Application to add dependants 2014

Discovery
Health Medical Scheme

Contact us

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

Thank you for applying to add your dependant(s) to your membership of 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.

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 10).
Step 3: Sign section 5, 9 and 10.
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 your dependant(s) has been accepted and what will happen next.

Please choose a date you want cover to start for all dependants you are applying for. This date must be the same for all your dependants applying for cover.

Cover start date Y Y Y Y M M D D

1. Main member details

Membership number

Surname

First name(s) (as per identity document)

ID or passport number Country of issue

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

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

☐ Suite ☐ Postnet Suite Number

☐ PO Box ☐ Private Bag Box number

Suburb Postal code

Physical address

Suite/Unit number Complex name

Street number Street name

Suburb Postal code

Telephone (H) (W)

Cellphone Fax

Email

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

2. Adding a spouse or partner (only complete 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 Sex M F Date of birth Y Y Y Y M M D D

ID or passport number Country of issue

Marital status Married ☐ Single ☐ Divorced ☐ Widowed ☐

Discovery Health Medical Scheme Registration number 1125
113059 10/13

2. Adding a spouse or partner (only complete if applying for cover) *(continued)*

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) (W)

Cellphone Fax

Email

Addition of spouse to an existing membership

If addition of spouse to an existing membership is:

- due to 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 (only complete 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

ID or passport number Country of issue

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

If your dependant is 21 years and older, are they: 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

ID or passport number Country of issue

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

If your dependant is 21 years and older, are they: 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

ID or passport number Country of issue

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

If your dependant is 21 years and older, are they: 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

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.

1. We warrant that the member detailed in section 1 of this application form is an employee of our organisation.
2. The Scheme may bill us for the amount due for this dependant in the same manner as for other employees with the Scheme.

Authorised signatory

Name

Designation

5. If you have a KeyCare Plan

Complete this section if you are adding a spouse or partner to your membership.

Your KeyCare contributions depend on the higher income of you or your spouse or partner. Income for this purpose includes, but is not limited to, average monthly earnings over the last 12 months from guaranteed earnings, guaranteed allowances, company contributions and variable pay or commissions from employment (including self-employment and informal employment), pension and annuity proceeds, interest earned on active and passive investments, including rental income from leasing properties and distributions received from a trust.

IMPORTANT NOTICE:
Declaring income lower than your actual income constitutes fraud. This will lead to the immediate termination of your membership.
By signing this application form, you give us permission to verify your declared income using all relevant internal and external sources, as defined in 10.4.

	Spouse or partner
Total earnings over the past 12 months	**R**
Total monthly earnings	**R**
Occupation	

I declare that this income declaration is true and accurate.

Signature of main member

If the highest earner earns less than R100 000 each year, please provide the following supporting documents 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 or employer pension or state older person's grant
- If unemployed, UIF certificate.

Please complete this if you have a KeyCare Plus or KeyCare Access Plan.

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

* If your dependant lives far away from where they work or often need to work in different towns or provinces, they may need a second GP. Please only choose a second GP if this applies to them.

** 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 the dependant(s) you want to add previously belonged to. We will use this information to determine if we need to apply any waiting periods, late-joiner penalty fees, or both.

Spouse or partner

Scheme name	**Membership number**	**Start date**	**Are they still a member?**	**End date if they have already resigned**	**Reason for leaving**
		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	

Dependant 1

Scheme name	**Membership number**	**Start date**	**Are they still a member?**	**End date if they have already resigned**	**Reason for leaving**
		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	

Dependant 2

Scheme name	**Membership number**	**Start date**	**Are they still a member?**	**End date if they have already resigned**	**Reason for leaving**
		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	

6. Previous medical scheme details *(continued)*

Dependant 3

Scheme name	Membership number	Start date	Are they still a member?	End date if they have already resigned	Reason for leaving
		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	

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:

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 **7.2**.

If you answer no to any question in 7.1, you must complete all the medical questions in section 8.

7.2 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, on going medicine for a medical condition? 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 **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.**

During these three months, the Discovery Health Medical Scheme we will only cover claims for Prescribed Minimum Benefits according to the Scheme's rules.

