

Applying to join Discovery Health Medical Scheme when moving from another medical scheme in 2024



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 Discovery Health Medical Scheme. This document is an application form for membership. Complete this form when you are moving from another medical scheme. 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 certificates > Application forms.

What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally. You can access a list of the approved digital signatures from www.discovery.co.za, under Medical aid > Find documents and certificates > Application forms.
- All relevant sections must be signed by the main applicant. 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 www.discovery.co.za/medical-aid/scheme-rules.
- 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.
- Sign section 7 (if applying to become a KeyCare member), 9, 12 and 14.
- 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 a message 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 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 and your financial adviser will receive a welcome letter.

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

When you sign this application, you confirm that you have read and understood the terms and conditions (Section 13 of this form) for membership and agree to them.

I consent to my spouse and/or adult dependant, that is part of this application process, acting on my behalf and providing personal information, including health information, to Discovery Health for the purpose of my application to join Discovery Health Medical Scheme

Yes No

1. Moving from another medical scheme to Discovery Health Medical Scheme

Please complete this section before the rest of the application form. You must answer yes to both questions to complete this application form. If you answer no to either of these questions, you must complete an 'Applying to become a member of Discovery Health Medical Scheme' application form. Information regarding your previous medical history held by your previous medical scheme will not be transferred to Discovery Health Medical Scheme.

I confirm that all people named on this application:

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

Yes No

1.2. are currently or have been members of a South African medical scheme for at least the past 24 months.

Yes No

2. About yourself (main applicant)

When do you want your cover to start?

D	O	D	1	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---	---

Title

Initials

Surname

First names (according to identity document)

Gender M

F

Race African

Coloured

Indian/Asian

White

Other

You do not have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Do not want to disclose race

Date of birth

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Occupation

Tax Number

Gross monthly earnings R

ID or passport number

Telephone (H)

Telephone (W)

Cellphone

Email

Physical address while in South Africa

Suite/unit number

Complex name

Street number

Street name

Suburb

Postal code

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

Same as residential address Yes No

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

Postal code

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

Title

Initials

Surname

First name (as per identity document)

Gender M

F

Race African

Coloured

Indian/Asian

White

Other

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Do not want to disclose race

Date of birth

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Marital status Married

Single

Divorced

Widowed

ID or passport number

Telephone (H)

Cellphone

Email

Telephone (W)

4. About your dependants (only complete if they are also applying for cover)

Dependant 1

Title Initials

Surname

First names (according to identity document)

Gender M F

Race African Coloured Indian/Asian White Other

You do not have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Do not want to disclose race

Date of birth

ID or passport number

Relationship to main member

(For example mother or child. Where your child is not your biological child, please state your relationship, for example adopted child or foster child. Please give us legal proof of the relationship.)

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 names (according to identity document)

Gender M F

Race African Coloured Indian/Asian White Other

You do not have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Do not want to disclose race

Date of birth

ID or passport number

Relationship to main member

(For example mother or child. Where your child is not your biological child, please state your relationship, for example adopted child or foster child. Please give us legal proof of the relationship.)

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 names (according to identity document)

Gender M F

Race African Coloured Indian/Asian White Other

You do not have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Do not want to disclose race

Date of birth

ID or passport number

Relationship to main member

(For example mother or child. Where your child is not your biological child, please state your relationship, for example adopted child or foster child. Please give us legal proof of the relationship.)

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.

5. Your financial adviser's details

Financial adviser's name **SHAMIEM AHMED** Code **1 1 1 0 4 5 9 4 0 9**

Intermediary house **CLASSIQUE MEDICAL AID CONSULTANTS** Code **1 1 1 0 4 5 6 5 3 8**

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:

- 5.1. I am an accredited financial adviser in terms of the Medical Schemes Act 131 of 1998 and licensed by the Financial Services Board in terms of the Financial Advisory and Intermediary Services Act 37 at the date of signing this application form
- 5.2. I am appointed by the employer to provide advice about this application.
- 5.3. I have a valid contract with Discovery Health Medical Scheme and I have made the client aware of the commission I receive from Discovery Health Medical Scheme.
- 5.4. I am responsible for providing the employer with:
 - my name, physical address, postal address and telephone number
 - impartial advice that is in its best interest.
- 5.5. I am accountable for any advice I give to the employer and main applicant about the completion of this application form and joining Discovery Health Medical Scheme.

Signature of financial adviser  Date

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

6. 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 Smart	<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"/> Essential	<input type="checkbox"/> Essential Dynamic	<input type="checkbox"/> Essential	<input type="checkbox"/> KeyCare Start
			<input type="checkbox"/> Essential Delta		<input type="checkbox"/> Essential Delta	<input type="checkbox"/> KeyCare Start Regional
			<input type="checkbox"/> Coastal		<input type="checkbox"/> Coastal	

I would like to select that my health plan complies with the requirements of Shariah Yes No

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.

