Application to add dependants 2017

Contact us

Tel (Members): 0860 99 88 77, Tel (Health partner): 0860 44 55 66, PO Box 784262, Sandton, 2146, www.discovery.co.za

Who we are

The Discovery Health Medical Scheme (referred to as 'the Scheme'), registration number 1125, is the medical scheme that you are applying to become a member of. This is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company, an authorised financial services provider and is responsible for the administration of your membership on behalf of the Scheme.

Thank you for deciding to apply to join the Discovery Health Medical Scheme. This document is an application form for membership. It also contains some rules for membership. Please make sure you read and understand these rules.

What you must do

- Fill in the form in black ink, please print clearly.
- Read and understand the rules for membership (section 10).
- Sign section 5 (if applying to become a KeyCare member) 9 and 10.
- Please make sure the main applicant signs and dates any changes.
- Fax the completed and signed form to **011 539 3000** or email it 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 send us your application form, here is what will happen:

- If any details are missing or if we need more information for underwriting purposes, we will contact you.
- We will activate your membership and send you or your financial adviser an acceptance letter (if no waiting periods and/or late-joiner penalties are applied). Where you have waiting periods and/or late joiner penalties we will issue a counter-offer letter which will indicate any conditions applicable to your membership. You may accept the offer by signing and returning this letter for us to activate your membership.
- We will send you or your financial adviser a welcome letter, SMS or an email to let you know when your application is considered to have been fully and completely made. This date may differ from the date on which you sign the application form.
- You will then get a pack in the post.

If you do not hear from us seven days after sending us 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 rules for membership and agree to them.

Cover start date 2 0 1 7 ☐ ☐ 0 1

1. Main member details

Membership number ______

Title ______ Initials ______ Surname ______

First name(s) (as per identity document) ______

ID or passport number ______ Country of issue ______

Preferred name ______ Sex ☐ M ☐ F Date of birth YYYY MM DD

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

☐ PO Box ☐ Private Bag ☐ Suite ☐ Postnet Suite

Number ______ Suburb ______ Postal code ______

Physical address

Suite/Unit number ______ Complex name ______

Street number ______ Street name ______

Suburb ______ Postal code ______

Telephone (H) ______ Telephone (W) ______

Cellphone ______ Fax ______

Email ______

If your post is delivered to your street address, please complete these details under physical address.

2. Adding a spouse or partner (if applying for cover)

Only complete this section if you are adding a spouse or partner.

Title ______ Initials ______ Surname ______

First name(s) (as per identity document) ______

Preferred name ______ Sex ☐ M ☐ F Date of birth YYYY MM DD

Adding a spouse or partner (if applying for cover) ***(continued)***

ID or passport number ____________________ Country of issue ____________________

Marital status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Date of marriage to main applicant (where applicable). Please attach a copy of an official certificate. | Y Y Y Y | M M | D D |

Previous or maiden name ____________________

Telephone (H) ____________________ Telephone (W) ____________________

Cellphone ____________________ Fax ____________________

Email ____________________

Addition of spouse to an existing membership

If addition of spouse to an existing membership is:

due to a legal and registered marriage within the last three months, an official certificate must accompany this application form to avoid underwriting.

for a spouse married for a period of more than three months, full underwriting will apply.

3. Adding your dependants (if applying for cover)

Dependant 1

Title __________ Initials __________ Surname ____________________

First name(s) (as per identity document) ____________________

Preferred name ____________________ Sex ☐ M ☐ F Date of birth | Y Y Y Y | M M | D D |

ID or passport number ____________________ Country of issue ____________________

Relationship to main member

(For example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

____

If your dependant is 21 years and older, are they: Married? ☐ Yes ☐ No Financially dependent on you? ☐ Yes ☐ No

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

Dependant 2

Title __________ Initials __________ Surname ____________________

First name(s) (as per identity document) ____________________

Preferred name ____________________ Sex ☐ M ☐ F Date of birth | Y Y Y Y | M M | D D |

