Application to add dependants 2018

Discovery Health Medical Scheme

Contact us

Tel (Members): 0860 99 88 77, Tel (Health partner): 0860 44 55 66, PO Box 784262, Sandton, 2146, www.discovery.co.za

Who we are

Discovery Health Medical Scheme (referred to as 'the Scheme'), registration number 1125, 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, registration number 1997/013480/07, (referred to as 'the administrator') 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.

Purpose of the form

Thank you for deciding to apply to join the Discovery Health Medical Scheme. This document is an application form to add dependants to your membership.

It also contains some rules for membership. Please make sure you read and understand these rules.

What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally by using Microsoft Word.
- All relevant sections must be physically signed by the main applicant and cannot be signed digitally. The main applicant must sign and date any changes.
- Read and understand the rules for membership (Section 10).
- Sign section 5 (if applying to become a KeyCare member) 9 and 10.
- Fax the completed and signed form to **011 539 3000** or email it to **application@discovery.co.za**
- Please attach a copy of each applicant's identity document. We also accept valid passports and birth certificates for children.

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

- You will be contacted if any details are missing or if more information is required for underwriting purposes.
- We will activate your dependant's membership and send you or your financial adviser an acceptance letter (if no waiting periods and/or late-joiner penalties are applied). Where your dependant's have waiting periods and/or late joiner penalties we will issue a counter-offer letter which will indicate any conditions applicable to the membership. You may accept the offer by signing and returning this letter for us to activate your dependant's membership.
- You or your financial adviser will receive a welcome letter, SMS or an email to let you know when your application is considered to have been fully and completely made. This date may differ from the date on which you sign the application form.

If you do not hear from the Scheme seven days after submitting your application form, please contact us on 0860 100 345 or your financial adviser.

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

Cover start date Y Y Y Y M M D D

1. Main member details

Membership number N N N N N N N N N

Title _____ Initials _____ Surname _____

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

Preferred name _____ Gender ☐ M ☐ F Date of birth Y Y Y Y M M D D

ID or passport number N N N N N N N N N N N N N Country of issue _____

Previous or maiden _____ Marital status _____

Telephone (H) _____ _____ Telephone (W) _____ _____

Cellphone _____ _____ Fax _____ _____

Email _____

Physical address while in South Africa

Suite/Unit number _____ Complex name _____

Street number _____ Street name _____

Suburb _____ Post code _____

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

If you do not complete a postal address, we will use your physical address for post.

☐ PO Box ☐ Private Bag Box number _____

☐ Suite ☐ Postnet Suite Number _____

Suburb _____ Post code _____

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2. Adding a spouse or partner (if applying for cover)

Only complete this section if you are adding a spouse or partner.

Title _____ Initials _____ Surname _____

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

Preferred name _____ Gender ☐ M ☐ F Date of birth Y Y Y Y M M D D

ID or passport number N N N N N N N N N N N N N Country of issue _____

Marital status ☐ Married ☐ Single ☐ Divorced ☐ Widowed Y Y Y Y M M D D

Date of marriage to main applicant (where applicable). Please attach a copy of an official certificate Y Y Y Y M M D D

Previous or maiden name _____

Telephone (H) _____ _____ Telephone (W) _____ _____

Cellphone _____ _____ Fax _____ _____

Email _____

Addition of spouse to an existing membership

If addition of spouse or partner to an existing membership is:

- As a result of a legal and registered marriage within the last three months, an official certificate must accompany this application form to avoid underwriting.
- For a spouse married for a period of more than three months, full underwriting will apply.

3. Adding your dependants (if applying for cover)

Dependant 1

Title _____ Initials _____ Surname _____

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

Preferred name _____ Gender ☐ M ☐ F Date of birth Y Y Y Y M M D D

ID or passport number N N N N N N N N N N N N N Country of issue _____

Relationship to main member

(For example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

_____

If your dependant is 21 years and older, are they: Married ☐ Yes ☐ No Financially dependent on you? ☐ 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 _____ Gender ☐ M ☐ F Date of birth Y Y Y Y M M D D

ID or passport number N N N N N N N N N N N N N Country of issue _____

Relationship to main member

(For example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

_____

If your dependant is 21 years and older, are they: Married ☐ Yes ☐ No Financially dependent on you? ☐ 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 _____ Gender ☐ M ☐ F Date of birth Y Y Y Y M M D D

ID or passport number N N N N N N N N N N N N N Country of issue _____

Relationship to main member

(For example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

_____

If your dependant is 21 years and older, are they: Married ☐ Yes ☐ No Financially dependent on you? ☐ Yes ☐ No

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

4. Your employer warranty (additions to employer groups need to be signed by the HR or payroll contact)

Please ensure your employer completes this warranty if you are part of an employer group.

