Please fax completed applications to 021 7978856 or email it to enquiries@classmed.co.za

Applying to become a member of Discovery Health Medical Scheme in 2022

Discovery Health Medical Scheme

CLASSIQUE MEDICAL AID CONSULTANTS
AUTHORISED FSB 7761
7 TORRENS ROAD WYNBERG, 7800
Tel. (021) 797 8885 Fax (021) 7978856
Website : www.classmed.co.za

Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are applying to become a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (members): 0860 99 88 77, Tel (health partners): 0860 44 55 66, **www.discovery.co.za**, PO Box 784262, Sandton, 2146, 1 Discovery Place, Sandton, 2196.

Purpose of the form

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

The information requested in this application form is required to enable the Scheme to process your membership application and to help in the administration of your membership as well better administer the affairs of the Scheme.

This application form also contains terms and conditions applicable to your membership (Section 13). Please make sure you read and understand these terms and conditions. This document is valid for 90 days from date of signing it. Make reference to the footnote that indicates the expiry date of the form.

Download the latest version of all forms from www.discovery.co.za, under Medical Aid > Find documents and your certificates

What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally.
- 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 terms and conditions for membership (Section 13) and the Scheme Rules. The full set of Scheme Rules is available on request at www.discovery.co.za/medical-aid/scheme-rules.
- Sign section 6 (if applying to become a KeyCare member), 8, 12 and 14.
- Provision is made in this form for you and your dependants to provide information relating to your race. This information is required by the Council for Medical Scheme for statistical purposes only. You are not compelled to provide this information.
- Email the completed and signed form to **application@discovery.co.za** or fax it to **011 539 3000**.
- Please attach a copy of each applicant's identity document. We also accept valid passports and birth certificates for children.

Once you submit 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 and to process your application.
- You will receive an SMS and you (and your financial adviser, if you have chosen one) will receive 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 standard terms of acceptance are offered (no waiting periods or late-joiner penalties), your membership will be activated and you (or your financial adviser if you appointed one) will receive a welcome letter. For any non-standard terms, a counter-offer letter will be issued, which will indicate any conditions applicable to your membership (waiting periods and/or late-joiner penalties). You may accept the offer by signing and returning this letter to activate your membership. Once we receive your acceptance you or your financial adviser will receive a welcome letter.

If you do not hear from the Scheme within 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 terms and conditions (Section 13 of this form) for membership and agree to them.

1. About yourself (main applicant)

When do you want your cover to start? D D - M M - Y Y Y Y

Title | Initials

Surname

First name(s) (as per identity document)

Preferred name

Gender F M

Race African Coloured Indian / Asian White Other

This information is required by the Council for Medical Scheme for statistical purposes. You are not compelled to provide this information.

Do not want to disclose

Date of birth D D - M M - Y Y Y Y | Occupation

Tax Number

Gross monthly earnings **R** .

ID or passport number

Country of issue

Telephone (H) - | Telephone (W) -

Cellphone -

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

2. About your spouse or partner (only complete if applying for cover)

Title | Initials

Surname

First name(s) (as per identity document)

Preferred name | Gender M F

Race African Coloured Indian / Asian White Other

This information is required by the Council for Medical Scheme for statistical purposes. You are not compelled to provide this information.

Do not want to disclose

Date of birth D D - M M - Y Y Y Y

Marital status Married Single Divorced Widowed

ID or passport number | Country of issue

Telephone (H) - | Telephone (W) -

Cellphone -

Email

3. About your dependants (only complete if applying for cover)

Dependant 1

Title | Initials

Surname

First name(s) (as per identity document)

Preferred name | Gender M F

Race African Coloured Indian / Asian White Other

This information is required by the Council for Medical Scheme for statistical purposes. You are not compelled to provide this information.

Do not want to disclose

Date of birth D D - M M - Y Y Y Y

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, i.e. adopted child, foster child. Please provide legal proof)

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

Married Yes No | Financially dependant on you? Yes No

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

Does your dependant's spouse earn an income? Yes No | How much does your dependant's spouse earn per month? R .

Dependant 2

Title | Initials

Surname

First name(s) (as per identity document)

Preferred name | Gender M F

Race African Coloured Indian / Asian White Other

This information is required by the Council for Medical Scheme for statistical purposes. You are not compelled to provide this information.

