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

Discovery Health Medical Scheme

Contact us

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

This document is an application form to change the main member on an existing Discovery Health 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 three steps:

Step 1: Fill in the form

Step 2: Read and understand the rules for membership

Step 3: Sign section 7 and 8.

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 what will happen next.

How to complete this application form

- This form must be completed by the person applying to be the main member.
- Please use one letter per block, complete with black ink and print clearly.
- To avoid administrative delays, please ensure this application is completed in full.
- Once completed, please fax it to **011 539 3182**.

1. About your employer

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

Employee number

Branch name | Branch number

2. About the new main member

Date membership of new main member starts **2 0** (Y Y M M) **0 1** | Membership number

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)

Marital status Married ☐ Single ☐ Divorced ☐ Widowed ☐ | Preferred language English ☐ Afrikaans ☐

Previous or maiden name (where applicable)

Tax number | Occupation

Total monthly earnings R

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

113059 12/13

2. About the new main member *(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. If you have a KeyCare Plan

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 your permission to verify your declared income using all relevant internal and external sources, as per 8.3.

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

I declare that this income declaration is true and accurate.

Signature of main applicant

If the highest earner earns less than R100 000 each year, please provide the following supporting documents as proof of income:

- Last 3 months' 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**
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 our records.

Please note: you can only access day-to-day cover and chronic benefits through the KeyCare general practitioner(s) you chose above.

4. Details of previous main member (if applying for cover)

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

Title | Initials | Surname

First name(s) (as per identity document)

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

Marital status Married ☐ Single ☐ Divorced ☐ Widowed ☐ Preferred language English ☐ Afrikaans ☐

ID or passport number | Country of issue

Telephone (H) | (W)

Cellphone | Fax

Email

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

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

Please specify your monthly income R

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

5. Your banking details

5.1 Your contributions

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

Please note: we cannot accept credit card account details.

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 membership is not activated in time for the debit order date you chose above, you will have two separate debit orders in the first month you pay your contribution, because you pay your contribution in advance. The first debit order will be collected on the first day of the month and the second debit order will be collected on the actual date you have chosen in the same month. From then on we will collect your monthly contribution on the date you have chosen.

5.2 Your claims refund

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

Please attach a copy of ID and original bank statement or letter of confirmation from the bank for all claims refund banking details whether different to contributions banking details or not.

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

Please note: we cannot accept credit card account details.

Bank name

Branch name

Branch code – –

Account number

Type of account Cheque ☐ Savings ☐

Accountholder

By signing this application, you agree that once claims have been refunded into the bank account you have chosen, the Scheme will not be responsible in any way for the amounts refunded.

Signature of accountholder

6. Your financial adviser's details

Financial adviser's name

Code

Intermediary house

Code

Financial adviser's contact details:

Telephone (W)

Cellphone

Lead number

Email

Bank reference number (if applicable)

(Mandatory for all ABSA and FNB financial advisers)

Declaration

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 Discovery Health Medical 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 appication form and joining the Discovery Health Medical Scheme.

Financial adviser's signature

7. Permission to process and disclose 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,
   - 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

8. Rules for membership

8.1 Rules for membership
Rules of the Discovery Health Medical Scheme records the 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 all matters relating to this application and your membership of the Discovery Health Medical Scheme. Please speak to your financial adviser or us if there is anything you do not understand.

8.2 Acting for others
You understand that you take over the rights and responsibilities of the main member and become the main member yourself.
By signing this document, you confirm that:

- you have received permission from your spouse and any dependants over 18 to act for them in any matter relating to this application.

8.3 Giving information
You agree to always give the Scheme true, correct and complete information.

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 Limited, medical practitioners, financial advisers, credit bureaus or industry regulatory bodies. Discovery Health (Pty) Ltd and 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 permission that the Discovery Health Medical Scheme may get any information that is relevant to your application from your employer.

8.4 About becoming a main member
You must ensure contributions are paid on time
As the new main member of the Scheme, you will now become responsible for ensuring that the contributions are paid on time every month.

Transfer of rights
When you take over the rights and responsibilities of the main member, you agree to become responsible for any debts that the previous main member may have incurred resulting from their membership of the Discovery Health Medical Scheme. By using your Medical Savings Account, you may incur certain debts or responsibilities that you will be responsible for if you end your membership with the Scheme.

If you are taking over the rights of the main member because of the death of the previous main member, these terms and conditions will apply similarly to you. Neither Discovery Health (Pty) Ltd nor the Discovery Health Medical Scheme will be responsible for any aspects relating to the deceased estate of the previous main member. By signing this application, you indemnify us against any claims from any third party resulting from the administration of the estate. This means that you agree to pay any amounts that the law says we must pay to a third party resulting from the administration of the estate.

We may record calls
We do record telephone conversations with you and with those you apply for.

The recordings will be processed and stored as required by law.

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

Signature of main applicant

Signature of previous main member*

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