ID or passport number ____________________ Country of issue ____________________

Relationship to main member

(For example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

____

If your dependant is 21 years and older, are they: Married? ☐ Yes ☐ No Financially dependent on you? ☐ Yes ☐ No

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

Dependant 3

Title __________ Initials __________ Surname ____________________

First name(s) (as per identity document) ____________________

Preferred name ____________________ Sex ☐ M ☐ F Date of birth | Y Y Y Y | M M | D D |

ID or passport number ____________________ Country of issue ____________________

Relationship to main member

(For example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

____

If your dependant is 21 years and older, are they: Married? ☐ Yes ☐ No Financially dependent on you? ☐ Yes ☐ No

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

4. Your employer warranty (additions to employer groups need to be signed by the HR or payroll contact)

Please ensure your employer completes this warranty if you are part of an employer group.

4.1. We warrant that the member detailed in section 1 of this application form is an employee of our organisation.

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

Authorised signatory ____________________

Name ____________________

Designation ____________________

5. If you have a KeyCare Plan

Income verification will be conducted for the lower income bands. Income is considered as: The higher of the main member's or registered spouse or partner's earnings, commission and rewards from employment; interest from investments; income from leasing of assets or property; distributions received from a trust, pension and/or provident fund; receipt of any financial assistance in terms of any statutory social assistance programme.

IMPORTANT NOTICE:

Declaring income lower than your actual income constitutes fraud. This may lead to the termination of your membership and criminal charges may be brought against you.

By signing this application form, you give us permission to verify your declared income using all relevant internal and external sources, as defined in 10.5.

	Spouse or partner	Adult dependant
Total earnings over the last 12 months	R	R
Total monthly earnings	R	R
Occupation		

I declare that this income declaration is true and accurate.

Signature of main member Please do not sign incomplete forms.

If the highest earner earns less than R137 000 each year, please provide the following supporting documents as proof of income:

- Last 3 months' (90 consecutive days) bank statements; **and**
- If employed, your last 3 months' payslips and commission schedules, or most recent tax year's IRP5 certificate
- If student, proof of enrolment at academic institution
- If self-employed, most current financial statements
- If pensioner, proof of annuity or employer pension or state older person's grant
- If unemployed, UIF certificate

Please complete this if you have a KeyCare Plus or KeyCare Access Plan. Please select a GP on the KeyCare GP Network.

	Name	GP name	Practice number	Second GP name*	Practice number
Spouse or partner					
Dependant 1**					
Dependant 2**					
Dependant 3**					

* If your dependant lives far away from where they work or often need to work in different towns or provinces, they may need a second GP. Please only choose a second GP if this applies to them.

** Please make sure that the dependant information you give above is the same as the dependant information in section 2 and 3 of this form.

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 your dependants belonged to. We will use this information to determine if we need to apply any waiting periods, late-joiner penalty fees, or both. Please give us proof in the form of a membership certificate.

Spouse or partner

Name	Scheme name	Start date			End date if already resigned			Are they still a member?	Reason for leaving
		YYYY	MM	DD	YYYY	MM	DD	☐ Yes ☐ No	
		YYYY	MM	DD	YYYY	MM	DD	☐ Yes ☐ No	
		YYYY	MM	DD	YYYY	MM	DD	☐ Yes ☐ No	
		YYYY	MM	DD	YYYY	MM	DD	☐ Yes ☐ No	
		YYYY	MM	DD	YYYY	MM	DD	☐ Yes ☐ No	

If all dependants were on the same medical scheme(s) as completed above, please tick here to confirm this. ☐

If any of your dependants applying for cover belonged to different medical schemes, please complete them below:

Name	Scheme name	Start date			End date if already resigned			Are they still a member?	Reason for leaving
		YYYY	MM	DD	YYYY	MM	DD	☐ Yes ☐ No	
		YYYY	MM	DD	YYYY	MM	DD	☐ Yes ☐ No	
		YYYY	MM	DD	YYYY	MM	DD	☐ Yes ☐ No	
		YYYY	MM	DD	YYYY	MM	DD	☐ Yes ☐ No	
		YYYY	MM	DD	YYYY	MM	DD	☐ Yes ☐ No	

7. Moving from another medical scheme

Please make sure that you have completed section 6.