Do not want to disclose

Date of birth D D - M M - Y Y Y Y

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, i.e. adopted child, foster child. Please provide legal proof)

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

Married Yes No | Financially dependant on you? Yes No

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

Does your dependant's spouse earn an income? Yes No | How much does your dependant's spouse earn each month R .

Dependant 3

Title | Initials

Surname

First name(s) (as per identity document)

Preferred name | Gender M F

Race African Coloured Indian / Asian White Other

This information is required by the Council for Medical Scheme for statistical purposes. You are not compelled to provide this information.

Do not want to disclose ☐

Date of birth D D - M M - Y Y Y Y

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, i.e. adopted child, foster child. Please provide legal proof)

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

Married ☐ Yes ☐ No | Financially dependant on you? ☐ Yes ☐ No

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

Does your dependant's spouse earn an income? ☐ Yes ☐ No | How much does your dependant's spouse earn each month? R .

Are you applying for more than 3 Dependants? ☐ Yes ☐ No

Note: If you are applying for more than 3 dependants, please add the details on a separate page.

4. Your financial adviser's details

Do you have a financial adviser? Yes ☐ No ☐

If yes, your financial adviser must complete the details below

Financial adviser's name **DEON VALENTINE** | Code **1110456546**

Intermediary house **CLASSIQUE MEDICAL AID CONSULTANTS** | Code **1110456538**

Financial adviser's telephone number (W) **0 2 1 7 9 7 8 8 8 5** | Lead number

Email **enquiries@classmed.co.za**

Bank reference number (if applicable) (Mandatory for all ABSA and FNB financial advisers)

I declare that:

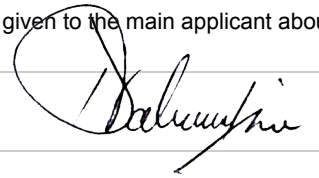
4.1. I am an accredited financial adviser in terms of the Medical Schemes Act and licensed by the Financial Sector Conduct Authority in terms of the Financial Advisory and Intermediary Services Act at the date of signing this application form.

4.2. I am appointed by the main applicant to provide advice about this application.

4.3. I have a valid contract with Discovery Health Medical Scheme and I have made the client aware of the commission payable by Discovery Health Medical Scheme.

4.4. I am responsible for providing the main applicant with:
- my name, physical address, postal address and the telephone number
- impartial advice that is in his or her best interest.

4.5. I am accountable for any advice given to the main applicant about completion of this application form and joining Discovery Health Medical Scheme.

Signature of financial adviser  Signature of main applicant

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

5. Please select your health plan

Executive Plan	Comprehensive Series	Priority Series	Saver Series	Smart Series	Core Series	KeyCare Series
☐ Executive	☐ Classic	☐ Classic	☐ Classic	☐ Classic	☐ Classic	☐ KeyCare Plus
	☐ Classic Delta	☐ Essential	☐ Classic Delta	☐ Essential	☐ Classic Delta	☐ KeyCare Core
	☐ Classic Smart		☐ Essential		☐ Essential	☐ KeyCare Start
	☐ Essential		☐ Essential Delta		☐ Essential Delta	
	☐ Essential Delta		☐ Coastal		☐ Coastal	

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

Discovery Health Rate is the medical scheme rate subject to funds available.

Cost is the full amount of the claim subject to funds available.

You have the right to ask for help in selecting a health plan that suits your needs. Whether you have requested help or made the decision on your own, by signing this application, you confirm that you are familiar with the conditions and benefits of the plan you select.

6. If you choose a KeyCare plan

Income is defined as guaranteed gross monthly earnings of main member and spouse before deductions.

IMPORTANT NOTICE:

Declaring income lower than your actual income is fraud. This may lead to the 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, indicated in 13.4 of the terms and conditions of membership (Section 13)

	Main member	**Spouse or Partner**
Gross earnings over the last 12 months	R	R
Gross 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.**

Please complete this if you selected a KeyCare plan.

If you have selected a KeyCare plan, Income verification will be conducted for the lower income bands.

Please complete this if you have selected the KeyCare Plus or KeyCare Start Plan.

- **For KeyCare Plus please select a GP on the KeyCare GP Network**
- **For KeyCare Start please select a GP on the KeyCare Start GP Network**

If you select a KeyCare Plus plan and 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					
Spouse or partner					
Dependant 1**					
Dependant 2**					
Dependant 3**					

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

7. Your employment details (only complete if your employer pays the contributions on your behalf)

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

Name of employer | Employer and billing number

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

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

Branch name | Branch number

Employer warranty

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

7.1.1 We warrant that the main applicant detailed in section 1 is an employee of our organisation.

7.1.2 Discovery Health Medical Scheme may bill us for the amount due for this member in the same way as it does for our other employees Health Medical Scheme.