4.1. We warrant that the member detailed in section 1 of this application form is an employee of our organisation.

4.2. The Discovery Health Medical Scheme may bill us for the amount due for this dependant in the same way as it does for our other employees with the Discovery Health Medical Scheme.

Authorised signatory _____

Name _____

Designation _____

5. 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. 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 earnings over the last 12 months	R	R
Total monthly earnings	R	R

I declare that this income declaration is true and accurate.

Signature of main applicant _____ ⚠ **Please only sign if information is true, complete and correct.**

If you are applying in your private capacity and the highest earner earned less than R146 400 for each year, 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 and you have earned less than R146 400 for each year, then please provide the following supporting documentation as proof of income:

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

Please complete this if you have selected the KeyCare Plus or KeyCare Access Plan. Please select a GP on the KeyCare GP Network.

* 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.

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

** Please make sure that the dependant information you give above is the same as the dependant information in section 2 and 3 of this form.

6. Previous medical scheme details (Please give us proof in the form of a membership certificate)

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

Were all your dependants on the same medical scheme. ☐ Yes ☐ No

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

Name	Scheme name	Start date	End date if already resigned	Are they still a member?	Reason for leaving
		Y Y Y Y M M D D	Y Y Y Y M M D D	☐ Yes ☐ No	
		Y Y Y Y M M D D	Y Y Y Y M M D D	☐ Yes ☐ No	
		Y Y Y Y M M D D	Y Y Y Y M M D D	☐ Yes ☐ No	
		Y Y Y Y M M D D	Y Y Y Y M M D D	☐ Yes ☐ No	
		Y Y Y Y M M D D	Y Y Y Y M M D D	☐ Yes ☐ No	

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7. Moving from another medical scheme

Please make sure that you have completed section 6.

7.1. I confirm that all people named on this application:

7.1.1. have not had a break in membership of more than 90 days since resigning from the previous South African medical scheme, and ☐ Yes ☐ No

7.1.2. are currently or have been members of a South African medical scheme for at least the past 24 months. ☐ Yes ☐ No

If you answered **yes** to the above questions, please answer the questions in **7.2.**

If you answered **no** in 7.1, you must complete all the medical questions in **section 8.**

7.2. For any person named on this application form:

7.2.1. Have they been admitted to hospital in the 12 months before this application? ☐ Yes ☐ No

7.2.2. Are they currently taking regular, ongoing medicine and/or treatment of a medical condition? ☐ Yes ☐ No

7.2.3. 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 **7.2**, we will not apply any waiting periods and you **do not have to complete section 8**.

If you answered **yes** to **any** questions in **7.2**, we will apply a three-month general waiting period to your application and you **do not have to complete Section 8.**

If you feel that a three-month general waiting period should not be applied and you want to give us more information, please complete section 8. During these three months, we will only cover claims relating to Prescribed Minimum Benefits according to the Scheme's rules.

8. Your health questions

The spouse or partner and all dependants applying for cover needs to complete section 8.

Spouse or partner ☐ Yes ☐ No

Treating healthcare professional's name _____

Telephone _____ _____

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? _____

Dependant 1 Name _____

Treating healthcare professional's name _____

Telephone _____ _____

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? _____

Dependant 2 Name _____

Treating healthcare professional's name _____

Telephone _____ _____

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? _____

Dependant 3 Name _____

Treating healthcare professional's name _____

Telephone _____ _____

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? _____

Your health questions (continued

Information on symptoms, conditions or disorders (Must be completed for the main applicant, spouse/partner and all dependants)

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? We have listed some examples of conditions, symptoms or disorders under each question. These are only examples and not the full list of conditions, symptoms or disorders. Please include congenital abnormalities.