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

7.1.1. have not had a break in membership of more than 90 days since resigning from the previous South African medical scheme, and ☐ Yes ☐ No

7.1.2. are currently or have been members of a South African medical scheme for at least the past 24 months. ☐ Yes ☐ No

Moving from another medical scheme (continued)

If you answered **yes** to the above questions, please answer the questions in **7.2.**

If you answered **no** in 7.1, you must complete all the medical questions in **section 8.**

7.2. For any person named on this application form:

7.2.1. Have they been admitted to hospital in the 12 months before this application? ☐ Yes ☐ No

7.2.2. Are they currently taking regular, ongoing medicine and/or treatment of a medical condition? ☐ Yes ☐ No

7.2.3. Are they planning to or reasonably expecting to be hospitalised (including for pregnancy) or expecting to receive dental or medical treatment costing more than R2 000 in the next 12 months? ☐ Yes ☐ No

If you answered **no** to **all** questions in **7.2**, we will not apply any waiting periods and you **do not** have to complete section 8.

If you answered **yes** to **any** questions in **7.2**, we will apply a three-month general waiting period to your application and you **do not have to complete Section 8.**

During these three months, we will only cover claims for Prescribed Minimum Benefits according to the Scheme's rules.

8. Your health questions

The spouse or partner and all dependants applying for cover need to complete Section 8.

Spouse or partner ☐ Yes ☐ No

How tall are you? _____ . ________ metres How much do you weigh? __________ kilograms

Your blood type _______ Your allergies ____________________

Do you drink alcohol? ☐ Yes ☐ No How many units of alcohol do you drink each week? __________

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? ☐ Yes ☐ No Amount each day __________

If **no**, have you smoked in the last 24 months? ☐ Yes ☐ No If **yes**, amount each day __________

If you stopped smoking, what was your reason for stopping? ____________________

Dependant 1 Name ____________________

How tall are you? _____ . ________ metres How much do you weigh? __________ kilograms

Your blood type _______ Your allergies ____________________

Do you drink alcohol? ☐ Yes ☐ No How many units of alcohol do you drink each week? __________

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? ☐ Yes ☐ No Amount each day __________

If **no**, have you smoked in the last 24 months? ☐ Yes ☐ No If **yes**, amount each day __________

If you stopped smoking, what was your reason for stopping? ____________________

Dependant 2 Name ____________________

How tall are you? _____ . ________ metres How much do you weigh? __________ kilograms

Your blood type _______ Your allergies ____________________

Do you drink alcohol? ☐ Yes ☐ No How many units of alcohol do you drink each week? __________

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? ☐ Yes ☐ No Amount each day __________

If **no**, have you smoked in the last 24 months? ☐ Yes ☐ No If **yes**, amount each day __________

If you stopped smoking, what was your reason for stopping? ____________________

Dependant 3 Name ____________________

How tall are you? _____ . ________ metres How much do you weigh? __________ kilograms

Your blood type _______ Your allergies ____________________

Do you drink alcohol? ☐ Yes ☐ No How many units of alcohol do you drink each week? __________

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? ☐ Yes ☐ No Amount each day __________

If **no**, have you smoked in the last 24 months? ☐ Yes ☐ No If **yes**, amount each day __________

If you stopped smoking, what was your reason for stopping? ____________________

Have any of your **dependants** in this application ever experienced, been treated for, or are they currently suffering from any of the following symptoms, conditions or disorders? We have listed some examples of conditions, symptoms or disorders under each question. These are only examples and not the full list of conditions, symptoms or disorders. Please include congenital abnormalities.

You must tell us in writing if any of the information you gave, in your dependants' application for membership, changes between the day you sign this document and the day their membership starts.