Authorised signatory	
Name	
Designation	

7.2. **Only complete this section if you own your own business and your business will be paying your contribution:**

Name of your business			
Registration number		Vat number	
Telephone		Fax	

8. Your banking details

8.1 Your contributions

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

Please note: We cannot accept credit card account details and only South African banking details are accepted.

If we are debiting a third party account, the main member must sign next to the account holder.

Branch name		Branch code	
Account number		Type of account	☐ Cheque ☐ Savings
Account holder			
Account holder's physical address (own/3rd party/trust/company)			
Account holder contact details			
Account holder email address			

As part of Payment Association of South Africa (PASA) debit order mandate requirements you are required to supply the account holders residential address, email address and contact number. Please note that the details you supply will only be used for the PASA debit order mandate requirement and will not be used to update the contact details we have on system, if you wish to update any contact details please visit www.discovery.co.za.

We will debit your account on the first working day of the month. If your membership is not activated in time for the debit order collection, your first contribution will be collected with the next debit order unless it has been paid in the interim.Once your account is paid up to date, you may change your debit order date to a variable debit order date by contacting us on 0860 99 88 77.

8.2 Your claims refund

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

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. We no longer issue cheques. If no details are provided it will impact your claims payment. If we are paying a third party bank account, the main member must insert the ID number of the third party.

Bank name			
Branch name		Branch code	
Account number		Type of account	☐ Cheque ☐ Savings
Account holder			
Account holder contact details			
Account holder email address			

If we are paying a third party bank account, the main member must insert the ID number of the third party.

ID Number

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 account holder

Signature of main member

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

9. 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 you previously belonged to. We will use this information to determine if we need to apply any late-joiner penalty fees. We may also also the information on the membership certificate to determine if we can apply waiting periods.

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
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	

10. Moving from another medical scheme

Please make sure that you have completed section 9.

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

10.1.1. have not had a break in membership of more than 90 days since resigning from the previous South African medical scheme, and

Yes No

10.1.2. 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 10.2.
If you answer no to any question in 10.1, you must complete all the medical questions in section 11.

10.2. For any person named on this application form:

10.2.1. Have they been admitted to hospital in the 12 months before this application?

Yes No

10.2.2. Are they currently taking regular, ongoing medicine and/or treatment of a medical condition or symptom?

Yes No

10.2.3. Are they planning to or reasonably expecting to be hospitalised (including for pregnancy) or expecting to receive dental or medical treatment/investigations costing more than R2 000 in the next 12 months?

Yes No

If you answered yes to any questions in 10.2, we will apply a three-month general waiting period to your application and you do not have to complete Section 11.

During these three months, we will only cover claims relating to Prescribed Minimum Benefits according to the Scheme's rules. If you feel that a three-month general waiting period should not be applied and you want to give us more information, please complete section 11.

11. Your health questions

Information on symptoms, conditions or disorders (must be completed for the main applicant, spouse/partner and all dependants and must include information on conditions even if covered or not previous memberships)

Have **you or any dependant/s** 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.

We use this information only for lawful purposes, for example, enabling us and our administrator to process your application and to optimally administer your membership, to verify whether the information you provide on this application form is true and complete, to provide you with customized information relevant to your health status, to develop disease management programs for specific conditions, to review and enhance Scheme benefits, to improve Scheme's financial modeling, to assist the Scheme to better assess and mitigate its risk and other beneficial uses. A condition specific waiting period will only be imposed on your membership if you or your dependant received or were recommended any medical advice, diagnosis, care or treatment within a 12-month period ending on the date on which this application is considered to be fully and properly made.

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.

Indication of existing medical conditions on this application does not automatically enroll you/your dependants onto the Scheme's Disease Management programme. For more information with regards to the Schemes disease management enrollment visit **www.discovery.co.za.**

Please answer ALL questions by ticking "Yes" or "No".

11.1 Tumours, growths and disorders of the skin ☐ Yes ☐ No

Example: abnormal pap smear results, skin lesions, eczema, psoriasis, breast disease, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abscess,abnormal mammogram result, abnormal PSA (prostate specific antigen), any autoimmune conditions, any congenital conditions, any other abnormal cancer-screening or diagnostic test result/s or other skin conditions.

