Discovery Health

Contact us

Tel: 0860 99 88 77, PO Box 784262, Sandton, 2146, www.discovery.co.za

Applying to become a member of Discovery Health Medical Scheme in 2010

Thank you for deciding to apply to join the Discovery Health Medical Scheme. This document is an application form for membership. It also contains some rules for membership. Please make sure you read and understand the rules.

Who we are

The Discovery Health Medical Scheme (referred to as 'the Scheme') is the medical scheme that you are applying to become a member of. This is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'we' 'us' and 'our' or as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

What you must do

Please go through these steps:

Step 1: Fill in the form in black ink, using one letter per block. Please print clearly.

Step 2: Read and understand the rules for membership (section 12).

Step 3: Sign section 8 and section 12.

Step 4: Please make sure the main applicant signs and dates any changes.

Step 5: Fax the completed and signed form to **011 539 3000** or email it to **application@discovery.co.za**

Step 6: Please attach a copy of each applicant's identity document to this application form. We also accept valid passports and birth certificates for children.

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

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

1. If you already have a Discovery Health Medical Scheme membership

If you were an active member of the Discovery Health Medical Scheme in the month before the date you want your membership to be effective, please contact us or speak to your financial adviser first to see if we can transfer your membership instead of completing this application.

2. About yourself (main applicant)

When do you want your cover to start? 2 0 Y Y M M 0 1

Title ☐ Initials ☐ Surname ☐

First name(s) (as per identity document) ☐

Preferred name ☐ Sex M F Date of birth Y Y Y Y M M D D

Previous or maiden name ☐

Preferred communication Email ☐ Post ☐ By choosing email, you will receive your communication quicker and there is less of an impact on the environment.

Preferred language English ☐ Afrikaans ☐

ID or passport number ☐ Country of issue ☐

Telephone (H) ☐ (W) ☐

Cellphone ☐ Fax ☐

Email ☐

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

☐ PO Box ☐ Private Bag Box number ☐

☐ Suite ☐ Postnet Suite Number ☐

Suburb ☐ Postal code ☐

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2. About yourself (main applicant) *(continued)*

If your post is delivered to your street address, please complete these details under physical address.

Physical address:

Suite/Unit number Complex name

Street number Street name

Suburb Postal code

Occupation Tax number

3. About your spouse or partner (if applying for cover)

Title Initials Surname

First name(s) (as per identity document)

Preferred name Sex M F Date of birth Y Y Y Y M M D D

Previous or maiden name

ID or passport number Country of issue

Telephone (H) (W)

Cellphone Tax number

Email

4. About your dependants (if applying for cover)

Dependant 1

Title Initials Surname

First name(s) (as per identity document)

Preferred name Sex M F Date of birth Y Y Y Y M M D D

Relationship to main member (for example, mother, child. Where your child is not your biological child, please state relationship, for example adopted child, foster child. Please supply legal proof)

ID or passport number Country of issue

Is your dependant: married? Yes ☐ No ☐ financially dependent on you? Yes ☐ No ☐ disabled? Yes ☐ No ☐ a full-time student? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐ How much does your dependant earn each month? R

Dependant 2

Title Initials Surname

First name(s) (as per identity document)

Preferred name Sex M F Date of birth Y Y Y Y M M D D

Relationship to main member (for example, mother, child. Where your child is not your biological child, please state relationship, for example adopted child, foster child. Please supply legal proof)

ID or passport number Country of issue

Is your dependant: married? Yes ☐ No ☐ financially dependent on you? Yes ☐ No ☐ disabled? Yes ☐ No ☐ a full-time student? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐ How much does your dependant earn each month? R

Dependant 3

Title Initials Surname

First name(s) (as per identity document)

Preferred name Sex M F Date of birth Y Y Y Y M M D D

Relationship to main member (for example, mother, child. Where your child is not your biological child, please state relationship, for example adopted child, foster child. Please supply legal proof)