When you make a claim that is eligible for payment, the Scheme will use the money available in your Medical Savings Account (MSA) to pay for it. Your MSA is a combination of your annual MSA allocation, which is the amount of money you receive at the start of each year, and your accumulated MSA, which is the money that you didn't spend in previous years and that carried over to the current year.

7. If you choose a KeyCare plan

Please complete this section if you selected a KeyCare plan.

Income is defined as guaranteed gross monthly earnings of the main member and the spouse before deductions. If you have selected a KeyCare plan, Income Verification will be conducted for the lower income bands.

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. If your income is not declared, your income verification status will default to the highest income band. It is your responsibility to give accurate income information, otherwise the Scheme may not be in a position to pay back the excess amount you paid.

	Main member	Spouse or partner
Gross earnings over the last 12 months	R	R
Gross monthly earnings	R	R

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).

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 have selected the KeyCare Plus, KeyCare Start or KeyCare Start Regional 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.
- For KeyCare Start Regional please select a GP on the KeyCare Start Regional GP Network.
- If you have selected the KeyCare Start Regional Plan, which offers comprehensive and affordable cover in and around Polokwane, Tzaneen, Mbombela, Trichardt, Bellville and George, please make sure that you stay or work in one of these locations so that the full benefit suite is available to you.

	Name	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. Please

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

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

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

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

Name of employer	<input type="text"/>	Employer and billing number	<input type="text"/>								
Employee number	<input type="text"/>	Date of employment	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
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	<input type="text"/>	Branch number	<input type="text"/>								

Employer warranty

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

8.1.1 We warrant that the main applicant detailed in section 2 is an employee of our organisation.

8.1.2. 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 with Discovery Health Medical Scheme.

Authorised signatory	<input type="text"/>
Name	<input type="text"/>
Designation	<input type="text"/>

8.2 Only complete this section if you own your own business and your business will be paying your contribution:

Name of your business	<input type="text"/>																																										
Registration number	<table border="1"><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></tr></table>																					VAT number	<input type="text"/>																				
Telephone	<table border="1"><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></tr></table>																					Fax	<table border="1"><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></tr></table>																				

9. Your banking details

9.1. 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.

Bank name	<input type="text"/>		
Branch name	<input type="text"/>	Branch code	<input type="text"/>
Account number	<input type="text"/>	Type of account	<input type="checkbox"/> Cheque <input type="checkbox"/> Savings
Account holder	<input type="text"/>		
Account holder's physical address (own/3rd party/company/trust)	<input type="text"/>		
Account holder contact number	<input type="text"/>		
Account holder email address	<input type="text"/>		

If we are debiting from a third party bank account, the main member must insert the ID or passport number of the third party.

ID or passport number	<table border="1"><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></tr></table>																				

If the third party bank account is a Joint account Company account or Trust account

please provide proof of bank account. Refer to Annexure A at the back of the application form for the proof of bank account required.

According to Payments 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 the membership is not activated in time for the debit order collection and there is an amount outstanding Discovery Health will collect that amount in the interim, upon activation . 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.

9.2. 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	<input type="text"/>		
Branch name	<input type="text"/>	Branch code	<input type="text"/>
Account number	<input type="text"/>	Type of account	<input type="checkbox"/> Cheque <input type="checkbox"/> Savings
Account holder	<input type="text"/>		
Account holder's physical address (own/3rd party/company/trust)	<input type="text"/>		
Account holder contact number	<input type="text"/>		
Account holder email address	<input type="text"/>		

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

ID Number

If the third party bank account is a Joint account Company account or Trust account

please provide proof of bank account. Refer to Annexure A at the back of the application form for the proof of bank account required.

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 and you understand that you may not transfer, assign, pledge or cede the payment or receipt of any benefit by or from the Scheme to any person and if you do or attempt to do so, the Scheme may withhold, suspend or discontinue the payment of such benefit.

Signature of account holder

Signature of main applicant

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

10. 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 and your dependants 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.**

Were all your dependants on the same medical scheme Yes No

If you and 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
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

11. Moving from another medical scheme

Please make sure that you have completed section 10

For any person named on this application form:

- 11.1 Have you or any of your dependants been admitted to hospital in the 12 months before this application? Yes No
- 11.2. Are you or any of your dependants currently taking regular, on-going medicine and/or receiving treatment for a medical condition or symptom? Yes No
- 11.3. Are you or any of your dependants 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 **no** to all of the above questions, we will not apply any waiting periods.