Please take note that if any of your dependants in this application have any symptom or condition not listed in the questions below, you should highlight and provide full details of this symptom or condition in response to question 8.18 below.

Your health questions *(continued)*

8.1. **Tumours and growths** ☐ Yes ☐ No

Example: abnormal pap smear results, pre-cancerous skin lesions, breast disease, non-cancerous tumours, cancerous tumours, fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abnormal mammogram result, abnormal PSA (prostate specific antigen) result.

Patient name	Medical diagnosis	Date first diagnosed			Date of last symptoms, consultation and/or hospitalisation			Medicine used for this condition and dosage	Date of last treatment taken		
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD

8.2. **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, congenital heart disease, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker.

Patient name	Medical diagnosis	Date first diagnosed			Date of last symptoms, consultation and/or hospitalisation			Medicine used for this condition and dosage	Date of last treatment taken		
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD

8.3. **Gynaecological and obstetrics conditions** ☐ Yes ☐ No

Example: abnormal pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility.

Patient name	Medical diagnosis	Date first diagnosed			Date of last symptoms, consultation and/or hospitalisation			Medicine used for this condition and dosage	Date of last treatment taken		
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD

8.4. **Are any of your dependants pregnant?** ☐ Yes ☐ No

Patient name ____

8.5. **Mental health** ☐ Yes ☐ No

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

Patient name	Medical diagnosis	Date first diagnosed			Date of last symptoms, consultation and/or hospitalisation			Medicine used for this condition and dosage	Date of last treatment taken		
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD

8.6. **Metabolic or endocrine conditions** ☐ Yes ☐ No

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

Patient name	Medical diagnosis	Date first diagnosed			Date of last symptoms, consultation and/or hospitalisation			Medicine used for this condition and dosage	Date of last treatment taken		
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD

8.7. **Abdominal conditions** ☐ Yes ☐ No

Example: hepatitis, cirrhosis, portal hypertension, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis, gall bladder, gall stones, GORD (reflux), heartburn, oesophageal disease, hernias, atrophic gastritis, ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis.

Patient name	Medical diagnosis	Date first diagnosed			Date of last symptoms, consultation and/or hospitalisation			Medicine used for this condition and dosage	Date of last treatment taken		
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD

8.8. **Brain and nerve conditions** ☐ Yes ☐ No

Example: stroke, epilepsy, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, cerebral palsy, Parkinson's disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, mental retardation, CVA.

Patient name	Medical diagnosis	Date first diagnosed			Date of last symptoms, consultation and/or hospitalisation			Medicine used for this condition and dosage	Date of last treatment taken		
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD

Your health questions *(continued)*

8.9. **Breathing and respiratory conditions** ☐ Yes ☐ No

Example: asthma, chronic obstructive pulmonary disease, bronchiectasis, tuberculosis, bronchitis or emphysema, cystic fibrosis, sarcoidosis, pneumonia.

Patient name	Medical diagnosis	Date first diagnosed			Date of last symptoms, consultation and/or hospitalisation			Medicine used for this condition and dosage	Date of last treatment taken		
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD

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

Example: arthritis (any form), ongoing back pain, ankylosing spondylitis, lupus, Sjögren's syndrome, scleroderma, polymyositis, dermatomyositis, polyarteritis nodosa, Wegener's granulomatosis, sarcoidosis, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, gout, fractures, physical disability.

Patient name	Medical diagnosis	Date first diagnosed			Date of last symptoms, consultation and/or hospitalisation			Medicine used for this condition and dosage	Date of last treatment taken		
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD

8.11. **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, bladder infections, other bladder or kidney problems.

Patient name	Medical diagnosis	Date first diagnosed			Date of last symptoms, consultation and/or hospitalisation			Medicine used for this condition and dosage	Date of last treatment taken		
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD

8.12. **Blood conditions** ☐ Yes ☐ No

Example: deep vein thrombosis, anaemia, ITP (platelet deficiency), polycythaemia vera, blood clotting diseases, leukaemia, lymphoma, pulmonary embolus, haemophilia and other bleeding disorders.

