Please email completed applications to enquiries@classmed.co.za

Applying to become a member of Discovery Health Medical Scheme in 2027

Discovery Health Medical Scheme

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 it 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 to 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 as well as our Privacy Statement providing information on how we will be processing your personal information. 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.

What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally. You can view the list of approved digital signature providers on **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 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**.
- 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 notification 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.
- 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). Your membership will only be activated if you agreed to the new terms.
- We will send your Welcome notification via WhatsApp and an Encrypted email, if you appointed a financial adviser, the Welcome email will be sent to them via Encrypted email.

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 as well as the Privacy statement and agree to them.

1. About yourself (main applicant)

When do you want your cover to start? D 0 D 1 M M Y Y Y Y

Title | Initials

Surname

First names (as per identity document)

ID or passport number

Gender M F Date of birth D D M M Y Y Y Y

Race African Coloured Indian/Asian White Other Do not want to disclose

This information is not mandatory. The Council for Medical Schemes collects this information for statistical purposes.

Discovery Health Medical Scheme, registration number 1125, is regulated by the Council for Medical Schemes and administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider.

Occupation

Tax number | Gross monthly earnings **R** .

Telephone (H) | Telephone (W)

Cellphone

Email

Physical address

Unit/Suite number | Complex/Building

Street number | Street name

Suburb

City | Postal code

Postal address (post collected from PO 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

City | Postal code

2. About your spouse or partner (only complete if you're also applying for cover for them)

Title | Initials

Surname

First names (as in identity document)

ID or passport number

Gender M F | Date of birth D D M M Y Y Y Y

Race African Coloured Indian/Asian White Other Do not want to disclose

This information is not mandatory. The Council for Medical Schemes collects this information for statistical purposes.

Marital status Married Single Divorced Widowed

Telephone (H) | Telephone (W)

Cellphone

Email

3. About your dependants (only complete if you're applying for cover for them)

Dependant 1

Title | Initials

Surname

First names (as in identity document)

ID or passport number

Gender M F | Date of birth D D M M Y Y Y Y

Race African Coloured Indian/Asian White Other Do not want to disclose

This information is not mandatory. The Council for Medical Schemes collects this information for statistical purposes.

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 attach proof of this relationship to this application.)

If over 18 years, provide cellphone number

If your dependant is 21 years or older:

Are they married? Yes No Are they financially dependent on you? Yes No

Do they earn an income? Yes No Does their spouse earn an income? Yes No

How much does your dependant earn each month? **R** .

How much does your dependant's spouse earn each month? **R** .

Dependant 2

Title Initials

Surname

First names (as in identity document)

ID or passport number

Gender M F Date of birth D D M M Y Y Y Y

Race African Coloured Indian/Asian White Other Do not want to disclose

This information is not mandatory. The Council for Medical Schemes collects this information for statistical purposes.

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 attach proof of this relationship to this application.)

If over 18 years, provide cellphone number

If your dependant is 21 years or older:

Are they married? Yes No Are they financially dependent on you? Yes No

Do they earn an income? Yes No Does their spouse earn an income? Yes No

How much does your dependant earn each month? **R** .

How much does your dependant's spouse earn each month? **R** .

Dependant 3

Title Initials

Surname

First names (as in identity document)

ID or passport number

Gender M F Date of birth D D M M Y Y Y Y

Race African Coloured Indian/Asian White Other Do not want to disclose

This information is not mandatory. The Council for Medical Schemes collects this information for statistical purposes.

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 attach proof of this relationship to this application.)

If over 18 years, provide cellphone number

If your dependant is 21 years or older:

Are they married? Yes No Are they financially dependent on you? Yes No

Do they earn an income? Yes No Does their spouse earn an income? Yes No

How much does your dependant earn each month? **R** .

How much does your dependant's spouse earn each month? **R** .

Are you applying for more than three dependants? Yes No

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

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4. Your financial adviser's details

Do you want an adviser? Yes ☐ No ☐

Please complete this section if you already have a financial adviser

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)

Declaration – to be completed by your financial adviser, if you have one

I declare that I have read, understood and agree to the broker declaration on **www.discovery.co.za/portal/rules**.

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 give advice about this application.

4.3. I have a valid contract with Discovery Health Medical Scheme and I have told the client about the commission that Discovery Health Medical Scheme pays me.

4.4. I am responsible for giving the main applicant:

- My name, physical address, postal address and the telephone number
- Impartial advice that is in the main applicant's best interest.

4.5. I am accountable for any advice I give to the main applicant about completing this application form and joining Discovery Healthcare Fund.

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 Saver Series	Smart Series	Core Series	KeyCare Series
Executive ☐	Classic ☐	Classic ☐	Classic ☐	Classic Smart ☐	Classic ☐	Classic ☐	KeyCare Plus ☐
	Classic Smart ☐	Essential ☐	Classic Delta ☐	Essential Smart ☐	Essential ☐	Classic Delta ☐	KeyCare Core ☐
			Essential ☐		Essential Dynamic ☐	Essential ☐	KeyCare Start ☐
			Essential Delta ☐		Active Smart ☐	Essential Delta ☐	KeyCare Start Regional ☐
			Coastal ☐			Coastal ☐	
						*Active Core ✓	

**Available from 1 January 2027 subject to approval by the Council for Medical Schemes*

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 Saving 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.