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

11.2. 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, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker, any autoimmune conditions, any congenital conditions, peripheral vascular disease.

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

11.3. Gynaecological and obstetrics conditions ☐ Yes ☐ No

Example: abnormal pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility, ectopic pregnancy, missed period, ovarian cyst, any autoimmune conditions, any congenital conditions.

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

11.4. Are you or any of your dependants pregnant or undergoing treatment/investigation for pregnancy? ☐ Yes ☐ No

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

11.5. Mental health ☐ Yes ☐ No

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

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

11.6. Metabolic or endocrine conditions ☐ Yes ☐ No

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

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

11.7. Abdominal conditions ☐ Yes ☐ No

Example: hepatitis, cirrhosis, portal hypertension, liver disease, liver failure, pancreatitis, cystic fibrosis, gall bladder/stones, GORD (reflux), heartburn, oesophageal disease, hernias, gastritis, ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis, Irritable bowel syndrome (IBS), Hemorrhoids, long standing constipation/diarrhea, ongoing abdominal pain, ascites (fluid in the abdomen) any autoimmune conditions, any congenital conditions.

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

11.8. Brain and nerve conditions ☐ Yes ☐ No

Example: stroke, epilepsy, seizures, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, other chronic headaches, cerebral palsy, Parkinson's disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, brain shunt (VP shunt),intellectual disability, CVA, bleeding on the brain, constipation, any autoimmune conditions, any congenital conditions.

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

11.9. Breathing and respiratory conditions ☐ Yes ☐ No

Example: asthma, chronic obstructive pulmonary disease, bronchiectasis, tuberculosis, bronchitis or emphysema, cystic fibrosis, sarcoidosis, pneumonia, interstitial lung diseasechronic cough > 3months, any autoimmune conditions, any congenital conditions.

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

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

Example: arthritis (any form), ongoing joint or muscular pain, ankylosing spondylitis, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, neurogenic bladder, gout, injury, physical disability, prosthesis, amputation, any autoimmune conditions, any congenital conditions.

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

11.11. 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, neurogenic bladder, bladder infections, other bladder or kidney problems, any autoimmune conditions, any congenital conditions.

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

11.12. Blood conditions ☐ Yes ☐ No

Example: deep vein thrombosis, anaemia, polycythaemia vera, blood clotting diseases, leukaemia, lymphoma, pulmonary embolus, haemophilia, haemochromatosis and other bleeding disorders, any autoimmune conditions, any congenital conditions.

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

11.13.Eye conditions ☐ Yes ☐ No

Example: cataract, keratoconus (cross linkage), corneal ulcer, uveitis, glaucoma, squint, ptosis, retinopathy, macular degeneration, cornea transplant, eye surgery, blurred vision,eye infections, blindness (partial or full), retinal detachment, any autoimmune conditions, any congenital conditions.

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

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

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

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

11.15. Male urogenital conditions ☐ Yes ☐ No

Example: prostate disorders, urogenital defects, varicocele, undescended testes, phimosis, urinary incontinence, retention, infertility, any autoimmune conditions, any congenital conditions.

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

11.16. 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/seen in casualty in the last 12 months?

Yes ☐ **No** ☐

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

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

11.18. Have you or any of your dependants been diagnosed with or received treatment for, any condition/symptom not mentioned in the questions above, in the last 12 months before this application?

Yes ☐ **No** ☐

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

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 or any related 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.

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

Definitions

The Scheme/we/us/our 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 Discovery Limited (registration number 1999/007789/06).

You and your refers to the member and the dependants on the medical scheme which may include your spouse, children and other dependants as the case may be.

Your personal information refers to personal information about you, and your employees (as relevant). It includes information about race, gender, sex, pregnancy, marital status, national, ethnic or social origin, colour, sexual orientation, age, physical or mental health, well-being, disability, religion, conscience, belief, culture, language and birth of the individual amongst other things.

Process(ing) (of) information means the lawful and reasonable automated or manual activity of collecting, recording, organising, storing, updating, distributing and removing or deleting personal information to ensure that such processing is adequate, relevant and not excessive given the purpose for which it is processed.

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, legal guardian or a legal representative appointed by a court to manage the finances, property, or estate of another person unable to do so because of mental or physical incapacity.

How we will process and disclose your personal information and communicate with you

1. The purpose of this Privacy Statement is to set out how we collect, use, share and otherwise process your personal information, in a manner that is compliant, ethical, adheres to industry best practice and applicable protection of personal information legislation as enacted from time to time.

