the banking details as provided above for the purposes of setting up the debit order, in need.
4. I confirm that the account listed above complies with the Financial Intelligence Centre Act ("FICA").
5. 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) _____

Signature of new main member _____ Date D D M M Y Y Y Y

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

Signature of previous main member*

Date D D M M Y Y Y Y

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

*** If the previous main member's signature cannot be obtained, please state the reason.**