

## Applying to join Discovery Health Medical Scheme as part of an employer group in 2022



CLASSIQUE MEDICAL AID CONSULTANTS AUTHORISED FSB 7761 7 TORRENS ROAD WYNBERG, 7800 Tel. (021) 797 8885 Fax (021) 7978856 Website : www.classmed.co.za
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### 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](http://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 as to better administer the affairs of the Scheme.

This application form also contains terms and conditions applicable to your membership (Section 10). 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](http://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 10) and the Scheme Rules. The full set of Scheme Rules is available on request.
- Sign section 5, 9 and 10.
- 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](mailto:application@discovery.co.za).
- Please attach a copy of each applicant's identity document. We also accept valid passports and birth certificates for children.

Once you 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 a SMS or an email to let you know when your application is considered to have been fully and completely made. This date may differ from the date on which you sign the application form.
- If 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 for membership and agree to them.**

## 1. About yourself (main applicant)

When do you want your cover to start?    -    -

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    -    -     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    -    -

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    -    -

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    -    -

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 

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

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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. Please select your health plan

Executive Plan	Comprehensive Series	Priority Series	Saver Series	Smart Series	Core Series	KeyCare Series
<input type="checkbox"/> Executive	<input type="checkbox"/> Classic	<input type="checkbox"/> Classic	<input type="checkbox"/> Classic	<input type="checkbox"/> Classic	<input type="checkbox"/> Classic	<input type="checkbox"/> KeyCare Plus
	<input type="checkbox"/> Classic Delta	<input type="checkbox"/> Essential	<input type="checkbox"/> Classic Delta	<input type="checkbox"/> Essential	<input type="checkbox"/> Classic Delta	<input type="checkbox"/> KeyCare Core
	<input type="checkbox"/> Classic Smart		<input type="checkbox"/> Essential		<input type="checkbox"/> Essential	<input type="checkbox"/> KeyCare Start
	<input type="checkbox"/> Essential		<input type="checkbox"/> Essential Delta		<input type="checkbox"/> Essential Delta	
	<input type="checkbox"/> Essential Delta		<input type="checkbox"/> Coastal		<input type="checkbox"/> Coastal	

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.

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.

**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			<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																							<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																					
Spouse or partner			<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																							<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																					
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\*\* Please make sure that the dependant information you give above is the same as the dependant information in section 3 of this form.

Please provide the details on a separate page if you are applying for more than 3 dependants.

## 5. Your banking details for claims refund

Your contributions will be paid by your employer as a salary deduction, you only need to give us banking details for claim refunds.

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.

**Please note: We cannot accept credit card account details and only South African banking details are accepted. We no longer issue cheques. If no details are provided we will not be able to refund your claims. 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's physical address (own/3rd party/trust/company)

Account holder contact number

Account holder email address

If third party bank details, please insert the third party ID number.

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 applicant

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

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

Please give us the details of all registered South African medical schemes that you previously belonged to. We will use this information to determine if we need to apply any late-joiner penalty fees. We may also use the information on the membership certificate to determine if we can apply waiting periods. Information regarding your previous medical history and your details that are held by your previous medical scheme will not be automatically transferred to Discovery Health Medical Scheme.

Were all your dependants on the same medical scheme  Yes  No

If not, please complete your dependants' previous medical scheme cover details 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	<input type="checkbox"/> Yes <input type="checkbox"/> No	

## 7. About your employer

**Please ask your employer to complete this section.**

Please attach a clear copy of your salary slip or the letter of employment

Name of employer  Employer or billing number

Employee number  Date of employment

Branch name

Branch number

If you are joining Discovery Health Medical Scheme more than three months after you were employed, please give one of the following reasons:

I was previously covered by my spouse or partner's medical scheme but:

I am now divorced  My spouse or partner has been retrenched

Date    -    -

My spouse or partner resigned  My spouse or partner is deceased

Date    -    -

I was a wage earner now earn a salary or I was a temporary or contract worker and I am now permanent

Date    -    -

I am now offered medical aid due to my new salary level or job grade

Date    -    -

### Employer warranty

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

Employer warranty

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

7.2. The 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 with the Discovery Health Medical Scheme.

Employer's signature

Name

Designation



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

### 8. Your financial adviser's details (to be completed by your financial adviser)

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)

### Declaration

I declare that I have read, understood and agree to the broker declaration on [www.discovery.co.za/portal/rules](http://www.discovery.co.za/portal/rules).

