Applying to become a member of Discovery Health Medical Scheme in 2014

Discovery Health Medical Scheme

Contact us

Tel: 0860 99 88 77, PO Box 784262, Sandton, 2146, www.discovery.co.za

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.

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 (referred to as 'we' 'us' and 'our' or as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

What you must do

Please go through these steps:

Step 1: Fill in the form in black ink, using one letter per block. Please print clearly.
Step 2: Read and understand the rules for membership (section 14).
Step 3: Sign section 7 (if applying to become a KeyCare member) 9, 13 and 14
Step 4: Please make sure the main applicant signs and dates any changes.
Step 5: Fax the completed and signed form to **011 539 3000** or email it to **application@discovery.co.za**
Step 6: Please attach a copy of each applicant's identity document. We also accept valid passports and birth certificates for children.

When you sign this application, you confirm that you have read and understood the rules for membership and agree to them.

If you have any questions, please let us or your financial adviser know. Once we have assessed your application, we will let you know if you have been accepted and what will happen next.

1. If you already have a Discovery Health Medical Scheme membership

If you are an active main member of the Discovery Health Medical Scheme in the month before the date you want your membership to be effective, please contact us or speak to your employer or financial adviser first to see if we can transfer your membership instead of completing the rest of this application. Please complete only this section and sections 13 and 14.

Membership number

Where I have not chosen my own financial adviser, I acknowledge and appoint my employer's contracted financial adviser for all matters relating to my membership of the Discovery Health Medical Scheme.

Signature of main applicant

2. About yourself (main applicant)

When do you want your cover to start? 2 0 Y Y M M 0 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

Previous or maiden name

Preferred language English ☐ Afrikaans ☐

Occupation Tax number

Total monthly earnings R

ID or passport number Country of issue

Telephone (H) (W)

Cellphone Fax

Email

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

☐ Suite ☐ Postnet Suite Number

☐ PO Box ☐ Private Bag Box number

Suburb Postal code

114122 GE09/13(14)

2. About yourself (main applicant) *(continued)*

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

Physical address:

Suite/Unit number | Complex name

Street number | Street name

Suburb | Postal code

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

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)

Previous or maiden name

ID or passport number | Country of issue

Telephone (H) | (W)

Cellphone | Tax number

Email

4. About your dependants (only complete 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, ie 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 ☐ disabled? Yes ☐ No ☐

a full-time student? 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, ie 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 ☐ disabled? Yes ☐ No ☐

a full-time student? 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, ie 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 ☐ disabled? Yes ☐ No ☐

a full-time student? Yes ☐ No ☐ Does your dependant earn an income? Yes ☐ No ☐

How much does your dependant earn each month? R

5. Your financial adviser's details

Financial adviser's name | Code

Intermediary house | Code

Financial adviser's telephone number (W) | Lead number

Email

Bank reference number (if applicable) (Mandatory for all ABSA and FNB financial advisers)

I declare that:

1. I am an accredited financial adviser in terms of the Medical Schemes Act and licensed by the FSB in terms of the FAIS Act at the date of signing this application form.
2. I am appointed by the client to provide advice about this application.
3. I have a valid contract with the Discovery Health Medical Scheme and I have made the client aware of the commission payable by Discovery Health Medical Scheme.
4. I am responsible for providing the applicant with:
   - my name, physical address, postal address and telephone number
   - impartial advice that is in his or her best interest.
5. I am accountable for any advice given to the member about completion of this application form and joining the Discovery Health Medical Scheme.

Financial adviser's signature

6. Please select your health plan

Executive Plan	Comprehensive Series	Priority Series	Saver Series	Core Series	KeyCare Series
☐ Executive	☐ Classic	☐ Classic	☐ Classic	☐ Classic	☐ KeyCare Plus
	☐ Classic Delta	☐ Essential	☐ Classic Delta	☐ Classic Delta	☐ KeyCare Access
	☐ Classic Zero MSA		☐ Essential	☐ Essential	☐ KeyCare Core
	☐ Essential		☐ Essential Delta	☐ Essential Delta	
	☐ Essential Delta		☐ Coastal	☐ Coastal	

How would you like us to refund claims from the Medical Savings Account if your plan has one? Discovery Health Rate ☐ Cost ☐

You have the right to ask for help in selecting a health plan that suits your needs. By signing this application you confirm that you are familiar with the conditions and benefits of the plan you select.

7. If you choose a KeyCare Plan

Your KeyCare contributions depend on the higher income of you or your spouse or partner.
Income for this purpose includes, but is not limited to, average monthly earnings over the last 12 months from guaranteed earnings, guaranteed allowances, company contributions and variable pay or commissions from employment (including self-employment and informal employment); pension and annuity proceeds; interest earned on active and passive investments, including rental income from leasing properties; and distributions received from a trust.