You must tell us 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.

Please take note that if you or any of your dependants have any symptom or condition not listed in the questions below, you should highlight and provide full details of this symptom or condition in response to question 11.18 below. Please answer ALL questions by ticking "Yes" or "No".

8.1. **Tumours and growths** ☐ Yes ☐ No

Example: abnormal pap smear results, skin lesions, breast disease, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abnormal mammogram result, abnormal PSA (prostate specific antigen) result.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

8.2. **Heart and circulation conditions** ☐ Yes ☐ No

Example: chest pain, palpitations, shortness of breath, coronary heart disease, angina, heart attack, arrhythmia, high blood pressure (hypertension), cardiomyopathy, valvular heart disease or heart valve replacement, congenital heart disease, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

8.3. **Gynaecological and obstetrics conditions** ☐ Yes ☐ No

Example: abnormal pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility, ectopic pregnancy.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

8.4. **Are you or any of your dependants pregnant?** ☐ Yes ☐ No

Patient name _____

8.5. **Mental health** ☐ Yes ☐ No

Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (like narcolepsy), eating disorders, Alzheimer's disease, autism, dementia, attention deficit-hyperactivity disorder, drug and/or alcohol abuse or rehabilitation, suicide attempt, counselling, bulimia and any other psychological conditions.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

8.6. **Metabolic or endocrine conditions** ☐ Yes ☐ No

Example: diabetes (high blood sugar), thyroid disease, Addison's disease, Cushing's syndrome, metabolic syndrome, parathyroid disease, Paget's disease, osteoporosis, growth deficiency, metabolic disorders, Conn's syndrome.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

Your health questions (continued

8.7. **Abdominal conditions** ☐ Yes ☐ No

Example: hepatitis, cirrhosis, portal hypertension, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis, gall bladder, gall stones, GORD (reflux), heartburn, oesophageal disease, hernias, atrophic gastritis, ulcers, stomach ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

8.8. **Brain and nerve conditions** ☐ Yes ☐ No

Example: stroke, epilepsy, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, cerebral palsy, Parkinson's disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, vetriculo-peritoneal shunt (VP shunt), mental retardation, CVA, bleeding on the brain.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

8.9. **Breathing and respiratory conditions** ☐ Yes ☐ No

Example: asthma, chronic obstructive pulmonary disease, bronchiectasis, tuberculosis, bronchitis or emphysema, cystic fibrosis, sarcoidosis, pneumonia.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

8.10. **Musculoskeletal (back, bone and muscle pain)** ☐ Yes ☐ No

Example: arthritis (any form), ongoing neck and/or back pain, ankylosing spondylitis, lupus, Sjögren's syndrome, scleroderma, polymyositis, dermatomyositis, polyarteritis nodosa, Wegener's granulomatosis, sarcoidosis, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, neurogenic bladder, gout, fractures, physical disability.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

8.11. **Kidney or urinary conditions including current or past dialysis** ☐ Yes ☐ No

Example: kidney and/or renal failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, bladder infections, other bladder or kidney problems.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

8.12. **Blood conditions** ☐ Yes ☐ No

Example: deep vein thrombosis, anaemia, ITP (platelet deficiency), polycythaemia vera, blood clotting diseases, leukaemia, lymphoma, pulmonary embolus, haemophilia and other bleeding disorders.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

8.13. **Eye conditions** ☐ Yes ☐ No

Example: cataract, keratoconus, corneal ulcer, uveitis, glaucoma, squint, ptosis, any abnormality of eyelids, retinopathy, macular degeneration, cornea transplant, eye surgery, blurry vision, blindness (partial or full), retinal detachment.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

Your health questions (continued)

8.14. **Ear, nose and throat (ENT) and dentistry conditions** ☐ Yes ☐ No

Example: chronic otitis media (middle ear infection), chronic otitis externa, hearing problems, hearing aid, cochlear implant, tonsillitis, adenoiditis, vertigo, deafness, sinus problem, nasal surgery, dental treatment or dental surgery.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

8.15. **Male urogenital conditions** ☐ Yes ☐ No

Example: prostate disorders, urogenital defects, varicocele, tumours, undescended testes, phimosis, urinary incontinence.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

