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

Applying to join Discovery Health Medical Scheme as part of an employer group 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 join.

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

Contact us

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

Purpose of the form

Thank you for deciding to apply to join the Discovery Health Medical Scheme. This document is an application form to join as part of an employer group. The information requested in this application form is needed to enable the Scheme to process your application and to help in the administration of your membership as well as to better administer the affairs of the Scheme.

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**.
- Sign all relevant sections and date any changes.
- Read and understand the terms and conditions for membership (Section 10), our Privacy Statement providing information on how we will be processing your personal information, and the Scheme rules. The full set of Scheme rules is available on request at **www.discovery.co.za/medical-aid/scheme-rules**.
- Sign Sections 5, 9 and 10.
- Email the completed and signed form to **application@discovery.co.za.**
- Please attach a copy of each applicant's identity document. We accept valid passports and birth certificates for children.
- Provision is made in this form for you and your dependants to provide information about your race. This information is needed by the Council for Medical Schemes for statistical purposes only. You don't have to provide this information.

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 needed for underwriting purposes and to process your application.
- You and your financial adviser (if you have chosen one) will receive a message or an email to let you know when your application is considered to have been fully and completely made. This date may differ from the date on which you sign the application form.
- If standard terms of acceptance are offered (no waiting periods or late-joiner penalties), your membership will be activated.
- 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 agree to the new terms.
- We will send your welcome notification by WhatsApp and encrypted email. If you appointed a financial adviser, the welcome notification will be sent to them by encrypted email.

If you do not hear from the Scheme within seven days after submitting your application form, please contact us on **0860 10 03 45** or your financial adviser.

When you sign this application, you confirm that you have read and understood the terms and conditions (Section 10 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.

4. 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*

You have the right to ask for help in choosing a health plan that suits your needs. Whether you have had help or made the decision on your own, by signing this application you confirm that you understand the conditions and benefits of the plan you choose.

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 as long as you have funds available. **Cost** is the full amount of the claim as long as you have funds available.

When you make a claim that is qualifies 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 has carried over to the current year.

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, Kimberley 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 add the details on a separate page if you are applying for more than three dependants.

5. Your banking details for claims refund

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

By signing this application, you agree that once claims have been refunded into the bank account you have chosen, the Scheme will not be responsible in any way for the amounts refunded and authorize Discovery Health to contact the account holder provided above to verify payments made or received, if necessary.

Please note: We cannot accept credit card account details and only South African banking details are accepted. We no longer issue cheques. If no details are provided, we will not be able to refund your claims. If we are paying a third-party bank account, the main member must insert the ID number of the third party.

Name of bank

Branch name Branch code - -

Account number Type of account Savings Cheque/Transmission/Transaction

Account holder

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

If 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 end of this 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. 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.**

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

Please give us the details of all registered South African medical schemes that you 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 list them below:

Name	Scheme name	Start date	End date	Reason for leaving

7. About your employer

Please ask your employer to complete this section.

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

Name of employer

Employer or billing number

Employee number

Date of employment D D M M Y Y Y Y

Branch name

Branch number

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

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

I am now divorced ☐ My spouse or partner has been retrenched ☐

Date D D M M Y Y Y Y

My spouse or partner resigned ☐ My spouse or partner is deceased ☐

Date D D M M Y Y Y Y

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

Date D D M M Y Y Y Y

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

Date D D M M Y Y Y Y

Employer warranty

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

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

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

Employer's authorised signature

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

Name

Designation

8. Appointment of financial adviser

If you already have a financial adviser, please ask them to complete this section:

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:

8.1. 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.

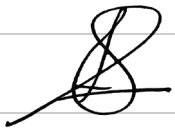
8.2. I am appointed by the employer to provide advice about this application.

8.3. I have a valid contract with Discovery Health Medical Scheme and I have made the client aware of the commission I receive from Discovery Health Medical Scheme.

8.4. 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.

8.5. 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 D D M M Y Y Y Y

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

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

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.

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.

10. 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 ☐

10.1. ***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.

10.2. ***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.

10.3. ***Acting for others***
You confirm you have the right to act for others.
By signing this document, you confirm that:
- You have the right to apply for membership and to act for those you apply for in any matter relating to this application.
- You have received permission from your spouse 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.

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

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

The Scheme might not pay for certain expenses immediately after you become a member
The Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before the Scheme starts paying for any general or specific medical conditions. We will 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.

10.6. ***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.

11. 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.