2. This Privacy Statement applies to you if you engage with us physically through our offices, or virtually through our website (https://www.discovery.co.za), email, mobile applications such as the Discovery App, social media platforms, over the phone, or otherwise as may be the case from time to time.
3. When you engage with the Scheme and Administrator, you entrust us with personal information about yourself, your family, and in some cases, your employees. We are committed to protecting your right to privacy. The Scheme and Administrator will keep your personal information confidential.
4. We take protecting your personal information seriously and are continuously developing and updating our security systems, processes and data governance policies.
5. We have a duty to take all reasonably practicable steps to ensure your personal information is complete, accurate, not misleading and updated on a regular basis. To enable this, we will always endeavour to obtain personal information from you directly. Where we are unable to do so, we will make use of verifiable independent third party data sources. Thus your personal information comprises information you may have given to us yourself or we may have collected from other sources.
6. 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.
7. You understand and/or acknowledge that when you include your spouse and/or dependents on your application, we will process their personal information for the activation of the policy/benefit and to pursue their legitimate interest. By submitting your dependents' relevant personal information, you hereby confirm that you are duly authorised to share such information with us. We will furthermore process their information for the purposes and in the manner set out in this Privacy Statement.
8. 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 on their behalf.
9. If you share your personal information with any third parties, we will not be responsible for how they use this information nor be responsible for any loss suffered by you or your employer (where applicable).
10. If you are an Employer Group with the Scheme ("the parties"), the parties accept responsibility to the extent that the processing activities of personal information fall under the control of that party and agrees to indemnify the other party/ies against any loss or damage, direct or indirect, that an employee may suffer because of any unauthorised use of the employees' personal information or if a breach of the employees' personal information occur, but only if the processing of that personal information is controlled by that party.
11. You understand, accept and consent that the Scheme and Administrator may process your personal information for the following purposes:
    11.1. to verify the accuracy, correctness and completeness of any information provided to the Scheme and Administrator in the course of processing an application for membership or providing services related to the membership;
    11.2. for the administration of your health plan;
    11.3. for the provision of managed care services to you on your health plan;
    11.4. 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;
    11.5. to profile and analyse risk;
    11.6. to share your personal information with external health providers for them to assess or evaluate certain clinical information, in the event that you are subject to such a clinical assessment.
12. Examples of when and how we will get and share your personal information include:
    12.1. 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;
    12.2. Getting your personal information with your chosen financial adviser during the application process to help the Administrator, if necessary, while we process your membership application;
    12.3. 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;
    12.4. 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.
    12.5. 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;
    12.6. 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
13. If a third party asks the Scheme and Administrator for any of your personal information, we will share it with them only if:
    13.1. you have have already given your consent for the disclosure of this information to that third party; or
    13.2. we have a legal or contractual duty to give the information to that third party.
14. The Scheme and the Administrator will provide your personal information to any entity (including an entity forming part of Discovery Limited) 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 an entity. This information will be provided for the administration of your or your dependant/s products or benefits with such entities.
15. 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 an academic or research party unless that 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.
16. You agree that the Scheme and Administrator may transfer your personal information outside South Africa:
    16.1. if you give us an email address that is hosted outside South Africa; or
    16.2. to administer certain services, for example, cloud services.

17. 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.
18. When we share your information, we will ensure that, the company, person or regulatory body (in or outside of South Africa) to whom we pass your personal information to agrees to treat your information with the same level of protection as we are obliged to.
19. You consent and agree that:
    19.1. we may process your information, including personal and special personal information, to adhere to South African legislative reporting obligations and to perform transaction monitoring activities;
    19.2. we may communicate such personal information to local Regulatory Bodies as well as to other relevant governance structure of Discovery Limited if any Legislative reportable matters are identified.
20. We may process your information using automated means (without human intervention in the decision making process) to make a decision about you or your application for any product or service. You may query the decision made about you.
21. 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.
22. 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 of Discovery Limited and/or any contracted third-party service providers may communicate with you about these.
23. You may opt out of Electronic Marketing on www.discovery.co.za or the Discovery App. We will store your personal information for the purpose to action this request and action it as soon as reasonably possible.
24. Unless required by law to keep your personal information for a certain period of time or purpose, 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.
25. 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:
    25.1. Legislation applicable to the Scheme and the Administrator:
    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
    25.2. Legislation specific to Discovery Health (Pty) Ltd only:
    Financial Advisory and Intermediary Services Act, 2002
26. The Scheme may change this Privacy Statement at any time. The current version is available on www.discovery.co.za/medical-aid/about-discovery-health-medical-scheme.
27. 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 in respect of this request. We are entitled to charge a fee for this service and will let you know what it is at the time of your request.
28. 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 complaints process to resolve the complaint. We explain the complaints and disputes process on the website **discovery.co.za/medical-aid/about-discovery-health-medical-scheme** or contact the Administrator's Information Officer at **privacy@discovery.co.za**. If, thereafter, you feel that we have not resolved your complaint adequately kindly contact the Information Regulator at: The Information Regulator (South Africa) |JD House | 27 Stiemens Street |Braamfontein |PO Box 31533 |Braamfontein |2017 | Tel: +27 (0) 10 023 5207 | Cell No: +27 (0) 82 746 4173 | **inforeg@justice.gov.za**