8.16. **Are you or any of your dependants expecting to have medical investigations or 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

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

8.17. **Have you or any of your dependants received or not yet received medical advice or treatment for symptoms, not yet diagnosed by a medical professional, in the last 12 months before this application?** ☐ Yes ☐ No

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

8.18. **Have you or any of your dependants been diagnosed with or received treatment for, any condition not mentioned in the questions above, in the last 12 months before this application?** ☐ Yes ☐ No

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

HIV

If you, or one or more of your dependants, are HIV-positive, you or they must call us on **0860 99 88 77** 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 HIVCare Programme. Discovery Health Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before Discovery Health Medical Scheme starts paying for any general or specific medical conditions. A 12-month condition specific waiting period may therefore apply to this condition. If you do not let us know about your HIV status within 7 days of your membership being active, we may end your Discovery Health Medical Scheme membership.

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

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.
You and your refers to the member and your registered dependants on your medical scheme plan.
Your personal information refers to personal information about you, your spouse, your dependants, your beneficiaries, and your employees (as relevant). It includes information about health, financial status, gender, age, contact numbers and addresses.
Process(ing) (of) information means the automated or manual activity of collecting, recording, organising, storing, updating, distributing and removing or deleting personal information.
Competent person means anyone who is legally competent to consent to any action or decision being taken for any matter concerning a member or dependant for example a parent or legal guardian.

1. When you engage with the Scheme and Administrator, you trust us with personal information about yourself, your family, and in some cases, your employees. We are committed to protecting your right to privacy.
   The purpose of this Privacy Statement is to set out how we collect, use, share and otherwise process your personal information, in line with the Protection of Personal Information Act ("POPIA").
2. You have the right to object to the processing of your personal information and have a choice whether or not to accept these terms and conditions. However, it is important to note that the Scheme and Administrator require your acceptance to activate and service your medical scheme membership. If you do not accept these terms and conditions, we cannot activate and service your medical scheme membership.
3. The Scheme and Administrator will keep your personal information confidential. You may have given us this information yourself or we may have collected it from other sources. If you share your personal information with any third parties, we will not be responsible for any loss suffered by you or your employer (where applicable).
4. You warrant that when you give the Scheme and Administrator personal information about your dependants, you have received their permission to share their personal information with us for the purposes set out in this Privacy Statement and any other related purposes.
5. If you are an employer, you agree to indemnify the Scheme and Administrator against any loss or damage, direct or indirect, that an employee suffers because of any unauthorised use of your employees' personal information.
6. If you are giving consent for a person under 18 (a minor) you confirm that you are a competent person and that you have authority to give their consent for them.
7. You agree that the Scheme and Administrator may process your personal information for the following purposes:
   - for the administration of your health plan;
   - for the provision of managed care services to you on your health plan;
   - for the provision of relevant information to a contracted third party who requires this information in order to provide a healthcare service to you on your health plan;
   - to profile and analyse risk;
   - to share your personal information with external health specialists for them to assess or evaluate certain clinical information, in the event that you are subject to such a clinical assessment.

   Examples of how this will happen include:
   I. Sharing your personal information with your chosen financial adviser during the application process to help the Administrator, if necessary, while we process your membership application;
   II. Getting 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 processing of 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;
   III. If you have joined as a member of an employer group, getting from and sharing with your employer information that is relevant to your application;
   IV. Communicating with you about any changes in your health plan, including your contributions or changes and enhancements to the benefits you are entitled to on the health plan you have chosen;
   V. Transferring your personal information outside the borders of the Republic of South Africa where appropriate, for example to administer international emergency or treatment benefit and Africa Benefit, or if you provide an email address which is hosted outside the borders of South Africa, or for processing, storage or academic research. We will ensure that anyone to whom we pass your personal information agrees to treat your information with the same level of protection as we are obliged to; If a third party asks the Scheme and Administrator for any of your personal information, we will share it with them only if:
   - you have already given your consent for the disclosure of this information to that third party; or
   - we have a legal or contractual duty to give the information to that third party.
8. The Scheme and the Administrator will provide your personal information to any other entity within the Discovery Group with whom you or your dependant/s already have a relationship; or where you or your dependant/s have applied for a product, service or benefit from such entity. This information will be provided for the administration of your or your dependant/s products or benefits with other entities within the Discovery Group.
9. The Scheme and Administrator may share and combine all your personal information for any one or more of the following purposes:
   - market, statistical and academic research; and
   - to customise our benefits and services to meet your needs.