If you answered **yes** to any of the above questions, we will apply a three-month general waiting period to your application.

During these three months, we will only cover claims relating to Prescribed Minimum Benefits according to the Scheme’s rules as referred to in Section 13.1. Indication of existing medical conditions on this application does not automatically enrol you/your dependants onto our condition-specific care programmes. For more information with regards to the Scheme’s condition-specific care programmes, visit www.discovery.co.za.

Please note that if you move from another medical scheme your previous medical history and your details are not automatically transferred to Discovery Health Medical Scheme.

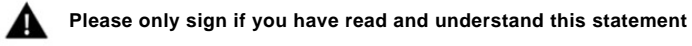
12. Our Privacy Statement – How we will process and disclose your personal information and communicate with you

When you engage with Discovery Health Medical Scheme, you are entrusting us with your personal information. We are committed to protecting your right to privacy and keeping your information safe. Our Privacy Statement tells you how we collect, use and share your personal information, including personal information about your spouse, employees, dependants, beneficiaries and life assureds, where applicable. To view and read our Privacy Statement, please follow this link: <https://www.discovery.co.za/medical-aid/about-discovery-health-medical-scheme> and scroll to, “YOUR PRIVACY IS IMPORTANT TO US” click on the **Privacy Statement** link.

Signature of main member Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

The main applicant must sign and date any changes.



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.

Do you agree that we may send you direct electronic marketing from time to time No, thank you Yes, I agree

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, to profile and analyse risk or to investigate fraud, waste and/or abuse (including by medical practitioners, contracted service providers or financial advisers).

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.

Monitor for possible non-disclosure.

To exclude the possibility of non-disclosure of material information, for the first 12 months we will monitor membership in the following cases:

- a) Claims of new beneficiaries with less than 24 months continuous medical scheme membership and with less than 90 days break, immediately prior to date of application.
- b) When an application is made for membership or admission for a person who was not a beneficiary of a medical scheme for a period of at least 90 (ninety) days preceding the date of application. In accordance with the Medical Schemes Act, we implore new applicants to disclose true and complete information to the Scheme.

It is always better to disclose too much than too little.

Please note that if membership is subject to the above-mentioned 12-month monitor period, the Scheme may request additional medical history upon receiving a claim and/or a request for authorisation.
In this case, the Scheme will only confirm benefits once it is satisfied with the additional information received.

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

This 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 other 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.
- If the membership or change in account details 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. 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;
- Acknowledge that my bank will treat each payment instruction to pay premiums or amounts due under this Agreement to Discovery Health 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 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 premiums or amounts due that was withdrawn by Discovery

Health whilst this Authority and Mandate was in force if such premiums or amounts were legally owing to Discovery Health in terms of the Agreement.

- Acknowledge that by signing this Authority and Mandate I am bound by the payment terms applicable to this Agreement.
- Acknowledgement that this Authority may be assigned to a third party if this agreement is also assigned to a third party.

Reference number

This Agreement reference number: System generated reference number

Abbreviated name

Abbreviated name as registered with the bank: DISCPREM

Deduction amount: as per your activation of membership letter

Deduction date: as per section 1 of your membership application form

Payment start date: as per section 1 of your membership application form

Account holder name

Signature of main applicant

Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

The main applicant must sign and date any changes.



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.

15. Banking details for a third party - Annexure A

Please attach the relevant proof of bank account if you give a third party's bank account details for claim refunds and / contribution debit orders.

Documents we need for a third-party bank account

(A third party can be anyone, such as your spouse, aunt, uncle, friend, father or son.)

- Proof of the account (bank statement or bank letter not older than three months)
- A copy of the third party's (account holder) ID, passport or driving licence
- A copy of the main member's ID, passport or driving licence

Documents we need for a joint bank account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of each of the joint owners.

Documents we need for a company account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of the persons who have authority to sign on behalf of the company
- A letter of authority. The letter must:
 - State that the account can be used
 - State the membership details (including the membership or policy numbers) for which the bank account will be used
 - Include the details of the signatory
 - Be dated and signed by an authorised person on behalf of the company
- A copy of the company's certificate of registration.
- A copy of the main member's ID, passport or driving licence

Documents we need for a trust account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of each of the trustees of the account
- A copy of the certificate of registration of the trust
- A copy of the trust resolution. The resolution must:
 - Show the trustees
 - Be dated and signed by an authorised person on behalf of the trust
 - Contain the membership or policy numbers
- A copy of the main member's ID, passport or driving licence

If you are completing the request on behalf of the main member, please include proof that you have the necessary authority to do so, for example, a letter of authority or a letter of executorship.