ID or passport number Country of issue

Is your dependant: married? Yes ☐ No ☐ financially dependent on you? Yes ☐ No ☐ disabled? Yes ☐ No ☐ a full-time student? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐ How much does your dependant earn each month? R

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5. Your financial adviser's details

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)

I declare that:

1. I am an accredited financial adviser in terms of the Medical Schemes Act and licensed by the FSB in terms of the FAIS Act at the date of signing this application form.
2. I am appointed by the client to provide advice about this application.
3. I have a valid contract with the Scheme and I have made the client aware of the commission payable by Discovery Health Medical Scheme.
4. I am responsible for providing the applicant with:
   - my name, physical address, postal address and telephone number
   - impartial advice that is in his or her best interest.
5. I am accountable for any advice given to the member about completion of this application form and joining the Scheme.

Financial adviser's signature

6. Please select your health plan

Executive Plan
- ☐ Executive

Comprehensive Plans
- ☐ Classic
- ☐ Classic Delta network option
- ☐ Essential
- ☐ Essential Delta network option

Priority Plans
- ☐ Classic
- ☐ Essential

Saver Plans
- ☐ Classic
- ☐ Classic Delta network option
- ☐ Essential
- ☐ Essential Delta network option
- ☐ Coastal

Core Plans
- ☐ Classic
- ☐ Classic Delta network option
- ☐ Essential
- ☐ Essential Delta network option
- ☐ Coastal

KeyCare Plans
- ☐ KeyCare Plus
- ☐ KeyCare Core

How would you like us to refund claims from the Medical Savings Account if your plan has one? Discovery Health Rate ☐ Cost ☐

You have the right to ask for help in selecting a health plan that suits your needs. By signing this application you confirm that you are familiar with the conditions and benefits of the plan you select.

Please complete this if you selected a KeyCare Plan:

If you have selected a KeyCare Plan, we calculate your contributions using the higher of the total cost to company of the main member or spouse or partner. Total cost to company includes guaranteed earnings, guaranteed allowances, company contributions and variable pay or commissions. We do not take bonuses, for example annual 13th cheques and once-off bonuses into account. Please give us proof of income. We may ask you for updated proof of income each year.

If you don't give us proof of income, we will place you in the highest income band.

Main member R (total monthly cost to company)

Spouse or partner R (total monthly cost to company)

Please complete this if you have selected the KeyCare Plus Plan

	Name	GP name	Practice number	Second GP name*	Practice number
Main applicant					
Spouse or partner					
Dependant 1**					
Dependant 2**					
Dependant 3**					

* If you live far away from where you work or you often need to work in different towns or provinces, you may need a second GP. Please only choose a second GP if this applies to you.

** Please make sure that the dependant information you give above is the same as the dependant information in section 4 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.

7. Your employment details

7.1 If your employer is paying your full contribution or a part of it and we need to debit their account, please complete 7.1:

Name of employer | Employer or billing number

Employee number | Date of employment Y Y Y Y M M D D

(or PERSAL number for government employees. Please attach a clear copy of your salary slip.)

Branch name | Branch number

Please ensure your employer completes this warranty if this application form is not submitted together with an employer application form:

Employer warranty

1. We warrant that the main applicant detailed in section 2 is an employee of our organisation.
2. The Scheme may bill us for the amount due for this member in the same way as it does for our other employees with the Scheme.

Authorised signatory(ies) 1. 2.

Name(s)

Designation(s)

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7. Your employment details *(continued)*

7.2 Only complete 7.2 if you own your own business and your business will be paying your contribution:

Name of your business

Registration number

VAT number

Telephone

Fax

Physical address

Code

Postal address

Code

8. Your banking details

8.1 Your contributions

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

Please note: we cannot accept credit card account details

Bank name

Branch name

Branch code – – –

Account number

Type of account Cheque ☐ Savings ☐

Accountholder

Please choose the date you would like us to debit your account:

1st ☐ 10th ☐ 15th ☐ 20th ☐ 25th ☐

If your application is captured after the date you chose above, your first debit order will go off on the first of the month and then on the chosen date after that.