6. If you choose a KeyCare plan

Please complete this section if you have chosen 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, we will need to verify your income.

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, Pretoria, Johannesburg, Bellville, George, Potchefstroom, Kimberly and Welkom, 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.

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:

8.1.1. We warrant that the main applicant detailed in section 1 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.

Employer's authorised signatory

Name

Designation

8.2. **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.

Name of bank

Branch name | Branch code - -

Account number | Type of account Cheque/Transmission/Transaction Savings

Account holder

I agree to inform the Scheme in writing of any changes that may occur.

Account holder's physical address (own/3rd party/trust/company)

Unit/Suite number | Complex/Building

Street number | Street name

Suburb

City | Postal code

Account holder contact details

Account holder email address

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

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

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 the 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.

8.2. Your claims refund

Can we use the same account provided for contributions to make any payments to you (e.g., claims payments, refunds of overpayments)? 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 or passport number of the third party.

Name of bank

Branch name | Branch code - -

Account number | Type of account Cheque/Transmission/Transaction Savings

Account holder

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

ID or passport 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 authorise Discovery Health to contact the account holder provided above to verify payments made or received, if necessary.

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.

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

Please give us the details of all the registered South African medical schemes that you and your dependants who are being added belonged to previously. We will use this information to decide if we need to apply late-joiner penalty fees. We may also use the information on the membership certificate to decide if we can apply the waiting periods. However, it is still your obligation to disclose the relevant information that we have asked for.

Were all your dependants on the same medical scheme? Yes No

If you and your dependants who are applying for the cover belonged to different medical schemes, please fill in the information below:

Name	Scheme name	Start date	End date	Reason for leaving

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

10.2. 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 question in 10.3.

During a three month general waiting period, if applicable, we will only cover claims relating to Prescribed Minimum Benefits in line with the Scheme's rules. You may complete Section 11 should you wish to provide us with additional information.

10.3. For any person named on this application form:

10.3.1. have they been admitted to hospital in the 12 months before this application?

Yes No

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

Yes No

10.3.3. 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

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 on previous memberships)

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 (which includes whether to impose a waiting period on your membership) and any other relevant uses.

Please note that the Council for Medical Schemes has oversight over any irregular use of your or your dependant's health information.

Please also note that the Medical Schemes Act restricts the ability of the Scheme to impose waiting periods. A condition specific waiting period cannot be imposed on you or any of your dependants relating to any condition that you disclose in this application **except if** you or your dependant received or were recommended any medical advice, diagnosis, care or treatment in respect of such a condition within a 12-month period ending on the date on which this application is considered to be fully and properly made.

Information disclosed by you relating to health conditions prior to the preceding 12 months can serve as a basis for the Scheme requiring that you undergo a medical examination, at the Scheme's cost. Should that medical examination reveal a current health condition, waiting periods may be apply in respect of such current condition.

Below we require you to advise us about whether **you or any dependant/s** specified in this application **at any time** have experienced, been treated/investigated 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 take note that if you or any of your dependants have any disorder, 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.

Please also note that you must tell us in writing if any of the information you gave, in this 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 further that any indication of existing medical conditions on this application does not automatically enrol 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". If you answered 'Yes', please provide full details in the sections provided.

11.1 Tumours, growths, cancerous, non-cancerous and disorders of the skin and breast **Yes** ☐ **No** ☐

Example: 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 tests (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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

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, deep vein thrombosis, pulmonary embolus, and varicose veins.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

11.4. Are you or any of your dependants pregnant or undergoing treatment/investigation to fall pregnant, trying to conceive, or undergoing fertility /reproductive treatment? Yes ☐ No ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

11.5. Mental health Yes ☐ No ☐

Example: mood disorders (like depression and bipolar disorders), 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

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, overweight, obesity, unexplained weight-loss, 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

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, coeliac disease, obesity, overweight, unintentional weight loss, incontinence, abdominal pain, colo-rectal symptoms/conditions Crohn's disease, ulcerative colitis, diverticulitis, Irritable bowel syndrome (IBS), Hemorrhoids, long standing constipation/diarrhea, 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

11.9. Breathing and respiratory conditions

Yes ☐ No ☐

Example: asthma, ventilator, oxygen therapy, CPAP, chronic obstructive pulmonary disease, bronchiectasis, tuberculosis, bronchitis or emphysema, cystic fibrosis, sarcoidosis, pneumonia, interstitial lung disease/chronic 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

11.10. Musculoskeletal (back, bone, injury and muscle pain)

Yes ☐ No ☐

Example: arthritis (any form), ongoing/intermittent joint or muscular pain, ankylosing spondylitis, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, gout, physical disability, prosthesis and internal insertion of surgical implants, amputation, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