Patient name	Medical diagnosis	Date first diagnosed			Date of last symptoms, consultation and/or hospitalisation			Medicine used for this condition and dosage	Date of last treatment taken		
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD

8.13. **Eye conditions** ☐ Yes ☐ No

Example: cataract, keratoconus, corneal ulcer, uveitis, glaucoma, squint, ptosis, any abnormality of eyelids, retinopathy, macular degeneration, cornea transplant, eye surgery, blurry vision, blindness (partial or full), retinal detachment.

Patient name	Medical diagnosis	Date first diagnosed			Date of last symptoms, consultation and/or hospitalisation			Medicine used for this condition and dosage	Date of last treatment taken		
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD

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

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

Patient name	Medical diagnosis	Date first diagnosed			Date of last symptoms, consultation and/or hospitalisation			Medicine used for this condition and dosage	Date of last treatment taken		
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD

8.15. **Male urogenital conditions** ☐ Yes ☐ No

Example: prostate disorders, urogenital defects, varicocele, tumours, undescended testes, phimosis, urinary incontinence.

Patient name	Medical diagnosis	Date first diagnosed			Date of last symptoms, consultation and/or hospitalisation			Medicine used for this condition and dosage	Date of last treatment taken		
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD
		YYYY	MM	DD	YYYY	MM	DD		YYYY	MM	DD

Your health questions *(continued)*

8.16. **Are any of your dependants expecting surgery or planning hospitalisation or treatment in the next 12 months or have you been admitted to hospital in the last 12 months?** ☐ Yes ☐ No

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		YYYY MM DD	YYYY MM DD		YYYY MM DD
		YYYY MM DD	YYYY MM DD		YYYY MM DD

8.17. **Have 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	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		YYYY MM DD	YYYY MM DD		YYYY MM DD
		YYYY MM DD	YYYY MM DD		YYYY MM DD

8.18. **Have any of your dependants been diagnosed with or received treatment for, any condition not mentioned in the questions above, in the last 12 months before this application?** ☐ Yes ☐ No

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		YYYY MM DD	YYYY MM DD		YYYY MM DD
		YYYY MM DD	YYYY MM DD		YYYY MM DD

HIV

You do not need to disclose the HIV status of you or your dependant(s) on this form if you do not feel comfortable doing so. However, if you, or one or more of your dependants, are HIV-positive, you or they must call us on **0860 99 88 77** within seven working days from the date we activate your Discovery Health Medical Scheme membership. We treat this information in the strictest confidence. If you, or one or more of your dependants are HIV-positive, it is in your interest to register on the HIVCare Programme. A 12-month condition specific waiting period may apply to this condition. If you do not let us know about your HIV status within 7 days of your membership being active, we may end your Discovery Health Medical Scheme membership.

9. Fair Collection Notice – how we will process and disclose your Personal Information and communicate with you

1. This Fair Collection Notice (“Notice”) explains how we obtain, use, disclose and otherwise process personal information, which may include health and financial information (“Personal Information”), as required by the Protection of Personal Information Act (“POPI”).
2. Acceptance of these terms and conditions is voluntary, but is a requirement for activation and servicing of your medical scheme membership. If you do not accept these terms and conditions, we cannot activate and service your membership.
3. Please note:
   a. We may amend this Notice from time to time. Please check our website periodically to inform yourself of any changes;
   b. You have the right to object to the processing of your Personal Information;
   c. If you believe that we have used your personal information contrary to applicable law, you must first attempt to resolve any concerns with us in terms of our complaints or disputes process. If you are not satisfied with such process, you have the right to lodge a complaint with the Information Regulator, under POPI.
4. Discovery Health Medical Scheme and the administrator (we/us) will keep any information, including Personal Information relating to yourself and your dependants and/or beneficiaries, supplied to us in this application or collected from other sources (“Your Personal Information”) confidential.
   You confirm that when you provide us with your Personal Information, your dependants and/or beneficiaries have provided you with the appropriate permission to disclose their Personal Information to us for the purposes set out below and any other related purposes. In the event of you providing information and signing consent on behalf of a minor (person younger than 18 years old) you confirm that you are a competent person and authorised to do so on their behalf.
5. You agree to us processing and disclosing your Personal Information in the following manner:
   We may collect, collate, process, store and disclose your Personal Information:
   a. For the administration of your health plan;
   b. For providing managed care services to you or any dependant/s on your health plan;
   c. For providing relevant information to a contracted third party who requires this information to provide a healthcare service to you or any dependant/s on your health plan;
   d. To profile and analyse risk;
   e. For academic research conducted by any company within the Discovery Group and/or contracted research and survey providers in South Africa as well as outside the borders of the Republic.