8. Your health questions

8A. Only the spouse or partner and any adult dependants applying for cover need to complete Section 8.A.

Spouse or partner

How tall are you? ☐ . ☐☐ metres

How much do you weigh? ☐☐☐ kilograms

Your blood type ☐

Your allergies

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

How tall are you? ☐ . ☐☐ metres

How much do you weigh? ☐☐☐ kilograms

Your blood type ☐

Your allergies

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

How tall are you? ☐ . ☐☐ metres

How much do you weigh? ☐☐☐ kilograms

Your blood type ☐

Your allergies

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?

8. Your health questions *(continued)*

Dependant 3

Name

How tall are you? . metres

How much do you weigh? kilograms

Your blood type

Your allergies

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?

8B. Have any of your **dependants** in this application ever experienced, been treated for, or are they 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 note that if you have any symptom or condition not listed in the questions below, you should highlight and provide full details of this symptom or condition in the response to 8.19 below.

8.1 Are any of your dependants pregnant? **Yes** ☐ **No** ☐

Patient name		

8.2 Cancer **Yes** ☐ **No** ☐

Example: abnormal pap smear results, pre-cancerous skin lesions, breast disease, breast lump, abnormal PSA (prostate specific antigen) result.

Patient 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 and/or hospitalisation	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 ☐
Medicine 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

8.3 Heart and circulation conditions **Yes** ☐ **No** ☐

Example: chest pain, palpitations, shortness of breath, coronary heart disease, angina, heart attack, arrhythmia, high blood pressure, 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	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	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 ☐
Medicine 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

8.4 Gynaecological and obsterics conditions **Yes** ☐ **No** ☐

Example: abnormal Pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome.

Patient 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 and/or hospitalisation	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 ☐
Medicine 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

8. Your health questions *(continued)*

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 rehabilitation.

Patient 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 and/or hospitalisation	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 ☐
Medicine 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

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

Example: diabetes, 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	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	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 ☐
Medicine 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

8.7. Liver and pancreas conditions **Yes** ☐ **No** ☐

Example: hepatitis, cirrhosis, portal hypertension, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis.

Patient 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 and/or hospitalisation	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 ☐
Medicine 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

8.8 Gastrointestinal conditions including temporary or permanent stoma **Yes** ☐ **No** ☐

Example: GORD (heartburn), oesophageal disease, hernias, atrophic gastritis, ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis.

Patient 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 and/or hospitalisation	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 ☐
Medicine 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

8. Your health questions *(continued)*

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

Example: stroke, epilepsy, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, cerebral palsy, Parkinson's disease, paraplegia or hemiplegia or quadriplegia, spinal cord injury, hydrocephalus.

Patient 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 and/or hospitalisation	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 ☐
Medicine 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

8.10 Respiratory conditions **Yes** ☐ **No** ☐

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

Patient 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 and/or hospitalisation	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 ☐
Medicine 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

8.11 Musculoskeletal and connective tissue conditions including symptoms and treatment of back pain **Yes** ☐ **No** ☐

Example: arthritis (any form), ongoing 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, gout, fractures.

Patient 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 and/or hospitalisation	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 ☐
Medicine 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

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

Examples: kidney/renal failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence.

Patient 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 and/or hospitalisation	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 ☐
Medicine 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

8. Your health questions *(continued)*

8.13 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	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	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 ☐
Medicine 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

8.14 Breast disease or any breast operation (male and female) **Yes** ☐ **No** ☐
Examples: fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abnormal mammogram result.

Patient 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 and/or hospitalisation	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 ☐
Medicine 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

8.15 Eye conditions **Yes** ☐ **No** ☐
Example: cataract, keratoconus, corneal ulcer, uveritis, glaucoma, squint, ptosis, any abnormality of eyelids, retinopathy, macular degeneration, cornea transplant, eye surgery, blurry vision.

Patient 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 and/or hospitalisation	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 ☐
Medicine 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

8.16 Ear, nose and throat (ENT) conditions **Yes** ☐ **No** ☐
Example: chronic otitis media (middle ear infection), chronic otitis externa, hearing problems, hearing aid, cochlear implant, tonsillitis, adenoiditis, vertigo.

