Application to transfer an existing member to an employer group 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**; PO Box 784262, Sandton, 2146; **www.discovery.co.za**; 1 Discovery Place, Sandton, 2196.

Purpose of the form

If you are an existing Discovery Health Medical Scheme main member transferring to another employer, you need to complete this form. This form may only be used if you have had no break in cover between your current membership and joining your new employer. Make reference to the footnote that indicates the expiry date of the form. Download the latest version of all forms from **www.discovery.co.za**, under Medical Aid > Find documents and your 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.za** under Medical Aid > Find documents and certificates > Application forms.
- The main applicant must sign and date any changes.
- Once completed, you can submit your documents on **www.discovery.co.za** under Medical Aid > Get Help > Submit a medical aid document and follow the guided steps through your VirtualAgent. If you are part of an employer group, please return this form to your human resources or salaries department.

1. Main policy holder details

Title | Initials

Surname

First name(s)

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

Membership number | Employee number

Current plan type

New plan type (if applicable)

Telephone (W) | Cellphone

New email (if applicable)

2. New employer details

Employer name: Raubex (PTY) Ltd | Date of employment (D D M M Y Y Y Y)

Employer number: 3 5 1 0 1 8 4 | Effective date of transfer (D D M M Y Y Y Y)

Branch name | Branch number: 0 1

3. Employer warranty (employer contact person to complete)

I acknowledge the transfer of the policyholder to the employer group.

Employer contact name: Petro Nel

Designation

Signature of employer contact | Date (D D M M Y Y Y Y)

4. Rules of membership

When you sign this document, you confirm that you have read and understood the rules of membership and you agree that all information provided on this form is correct. The full set of Scheme Rules is available on **www.discovery.co.za/medical-aid/scheme-rules**. You acknowledge and appoint the financial adviser contracted by your employer from time to time for all matters related to your membership.

Should you not want to appoint the financial adviser contracted by your employer, please contact your employer. The new employer will explain the terms of employment of their company.

Signed at (town or city) _____ on D D M M Y Y Y Y

Signature of policy holder _____

Please only sign if this information is true, complete an 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: _____