Can we use this account to refund claims to you? Yes ☐ No ☐

If you want to use a different account for claim refunds or if the banking details completed above belong to someone else, please complete 8.2 to tell us what account to use for claim refunds.

Signature of accountholder

8.2 Your claim refunds

If you do not want to use the same banking details for your contribution and claim refunds, please give us the details you would like to use:

Please note: we cannot accept credit card account details

Bank name

Branch name

Branch code – – –

Account number

Type of account Cheque ☐ Savings ☐

Accountholder

By signing below, 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.

Signature of main applicant

9. Previous medical scheme details

Please give us the details of all registered South African medical schemes that you previously belonged to. We will use this information to determine if we need to apply any waiting periods, late-joiner penalty fees, or both.

Main applicant

Scheme name	Membership number	Start date	Are you still a member?	End date if you have already resigned	Reason for leaving
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	

If all dependants were on the same medical scheme(s) as completed above, please tick here to confirm this. ☐

If any of your dependants applying for cover belonged to different medical schemes, please complete them below:

Spouse or partner

Scheme name	Membership number	Start date	Are you still a member?	End date if you have already resigned	Reason for leaving
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	

Dependant name

Scheme name	Membership number	Start date	Are you still a member?	End date if you have already resigned	Reason for leaving
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	

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9. Previous medical scheme details *(continued)*

Dependant name

Scheme name	Membership number	Start date	Are you still a member?	End date if you have already resigned	Reason for leaving
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	

Dependant name

Scheme name	Membership number	Start date	Are you still a member?	End date if you have already resigned	Reason for leaving
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	

10. Moving from another medical scheme

Please make sure that you have completed section 9.

If you answer no to any question in 10.1, you must complete all the medical questions in section 11.

10.1 I confirm that all people named on this application:

1. are currently or have been members of a South African medical scheme for at least the past 24 months, and — Yes ☐ No ☐
2. have not had a break in membership of more than 90 days since resigning from that South African medical scheme. — Yes ☐ No ☐

If you answered **yes** to the above questions, please answer the questions in **10.2.**

If you answered **no** in **10.1** you must complete **section 11**.

10.2 For any person named on this application form:

1. Have they been admitted to hospital in the 12 months before this application? — Yes ☐ No ☐
2. Are they currently taking regular medicine or reasonably expecting to need medicine where the treatment costs more than R200 a month? — Yes ☐ No ☐
3. Are they planning to or reasonably expecting to be hospitalised (including for pregnancy) or expecting to receive dental or medical treatment costing more than R2 000 in the next 12 months? — Yes ☐ No ☐

If you answered **no** to **all** questions in **10.2**, we will not apply any waiting periods and you **do not** have to complete section 11.

If you answered **yes** to **any** questions in **10.2**, we will apply a three-month general waiting period to your application and you **do not** have to complete Section 11. During these three months, we will only cover claims relating to Prescribed Minimum Benefits according to the Scheme's rules.

If you feel that a three-month general waiting period should not be applied and you want to give us more information, complete section 11.

11. Your medical questions

A. Only the main applicant, spouse or partner and any adult dependant applying for cover need to complete section 11.A.

Main applicant

How tall are you? ☐ . ☐☐ metres

How much do you weigh? ☐☐☐ kilograms

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week? ☐☐☐☐
1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day ☐☐☐

If **no**, have you smoked in the last 24 months? Yes ☐ No ☐ If **yes**, amount each day ☐☐☐

If you stopped smoking, what was your reason for stopping?

Spouse or partner

How tall are you? ☐ . ☐☐ metres

How much do you weigh? ☐☐☐ kilograms

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week? ☐☐☐☐
1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day ☐☐☐

If **no**, have you smoked in the last 24 months? Yes ☐ No ☐ If **yes**, amount each day ☐☐☐

If you stopped smoking, what was your reason for stopping?