Patient 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 and/or hospitalisation	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 ☐
Medicine 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

8.17 Male urogenital conditions **Yes** ☐ **No** ☐
Examples: prostate disorders, urogenital defects, varicocele, tumours, undescended testes, phymosis, urinary incontinence.

Patient 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 and/or hospitalisation	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 ☐
Medicine 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

8. Your health questions *(continued)*

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

Patient 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 and/or hospitalisation	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 ☐
Medicine 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

8.19 Have any of your dependants had any symptoms, not yet diagnosed by a medical professional, in the last 12 months before this application? Yes ☐ No ☐

Patient name		
Symptoms		
Date symptoms first appeared or were noticed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for these symptoms	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for these symptoms and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

8.20 Have any of your dependants 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		
Symptoms		
Date symptoms first noticed or appeared	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for these symptoms	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for these symptoms and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

8.21 Have 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 symptoms first noticed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	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 ☐
Medicine 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

HIV and AIDS

You do not need to disclose the HIV status of your dependant(s) on this form if you do not feel comfortable doing so. However, if 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 their 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 calling to register on the HIV*Care* Programme, please confirm these details. 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. Permission to process and disclose personal information and to communicate with you

Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider administers the Discovery Health Medical Scheme, registration number 1125.
Discovery Health Medical Scheme and Discovery Health (Pty) Ltd will keep your information and the information about those you apply for confidential. You agree to Discovery Health Medical Scheme and Discovery Health (Pty) Ltd processing and disclosing your information in the following manner:

1. Discovery Health Medical Scheme and Discovery Health (Pty) Ltd may collect, collate, process, store and disclose your and all your dependants' personal information, as provided in this application and any information we get about you and your dependant/s:
   - for the administration of your health plan,
   - for providing managed care services to you or any dependant/s on your health plan,

9. Permission to process and disclose personal information and to communicate with you *(continued)*

- for providing relevant information to a contracted third party who requires this information to provide a healthcare service to you or any dependant/s on your health plan; and
- to profile and analyse risk.

2. Discovery Health Medical Scheme and Discovery Health (Pty) Ltd will only share your personal and health information or the information of any dependant/s on your health plan if it is requested by a third party who you have already given your consent to for the disclosure of this information.
3. We will provide your personal and health information to any other entity within the Discovery Group where you or your dependant/s already has a relationship with or where you or your dependant's have applied for a product or benefit. This information will be provided for the administration of your or your dependant's products or benefits. 4.If we want to share your information for any other reason, we will do so only with your permission.
5. When providing Discovery Health Medical Scheme and Discovery Health (Pty) Ltd with personal and health information about a dependant on your health plan, you confirm that you have received appropriate permission to disclose this information to Discovery Health Medical Scheme and Discovery Health (Pty) Ltd.
6. Discovery Health Medical Scheme and Discovery Health (Pty) Ltd may provide any credit bureau or credit providers industry association with any information about your consumer credit record, including and not limited to information about your credit history, financial history, personal information and judgement or default history.
7. Discovery Health Medical Scheme and Discovery Health (Pty) Ltd will communicate 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.
8. Discovery Health Medical Scheme, Discovery Health (Pty) Ltd and any entity within the Discovery Group of companies will keep you updated on information about any offers or new products Discovery may make available at any time. Please contact us if you do not wish to receive any direct marketing information from us.

Signature of main applicant

10. Rules for membership

10.1 Rules for membership

The rules of the Discovery Health Medical Scheme records your rights and responsibilities for your membership of the Discovery Health Medical Scheme. They may change from time to time. You may ask Discovery Health (Pty) Ltd 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.

Where applicable you also acknowledge and confirm that the financial adviser you or your employer appointed, may communicate with us on this application and your membership of the Discovery Health Medical Scheme.

You give permission that Discovery Health Medical Scheme and Discovery Health (Pty) Ltd can share your medical information and other relevant personal information about you and your dependants with your chosen financial adviser. The information will be shared so that he or she can help Discovery Health (Pty) Ltd if necessary while we process your membership application.