   Examples of how this will happen includes:
   a. Sharing your Personal Information with your chosen financial adviser during the application process to help the administrator, if necessary, while we process your membership application;
   b. Getting your Personal Information from other relevant sources, including medical practitioners, contracted service providers, financial advisers, credit bureaus, entities that are part of Discovery Limited or industry regulatory bodies (“Sources”), and further processing of such information to consider your membership application, to conduct underwriting or risk assessments, or to consider a claim for medical expenses. We may (at any time and on an ongoing basis) verify with the Sources that your Personal Information is true, correct and complete;
   c. Getting and sharing any information that is relevant to your application from or with your employer, if you have joined as a member of an employer group;
   d. Communicating with you about any changes in your health plan, including your contributions or changes and enhancements to the benefits you are entitled to on the health plan you have chosen;
   e. Transferring your Personal Information outside the borders of the Republic of South Africa where appropriate, for example to administer the ISOS and Africa Benefit, if you provide an email address which is hosted outside the borders of South Africa, or for processing, storage or academic research. We will ensure that anyone to whom we pass your Personal Information agrees to treat your information with the same level of protection as we are obliged to;
   f. Making use of external health specialists to assess or evaluate certain clinical information. Your Personal Information will be shared with such specialist/s in the event that you or your dependants are subject to such a clinical assessment.
6. If asked to do so, we will share your Personal Information with a third party if you have already given your consent for the disclosure of this information to such third party or if a contractual relationship exists in terms of which we are obliged to provide the information to such third party.
7. We will provide your Personal Information to any other entity within the Discovery Group with whom you or your dependant/s already have a relationship or where you or your dependants have applied for a product or benefit from such entity. This information will be provided for the administration of your or your dependant’s products or benefits with other entities within the Discovery Group.
8. We may provide any credit bureau or credit providers industry association with any information about your consumer credit record, including personal information about any judgement or default history.
9. We and any entity within the Discovery Group will keep you updated on information about any offers or new products Discovery may make available at any time. Please contact us if you do not wish to receive any telephonic direct marketing information from us.
10. If we want to share your information for any other reason, we will do so only with your permission.
11. You have the right to request a copy of the Personal Information we hold about you. To do this, simply complete the ‘Data Subject Request Form’ on www.discovery.co.za/legal and specify what information you would like. We will take all reasonable steps to confirm your identity before providing details of your Personal Information.
    Please note that any such Data Subject Request may be subject to a payment of a legally allowable fee.
12. You have the right to contact and ask us to update, correct or delete your Personal Information.
13. You agree that we may retain your Personal Information until such time as you request us to destroy them (unless we are obliged by law to retain it, regardless of such request).
14. If the Scheme, the administrator or Discovery (Ltd), as the holding company of the administrator, becomes involved in a proposed or actual merger, acquisition or any form of sale of some or all its assets, we may use and disclose your Personal Information to third parties in connection with the evaluation of the transaction. The surviving company, or the acquiring company in the case of a sale of assets, would have access to your Personal Information which would continue to be subject to this Notice.
15. Discovery Health Medical Scheme and the administrator are required to collect and retain information in terms of the following legislation (amongst others):

15.1 The Medical Schemes Act, 1998
15.2 The Consumer Protection Act, 2008
15.3 The Protection of Personal Information Act, 2013
15.4 Electronic Communications and Transactions Act, 2002
15.5 Promotion of Access to Information Act, 2000
Legislation specific to the administrator only:
15.6 Financial Advisory and Intermediary Services Act, 2002

Signature of main applicant ______________________________ Please do not sign incomplete forms.