11. Your medical questions *(continued)*

Adult 1 (any dependant 21 years or older)

How tall are you? ☐ . ☐☐ metres

How much do you weigh? ☐☐☐ kilograms

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week? ☐☐☐☐

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day ☐☐☐

If **no**, have you smoked in the last 24 months? Yes ☐ No ☐ If **yes**, amount each day ☐☐☐

If you stopped smoking, what was your reason for stopping?

Adult 2 (any dependant 21 years or older)

How tall are you? ☐ . ☐☐ metres

How much do you weigh? ☐☐☐ kilograms

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week? ☐☐☐☐

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day ☐☐☐

If **no**, have you smoked in the last 24 months? Yes ☐ No ☐ If **yes**, amount each day ☐☐☐

If you stopped smoking, what was your reason for stopping?

B. Have you or **any dependant** in this application ever experienced, been treated for, or are you currently suffering from any of the following symptoms, conditions or disorders?

11.1 Cancer Yes ☐ No ☐

Example: any form of cancer or pre-cancerous growths.

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

11.2 Heart and circulation conditions Yes ☐ No ☐

Example: angina, chest pain, heart failure, murmurs, rheumatic fever, high blood pressure, heart attack, raised cholesterol, previous heart surgery or palpitations.

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

11.3 Gynaecological conditions Yes ☐ No ☐

Example: ovarian cysts, endometriosis, fibroids, cervical disorders, menstrual disorders or pregnancy.

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

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11. Your medical questions *(continued)*

11.4 Mental health **Yes** ☐ **No** ☐

Example: depression, anxiety, schizophrenia or bipolar disorder.

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

11.5 Metabolic or endocrine conditions **Yes** ☐ **No** ☐

Example: diabetes, thyroid disorders, growth disorders, Cushing's disease or Addison's disease.

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

11.6 Liver or pancreatic conditions **Yes** ☐ **No** ☐

Example: hepatitis, cirrhosis, liver failure, gallstones or pancreatitis.

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

11.7 Gastrointestinal conditions **Yes** ☐ **No** ☐

Example: Crohn's disease, ulcerative colitis or bleeding ulcers.

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

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

Example: stroke, multiple sclerosis, epilepsy, migraine, Parkinson's disease, quadriplegia, paraplegia or cerebral palsy.

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

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11. Your medical questions *(continued)*

11.9 Respiratory conditions **Yes** ☐ **No** ☐

Example: asthma, emphysema, chronic bronchitis, shortness of breath, persistent cough, cystic fibrosis, chronic obstructive airways disease, any lung surgery or coughing up of blood.

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

11.10 Musculoskeletal conditions **Yes** ☐ **No** ☐

Example: rheumatoid arthritis, osteoarthritis, myasthenia gravis, gout, osteoporosis, loss of limb, back problems and operations, slipped disk, back pain or any other conditions.

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

11.11 Kidney or urinary tract conditions **Yes** ☐ **No** ☐

Example: kidney failure, kidney stones, recurrent infections, nephritis, prostate problems, blood or protein in urine or polycystic kidneys.

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

11.12 Blood conditions **Yes** ☐ **No** ☐

Example: anaemia, leukaemia, bleeding disorders, haemophilia, lymphoma, deep vein thrombosis (blood clots) or pulmonary embolus.

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

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11. Your medical questions *(continued)*

11.13 Are you or any of your dependants expecting surgery or planning hospitalisation or treatment in the next 12 months or have you been admitted to hospital in the last 12 months? **Yes** ☐ **No** ☐

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

11.14 Any symptoms not yet diagnosed by a medical professional or any condition which is not covered by these questions? **Yes** ☐ **No** ☐

	Name:	**Name:**
Symptom or condition		
Date first diagnosed (if applicable)	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

11.15 Have you or any of your dependants received medical advice or treatment from a medical professional in the 12 months before this application? **Yes** ☐ **No** ☐

	Name:	**Name:**
Symptom or condition		
Date first diagnosed (if applicable)	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

HIV and AIDS

You do not need to disclose the HIV status of you or your dependant(s) on this form if you do not feel comfortable doing so. However, if you, or one or more of your dependants, are HIV-positive, you or they must call us on **0860 100 417** 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 one or more of your dependants, are HIV-positive, it is in your interest to register on the HIV*Care* Programme. A 12-month condition specific waiting period may apply to this condition.