Please speak to your financial adviser or Discovery Health (Pty) Ltd if there is anything you do not understand.

10.2 Who you are applying for

You may apply to join the Discovery Health Medical 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 Discovery Health Medical Scheme rules. To be treated as financially dependent for this application, a dependant must earn an income of less than what is stated in the Discovery Health Medical Scheme rules, or you must have a legal responsibility to provide financially for them. Discovery Health (Pty) Ltd 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 and any dependants 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 Discovery Health Medical 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 Discovery Health Medical Scheme and Discovery Health (Pty) Ltd. It is important that you tell Discovery Health Medical Scheme and Discovery Health (Pty) Ltd 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.

Discovery Health (Pty) Ltd may ask those you apply for who are 18 and older for information and this will be treated as if Discovery Health Medical Scheme had asked you in your role as main member.

Your legal address

We 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.

Discovery Health Medical Scheme and Discovery Health (Pty) Ltd may get information about you 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 Discovery Health (Pty) Ltd and the Discovery Health Medical Scheme can get information about you and those you apply for from other relevant sources. These include any entity that is part of Discovery Limited, medical practitioners, financial advisers, credit bureaus or industry regulatory bodies. Discovery Health (Pty) Ltd and the Discovery Health Medical 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 Discovery Health Medical Scheme, is true, correct and complete.

You give your permission that the Discovery Health Medical Scheme and Discovery Health (Pty) Ltd may get any information that is relevant to your application from your employer.

Tell Discovery Health Medical Scheme or Discovery Health immediately if your information changes

You, your employer or your financial adviser must tell Discovery Health Medical Scheme or Discovery Health (Pty) Ltd 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 Discovery Health Medical Scheme may cancel your membership/s

The Discovery Health Medical Scheme may cancel any memberships immediately and keep any contributions paid, if you and those you apply for:

- do not give Discovery Health Medical Scheme and Discovery Health (Pty) Ltd information that later turns out to be relevant to this application.
- give Discovery Health Medical Scheme and Discovery Health (Pty) Ltd any information that is not true, correct and complete.
- do not tell Discovery Health Medical Scheme and Discovery Health (Pty) Ltd 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.

10.5 About becoming a member

Discovery Health Medical Scheme might not pay for certain expenses immediately after you become a member

Discovery Health Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before the Discovery Health Medical Scheme starts paying for any general or specific medical conditions. Please speak to your financial

10. Rules for membership *(continued)*

adviser or Discovery Health (Pty) Ltd 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 Discovery Health Medical 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 Discovery Health Medical 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.

Discovery Health (Pty) Ltd and the Discovery Health Medical Scheme may record telephone calls

Discovery Health (Pty) Ltd and the Discovery Health Medical 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.

10.6 Repaying money owed to the Scheme

Discovery Health Medical Scheme has the right at any time to collect from you any amount that you owe to the Scheme.

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 Discovery Health Medical 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 Discovery Health Medical 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 Discovery Health Medical 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 member

Date 2 0 Y Y M M D D

The main member must sign and date any changes

11 . What happens next with your application

Once you send Discovery Health (Pty) Ltd your application form, here is what will happen:

- Discovery Health (Pty) Ltd will capture and check your details.
- If any details are missing or if we need more information for underwriting purposes, Discovery Health (Pty) Ltd will contact you.
- Discovery Health (Pty) Ltd will send you or your financial adviser a 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.
- After accepting your application to join Discovery Health Medical Scheme, we will send you or your financial adviser a SMS and an email letter confirming acceptance. The SMS and email will advise you of when your membership will commence. Depending on your circumstances, it may also indicate any conditions applicable to your membership such as waiting periods or late joiner penalties.
- You will be required to sign this letter at the appropriate place and return it to Discovery Health (Pty) Ltd. When you do so, you confirm your start date and acceptance of any conditions applicable to your membership.
- 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 Discovery Health (Pty) Ltd seven days after sending us your application form, please contact Discovery Health (Pty) Ltd on 0860 100 345 or your financial adviser.