10. Discovery Health Medical Scheme rules for membership

10.1. ***Who "we" are***

Discovery Health Medical Scheme, registration no 1125, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, the administrator and managed care organisation for Discovery Health Medical Scheme, an authorised financial services provider.

10.2. ***Rules for membership***

The rules of the Discovery Health Medical Scheme record your rights and responsibilities for your membership of the Discovery Health Medical Scheme. They may change from time to time. You may ask us for a copy at any time.

When you sign this application, you confirm that you have read and understood the rules and you agree that you and those you apply for will be bound by them.

Where applicable you also acknowledge and confirm that the financial adviser you or your employer appointed, may communicate with us on this application and your membership of the Discovery Health Medical Scheme.

You give permission that we 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 he or she can help us if necessary while we process your membership application.

Please speak to your financial adviser or Discovery Health (Pty) Ltd if there is anything you do not understand.

10.3. ***Who you are applying for***

You may apply to join the Discovery Health Medical 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 Discovery Health Medical Scheme rules. For anyone to be treated as financially dependent for this application, you must have a responsibility to provide financially for that dependant. We might ask you to give us proof of financial or legal responsibility.

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

10.4. ***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 and any dependants over 18 to act for them in any matter relating to this application.

10.5. ***Giving and getting information***

You must give true, correct and complete information.

To consider your application for membership, the Discovery Health Medical 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

We 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.

Discovery Health Medical Scheme and the administrator may record telephone calls

We 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.

Discovery Health Medical Scheme and the administrator may get information about you from other relevant sources

To consider your application for membership, conduct underwriting or risk assessments or to consider a claim for medical expenses, you agree that we can get information about you and those you apply for from other relevant sources. These include any entity that is part of Discovery Limited, medical practitioners, financial advisers, credit bureaus or industry regulatory bodies. The administrator and the Discovery Health Medical Scheme may (at any time and on an ongoing basis) verify with the parties mentioned in this section that the information you give on this application and in respect of any matter pertaining to or that arose during your membership of the Discovery Health Medical Scheme, is true, correct and complete.

You give your permission that we may get any information that is relevant to your application from your employer.

Tell Discovery Health Medical Scheme or the administrator immediately if your information changes

You, your employer or your financial adviser must tell us in writing if any of the information you gave, in your application for membership, changes between the day you sign this document and the day your membership starts. This includes information about your health and the health of those you apply for. We need advance notice of any administrative changes such as cancellation of membership, as we do not accept backdated changes.

When the Discovery Health Medical Scheme may cancel your membership/s

The Discovery Health Medical 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.

Knowingly providing false information may lead to criminal charges being brought against you.

10.6. ***About becoming a member***

Discovery Health Medical Scheme might not pay for certain expenses immediately after you become a member

Discovery Health Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before the Discovery Health Medical Scheme starts paying for any general or specific medical conditions. Please speak to your financial adviser or to us to find out if waiting periods 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 Discovery Health Medical 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 Discovery Health Medical 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.

Discovery Health Medical Scheme rules for membership *(continued)*

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

Discovery Health Medical Scheme has the right at any time to collect from you any amount that you owe to the Scheme.

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 Discovery Health Medical 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 made available in an account called the 'Medical Savings Account'. If you leave the Discovery Health Medical 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 Discovery Health Medical 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.

Signature of main applicant ______________________ Date | YYYY | MM | DD |

The main applicant must sign and date any changes

Please do not sign incomplete forms.

Discovery Health Medical Scheme is a registered medical scheme and regulated by the Council for Medical Schemes (CMS). The CMS contact details are as follows: Email: complaints@medicalschemes.com | Customer Care Centre: 0861 123 267 | website: www.medicalschemes.com