Do you agree that we may send you direct electronic marketing from time to time

No, thank you ☐ Yes, I agree ☐

Signature of main member

Date D D - M M - Y Y Y Y

The main applicant must sign and date any changes.

Please only sign if you have read and understand this statement

13. Terms and Conditions applicable to Discovery Health Medical Scheme 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.

13.1. ***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 terms and conditions and you agree that you and those you apply for will be bound by these and Scheme Rules.

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

13.2. ***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.

13.3. ***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.

13.4. ***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.

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 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.

13.5. ***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.

13.6. ***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.

You will be able to identify the debit order for the money owing to the Scheme on your bank statement, the reference number DISCSETTLE will be used.

Signature of main applicant

Date D D - M M - Y Y Y Y

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

14. Debit order mandate

The signed authority and mandate refers to the application on the signed date ("the Agreement")

I, the undersigned:

- Warrant that the account information I have provided above is an account in my name and that the information furnished by me/us in this Authority and Mandate is true and correct:
- Authorise Discovery Health to issue and deliver payment instructions to my bank, recorded above, for the collection by Discovery Health from the bank account (or any bank or branch to which I may transfer my account) any amounts due under or in terms of this application on condition that the sum of such payment instructions will never exceed my obligations as framed in the Agreement which shall commence on the date that cover starts as requested on the application form and shall continue until this Authority and Mandate is terminated by me by giving Discovery Health no less than 20 ordinary working days written notice thereof or immediately in the event that I instruct my bank to withdraw this Authority and Mandate.
- Confirm that the payment instructions mentioned above must be issued on the first working day of the month. If the membership is not activated in time for the debit order collection and there is an amount outstanding Discovery Health can collect that amount in the interim, upon activation. If I change the date of the debit order after activation, I confirm that the payment instructions must be issued and delivered on the day that I have nominated (“payment day”) and thereafter on the same day in each and every successive month. If the payment day falls on a Sunday or recognised South African public holiday, the payment day will automatically be the next working day;
- Authorise Discovery Health to track my bank account and re-present the payment instruction referred to above in the event that there are insufficient funds in my bank account to meet my obligations under or in terms of this Agreement.
- Acknowledge that my bank account will treat each payment instruction to pay contributions or amounts due under this Agreement to Discovery Health Medical Scheme, as if each payment instruction came from me personally as the account holder.
- Undertake to advise Discovery Health in writing of any changes to my account details and acknowledge that Discovery Health will not be held responsible or liable for any claim, loss or harm that I or any third party may suffer as a result of me providing incorrect banking details herein or if the bank account is in the name of another person or entity or as a result of my failure to notify Discovery Health of a change in banking details or if the bank account has insufficient funds to meet my obligations under or in funds to meet my obligations under or in terms of the Agreement.
- Know and understand that the withdrawals hereby authorized will be processed through a computerized system provided by South African banks. The details of each withdrawal from my bank account will be printed on my bank statement and must show the reference number of the membership inserted in the Agreement so as to enable me to identify this membership;
- Acknowledge that although this Authority and Mandate may be terminated by me, such termination does not necessarily terminate this Agreement. In the event of such termination I am not entitled to any refund of any contributions or amounts due that was withdrawn by Discovery Health Medical Scheme whilst this Authority and Mandate was in force if such contributions or amounts were legally owing to Discovery Health Medical Scheme in terms of the Agreement;
- Acknowledge that by signing this Authority and Mandate I am bound by the payment terms applicable to this Agreement.

Signature

Date D D - M M - Y Y Y Y

Please only sign if information is true, correct and complete