**I declare that:**

8.1. 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.

8.2. I am appointed by the employer to provide advice about this application.


8.3. 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.

8.4. I am responsible for providing the employer and main applicant with:

- my name, physical address, postal address and the telephone number
- impartial advice that is in his or her best interest.

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

Signature of  
financial adviser



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

## 9. 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 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](http://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](http://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](http://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](http://discovery.co.za/medical-aid/about-discovery-health-medical-scheme) or contact the Administrator's Information Officer at [privacy@discovery.co.za](mailto: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 | [infoereg@justice.gov.za](mailto:infoereg@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   -   -

The main applicant must sign and date any changes.



Please only sign if you have read and understand this statement

## 10. 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.

### 10.1. *Scheme rules for membership*

The rules of the Scheme record your rights and responsibilities for your membership. They may change from time to time. You may ask us for a copy of these rules at any time or view these rules on [www.discovery.co.za](http://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

### 10.2. *Who you are applying for*

You may apply to join the Scheme on your own or together with other people – your spouse, your partner and people who are financially dependent on you as defined in the Scheme rules, as referred to above. For anyone to be treated as financially dependent for this application, you must have a responsibility to provide financially for that dependant. The Scheme or Administrator might ask you to give us proof of financial or legal responsibility.

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

### 10.3. *Acting for others*

You confirm you have the right to act for others.

By signing this document, you confirm that:

- you have the right to apply for membership and to act for those you apply for in any matter relating to this application.
- you have received permission from your spouse/partner and any dependant(s) over 18 to act for them in any matter relating to this application.

#### 10.4. ***Giving and getting information***

##### **You must give true, correct and complete information.**

To consider your application for membership, the Scheme must learn more about you and those you apply for.

Information about you and those you apply for must be true, correct and complete. This includes the details you give in this application form and in future dealings with us. It is important that you tell us about any medical condition, symptom or illness relating to you or those you apply for, even if you do not consider it relevant to your application. We may ask those you apply for who are 18 and older for more information about themselves.

##### **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.

#### 10.5. ***About becoming a member***

##### **The Scheme might not pay for certain expenses immediately after you become a member**

The Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before the Scheme starts paying for any general or specific medical conditions. We will advise if any waiting periods apply. Please speak to your financial adviser or the Administrator with regard to any waiting periods applicable to your membership and the memberships of those you apply for.

##### **Resign from current medical schemes when accepted**

It is illegal to be a member of more than one medical scheme at the same time. You and those you apply for must resign from your current medical schemes when you receive notice from the Scheme by letter, email or SMS telling you that you and those you apply for have been accepted.

**You must ensure contributions are paid on time**

As the main member of the Scheme, you are responsible for ensuring that your contributions and the contributions of those you apply for are paid on time every month to avoid suspension of benefits. The Scheme has the right to amend monthly contributions and benefits from time to time with prior notification.

**10.6. Repaying money owed to the Scheme**

The Scheme has the right at any time to collect from you any amount that you owe.

We will notify you if there is any amount that you owe to the Scheme.

**You must repay any medical savings owing if you leave the Scheme.**

When you become a member, depending on the plan you chose, you may have money available in advance to use for medical expenses during the year. This money is allocated to an account called the 'Medical Savings Account'. If you leave the Scheme before the year is up, you must repay the portion of medical savings you have used that is more than you have paid back to the Scheme over the year.

By signing this form, you agree that any money you owe to the Scheme may be deducted from any future claim payment amounts that are due to be paid to you.

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    -    -

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

**This form is only a complete application when it contains all the information we need to fully process your application. We take the date on which we receive the complete application as the application date, and not the date on which you sign the form**