   Your personal information may be shared with third parties such as academics and researchers, including those outside South Africa. We ensure that the academics and researchers will keep your personal information confidential and all data will be made anonymous to the extent possible and where appropriate. No personal information will be made available to a third party unless that third party has agreed to abide by strict confidentiality protocols that we require. If we publish the results of this research, you will not be identified by name. If we want to share your personal information for any other reason, we will do so only with your permission.
10. By signing this application form, you authorise the Scheme and Administrator to obtain and share information about your creditworthiness with any credit bureau or credit providers' industry association or industry body. This includes information about credit history, financial history, judgments, default history and sharing of information for purposes of risk analysis, tracing and any related purposes.
11. The Scheme and Administrator have the right to communicate with you electronically about any changes on your health plan, including your contributions or changes and improvements to the benefits you are entitled to on the health plan you have chosen.
12. The Scheme and Administrator have a duty to keep you updated about any offers and new products that are made available from time to time. The Scheme, Administrator, any entity within the Discovery Group and contracted third-party service providers may communicate with you about these.

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Our Privacy Statement (continued)

13. Please let the Administrator know if you do not wish to receive any direct telephonic marketing.
14. You have the right to know what personal information the Scheme holds about you. If you wish to receive this information please complete a 'PAIA Form to Request Access to Records' on www.discovery.co.za/medical-aid/about-discovery-health-medical-scheme and specify the information you would like. We will take all reasonable steps to confirm your identity before providing details of your personal information.
    We are entitled to charge a fee for this service and will let you know what it is at the time of your request.
15. You agree that the Scheme and Administrator may keep your personal information until you ask us to delete or destroy it. You have the right to ask us to update, correct or delete your personal information, unless the law requires us to keep it. Where we cannot delete your personal information, we will take all practical steps to de-personalise it.
16. Where the Scheme and Administrator are required by law to collect and keep personal information, we shall do so. At a minimum, this includes the following:
    - Medical Schemes Act, 1998
    - The Consumer Protection Act, 2008
    - The Protection of Personal Information Act, 2013
    - Electronic Communications and Transactions Act, 2002
    - Promotion of Access to Information Act, 2002

    Legislation specific to Discovery Health (Pty) Ltd only:
    - Financial Advisory and Intermediary Services Act, 2002
17. You agree that the Scheme and Administrator may transfer your personal information outside South Africa:
    - if you give us an email address that is hosted outside South Africa; or
    - to administer certain services, for example, cloud services.

    When we share your information to administer certain services, we will ensure that any country, company or person that we pass your personal information to agrees to treat your information with the same level of protection as we are obliged to.
18. If the Scheme or Administrator becomes involved in a proposed or actual amalgamation, transfer or merger, acquisition or any form of sale of any assets, as appropriate, we have the right to share your personal information with third parties in connection with the transaction. In the case of such an event, the new entity will have access to your personal information.
19. The Scheme may change this Privacy Statement at any time. The current version is available on www.discovery.co.za.
20. If you believe that the Scheme or Administrator have used your personal information contrary to this Privacy Statement, you have the right to lodge a complaint with the Information Regulator, under POPIA, but we encourage you to first follow our internal complains process to resolve the complaint. We explain the complaints and disputes process on the website www.discovery.co.za. Contact details for the Information Regulator: The Information Regulator (South Africa) |SALU Building | 316 Thabo Sehume Street | Pretoria | Tel: 012 406 4818 | Fax: 086 500 3351 | inforeg@justice.gov.za

Signature of main applicant _____ Date Y Y Y Y M M D D

⚠ **Please only sign if you have read and understand this statement**

10. 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.

10.1. ***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.

10.2. ***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.

10.3. ***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.

10.4. ***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.

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Discovery Health Medical Scheme rules for membership (continued)

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.

10.5. ***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.

10.6. ***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.

Signature of main applicant _____ Date | Y | Y | Y | Y | M | M | D | D |

The main applicant must sign and date any changes.

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