When you call in to register on the HIV*Care* Programme, please confirm these details.

12. Rules for membership

12.1 Rules for membership

Rules for membership are the rights and responsibilities for your membership of the Scheme. They may change from time to time. You may ask us for a copy at any time.

When you sign this application, you confirm that you have read and understood the rules and you agree that you and those you apply for will be bound by them. Please speak to your financial adviser or us if there is anything you do not understand.

12.2 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. To be treated as financially dependent for this application, a dependant must earn an income of less than what is stated in the Scheme rules, or you must have a legal responsibility to provide financially for them. We might ask you to give us proof of financial or legal responsibility.

You will be called the principal member or main member in our future communications to you.

12.3 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 and any dependants over 21 to act for them in any matter relating to this application.

Discovery Health (Pty) Ltd administers the Discovery Health Medical Scheme Registration number 1997/013480/07 An authorised financial services provider

12. Rules for membership *(continued)*

12.4 Giving information

You must give us 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 21 and older for information and it will be treated as if we had asked you in your role as main member.

We may get information from other relevant sources

To consider your application for membership, conduct underwriting or risk assessments or to consider a claim for medical expenses, you agree that we and the Scheme can get information about you and those you apply for from other relevant sources. These include any entity that is part of Discovery Holdings Limited, medical practitioners, financial advisers, credit bureaus or industry regulatory bodies. We and the Scheme may (at any time and on an ongoing basis) verify with the parties mentioned in this section that the information you give on this application and in respect of any matter pertaining to or that arose during your membership of the Scheme, is true, correct and complete.

I give my permission that the Scheme may get any information that is relevant to my application from my employer. This permission ends on the day that my cover with the Scheme starts.

Tell us about changes right away

If any of the information you gave to us changes between the day you sign this document and the day your membership starts, you must tell us in writing what the changes are. This includes information about your health and the health of those you apply for.

When the Scheme may cancel

The Scheme may cancel any memberships immediately and keep any contributions paid, 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.

12.5 Sharing information and confidentiality

When we may share your information

We and the Scheme will keep your information and the information about those you apply for confidential. We and the Scheme may share this information with other relevant parties only if the following conditions are met:

1. The information:
   - is needed only to administer the Scheme and any claims; or
   - is requested by a party who you have already given your consent to for the disclosure of this information.
2. The party that we and the Scheme share the information with agrees to keep the information confidential.

If we want to share your information for any other reason, we will do so only with your permission.

We and the Scheme may record calls

We and the Scheme 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.

12.6 About becoming a member

We will consider your application

We will consider your application and any one of the following will happen:

- we will accept you on these terms; or
- we will send a letter with revised terms; or
- we will let you know that we need more information about you and those you apply for before your cover can start.

We might not pay for certain expenses immediately

The Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before we start paying for any general or specific medical conditions. Please speak to your financial adviser or us to find out if waiting periods apply 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.

12.7 Repaying medical savings if you leave

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 made available in 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.

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

Signature of main applicant ______________________

The main applicant must sign and date any changes

13. What happens next with your application

Once you send us your application, here is what will happen:

- We capture and check your details.
- If any details are missing or if we need more information for underwriting purposes, we will contact you.
- We will send you or your financial adviser a letter, SMS or an email to let you know when we have accepted your application to join the Discovery Health Medical Scheme. This letter may contain certain conditions.
- You sign this letter to confirm your start date or acceptance of any waiting periods or late-joiner penalties (if we apply any) and return it to us.
- When we activate your membership, you will get an SMS from us.
- You will then get a pack in the post. This will contain details about your plan and all you need to get started.