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 (loss of bladder control or inability to empty the 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

11.12. Blood conditions

Yes ☐ No ☐

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

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

11.13. Eye conditions Yes ☐ No ☐

Example: cataract, intra-ocular pressure, visual disturbances, night blindness, 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

11.15. Male urogenital conditions Yes ☐ No ☐

Example: prostate disorders, urogenital defects, varicocele, abnormal PSA tests (prostate specific antigen), 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

11.18. Have you or any of your dependants ever been diagnosed with or received treatment for, any condition/symptoms or any allergic reactions or side-effects, 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

HIV and AIDS

If you or any of your dependants are HIV-positive, you or they must call us on **0860 99 88 77** within seven working days of the date we activate your Discovery Health Medical Scheme membership. We treat this information in the strictest confidence. If you or any of your dependants are, 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 period before Discovery Health Medical Scheme starts paying for any general or specific medical conditions. A 12-month condition-specific waiting period or a 3-month general waiting period may apply to this condition or any related condition. If you do not let us know about your or your dependant's 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

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 go to: **https://www.discovery.co.za/medical-aid/about-discovery-health-medical-scheme**. Under, **Your privacy is important to us**, click on **Privacy Statement**.

Signature of main applicant _____ Date D D M M Y Y Y Y

The applicant must sign and date any changes.
Please only sign if you have read and understand this statement.

13. Terms and conditions of Discovery Health Medical Scheme memberships

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.

May the Scheme and its Administrator send you direct electronic marketing (related to the business of the Scheme) 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. The rules may change from time to time. You may ask us for a copy of these rules at any time or view these rules at **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 by the Scheme rules.

Where applicable, you also acknowledge and confirm that you, your financial adviser or your employer may communicate with us about 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 dependants with your chosen financial adviser. The information will be shared so that they 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 or partner and people who are financially dependant on you as defined in the Scheme rules, as referred to above. For anyone to be treated as financially dependant 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 will 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 or partner and any dependants over the age of 18 to act for them in any matter relating to this application.
- You consent to your spouse or adult dependant, who is part of this application process acting on your behalf and providing personal information, including health information, to Discovery Health for the purpose of your application to join Discovery Health Medical Scheme.

- Discovery Health may be able to retrieve certain previous medical information we have for you, your spouse or partner and your dependants (if applicable) from previous memberships. However ,you must still disclose any and all relevant information as asked for above.

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 or older for more information about themselves. All the applicants still have to disclose all relevant information as asked for above.

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 we need 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) get your personal information from other relevant sources, including medical practitioners, contracted service providers, financial advisers, credit bureaus or industry regulatory bodies ('relevant sources'). They may process this information to consider your membership application, to conduct underwriting or risk assessments, to consider a claim for medical expenses, to profile and analyse risk or to investigate fraud, waste 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 memberships

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.

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:
In accordance with the Medical Schemes Act, all applicants are required to provide complete, accurate, and truthful information when applying for membership. It is always preferable to disclose more information rather than omit information that may be material to your application.
Failure to disclose material information, or providing false, inaccurate, or misleading information, may result in the cancellation of membership, the recovery of amounts paid by the Scheme, and/or the institution of criminal proceedings where applicable.
To ensure that all material information disclosed during the application process is accurate and complete, the Scheme may monitor your membership during the first 12 months of cover.
If additional information becomes available at a later stage, or if any information provided during the application process is found to be incomplete, incorrect, false, or misleading, the Scheme reserves the right to reassess any claim, benefit request, authorization, or membership decision.

This may result in:

- A temporary pause in the assessment or authorization of a benefit request or claim;
- A reassessment of previously approved benefits or claims;
- The withdrawal of an authorization where appropriate; and/or
- Any other action permitted in terms of the Medical Schemes Act and the Rules of the Scheme.

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 let you know if any waiting periods apply. Please speak to your financial adviser or the Administrator about any waiting periods that apply to your membership and the memberships of those you apply for.

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

You must make sure contributions are paid on time
As the main member of the Scheme, you are responsible for making sure 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 change monthly contributions and benefits from time to time with prior notification.

13.6. ***Repaying money owed to the Scheme***
The Scheme has the right to collect from you any amount that you owe at any time.
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 choose, 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 ends, 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 by the reference number 'DISCSETTLE'.

Signature of main applicant

Date D D M M Y Y Y Y

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.

Discovery Health Medical Scheme, registration number 1125, is regulated by the Council for Medical Schemes and administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider.

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 provided is either in my name or that I have the authority to use this account for debit order purposes 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.
- Acknowlegement 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: Your membership 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

Account holder signature

Date of signature D D M M Y Y Y Y

15. Annexure A: Third-party bank details

Banking details for a third party

A third party can be anyone, such as your spouse, aunt, uncle, friend, parent or adult child. Please attach the relevant proof of bank account if you give a third-party's bank account details for claim refunds or contribution debit orders.

Documents we need for a third-party bank account

- 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 people 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.