If you do not hear from us seven days after sending us your application, please contact your financial adviser or us on **0860 100 345**.

Discovery Health (Pty) Ltd administers the Discovery Health Medical Scheme Registration number 1997/013480/07 An authorised financial services provider

Contact us

Tel: 0860 99 88 77, PO Box 653574, Benmore, 2010, www.discovery.co.za

Application to join Vitality and KeyClub

Please make sure that you sign this application

Main applicant's surname

Main applicant's ID number

Please choose one of the following options:

- ☐ Vitality
- ☐ KeyClub
- ☐ Vitality and KeyClub
- ☐ KeyClub Starter*
- ☐ KeyClub and KeyClub Starter*

***KeyClub Starter is available to main members under age 65 on a KeyCare Plan, who are not in the highest income band.**

Banking details

If you are paying your own Vitality contribution, please complete this section.

Bank name

Branch name — Branch number – –

Account number — Type of account Cheque ☐ Savings ☐

Accountholder

Signature of accountholder — Signature of main applicant

Please note: If you are using someone else's bank account, the accountholder must sign above to confirm this.

Please choose the date you would like us to debit your account (if you are not a government employee):

1st ☐ 10th ☐ 15th ☐ 20th ☐ 25th ☐

If your application is captured after the date you chose above, your first debit order will go off on the first of the month and then on the chosen date after that.

If you are a government employee on the PERSAL payroll system, please tick the box below to tell us which day of the month you want us to debit your account.

1st ☐ 5th ☐ 8th ☐ 21st ☐ 26th ☐

The Discovery credit card

The DiscoveryCard is a Visa credit card.

Vitality members can get cash back, travel savings and a world of convenience through our DiscoveryCard partners.

Would you like to apply for a Discovery credit card? Yes ☐ No ☐ — Gross monthly salary R

Please note: When assessing your DiscoveryCard application, a credit check will be done. An accredited consultant will phone you to complete the application. A DiscoveryCard will only be issued subject to meeting credit approval criteria.

Vitality HealthStyle (Pty) Ltd Registration number 1999/007736/07 An authorised financial services provider

Rules for membership

Discovery Vitality is separate from the Scheme and administrator

Discovery Vitality is a separate company from Discovery Health (Pty) Ltd ('the administrator') and the Discovery Health Medical Scheme (referred to as 'the Scheme'). It is formally registered under the name Vitality HealthStyle (Pty) Ltd, (registration number 1999/007736/07) and takes care of the administration of the Vitality programme ('Discovery Vitality'), DiscoveryCard and the DiscoveryCard Loyalty Programme.

Rules of the Vitality programme

A full set of rules is available from Discovery Vitality on request. In the event of a conflict between what is set out here, on our website and the rules of Vitality, the rules will always apply.

Your contributions to Discovery Vitality are separate

The contributions you pay to Discovery Vitality are not part of the contributions you pay to the Scheme.

Permission to get information from the Scheme

You specifically give Discovery Vitality permission to get the relevant information from the Scheme in order to administer the Vitality programme and to increase our product offering to you.

Sharing your information

Discovery Vitality will keep your information and the information about those you apply for confidential. Discovery Vitality may share this information and information about your membership with other relevant parties, including your employer, only if the following two conditions are met:

1. The information is needed only to administer and promote the Vitality programme. This includes asking for and sharing details about your credit standing and the credit standing of those you apply for with any credit bureau in line with the requirements of the National Credit Act.
2. The parties that Discovery Vitality shares the information with will agree to keep the information confidential.

When you sign this application to join Vitality, you confirm that you have read and understood the rules for membership and you agree that you and those you apply for will be bound by them.

Signed at (town or city) ______________________ on 2 0 Y Y M M D D

Signature of main applicant ______________________

The main applicant must sign and date any changes

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