IMPORTANT NOTICE:
Declaring income lower than your actual income is fraud. This will lead to the immediate termination of your membership.
By signing this application form, you give your permission for us to verify your declared income using all relevant internal and external sources, as defined in 14.4.

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

I declare that this income declaration is true and accurate.

Signature of main applicant

If the highest earner earned less than R100 000 for each year then please provide the following supporting documentation 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 and/or employer pension and/or State Older Person's Grant
- If unemployed, UIF certificate

Please complete this if you have selected the KeyCare Plus or KeyCare Access Plan.

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

* If you live far away from where you work or you often need to work in different towns or provinces, you may need a second GP. Please only choose a second GP if this applies to you.

** Please make sure that the dependant information you give above is the same as the dependant information in section 4 of this form.

8. Your employment details

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

Name of employer | Employer or billing number

Employee number | Date of employment (Y Y Y Y M M D D)

(or PERSAL number for government employees. Please attach a clear copy of your salary slip.)

Branch name | Branch number

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

Employer warranty

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

Authorised signatory

Name

Designation

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

Name of your business

Registration number | VAT number

Telephone | Fax

Physical address | Postal address

Code | Code

9. Your banking details

9.1 Your contributions

If you will be paying your contributions in full, please complete this section:

Please note: we cannot accept credit card account details

Bank name

Branch name

Branch code – – –

Account number

Type of account Cheque ☐ Savings ☐

Accountholder

Please choose the date you would like us to debit your account

1st ☐ 10th ☐ 15th ☐ 20th ☐ 25th ☐

If your membership is not activated in time for the debit order date you chose above, you will have two separate debit orders in the first month you pay your contribution, because you pay your contribution in advance. The first debit order will be collected on the first day of the month for outstanding contributions and the second debit order will be collected on the actual date you have chosen in the same month. From then on we will collect your monthly contribution on the date you have chosen.

9.2 Your claims refund

Can we use the same account we deduct contributions from to refund your claims? Yes ☐ No ☐

If you do not want to use the same banking details for your contributions and claims refunds, please give us the details you would like to use:

Please note: we cannot accept credit card account details

Bank name

Branch name

Branch code – – –

Account number

Type of account Cheque ☐ Savings ☐

Accountholder

By signing this application, you agree that once claims have been refunded into the bank account you have chosen, the Discovery Health Medical Scheme will not be responsible in any way for the amounts refunded.

Signature of accountholder

10. Previous medical scheme details

Please give us the details of all registered South African medical schemes that you previously belonged to. We will use this information to determine if we need to apply any waiting periods, late-joiner penalty fees, or both. Please give us proof in the form of a membership certificate.

Main applicant

Scheme name	Membership number	Start date	Are you still a member?	End date if you have already resigned	Reason for leaving
		Y Y Y Y M M D D	Yes ☐ No ☐	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Yes ☐ No ☐	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Yes ☐ No ☐	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Yes ☐ No ☐	Y Y Y Y M M D D	

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

10. Previous medical scheme details *(continued)*

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

Spouse or partner

Scheme name	Membership number	Start date	Are they still a member?	End date if they have already resigned	Reason for leaving
		YYYYMMDD	Yes ☐ No ☐	YYYYMMDD	
		YYYYMMDD	Yes ☐ No ☐	YYYYMMDD	
		YYYYMMDD	Yes ☐ No ☐	YYYYMMDD	
		YYYYMMDD	Yes ☐ No ☐	YYYYMMDD	

Dependant name

Scheme name	Membership number	Start date	Are they still a member?	End date if they have already resigned	Reason for leaving
		YYYYMMDD	Yes ☐ No ☐	YYYYMMDD	
		YYYYMMDD	Yes ☐ No ☐	YYYYMMDD	
		YYYYMMDD	Yes ☐ No ☐	YYYYMMDD	
		YYYYMMDD	Yes ☐ No ☐	YYYYMMDD	

Dependant name

Scheme name	Membership number	Start date	Are they still a member?	End date if they have already resigned	Reason for leaving
		YYYYMMDD	Yes ☐ No ☐	YYYYMMDD	
		YYYYMMDD	Yes ☐ No ☐	YYYYMMDD	
		YYYYMMDD	Yes ☐ No ☐	YYYYMMDD	
		YYYYMMDD	Yes ☐ No ☐	YYYYMMDD	

Dependant name

Scheme name	Membership number	Start date	Are they still a member?	End date if they have already resigned	Reason for leaving
		YYYYMMDD	Yes ☐ No ☐	YYYYMMDD	
		YYYYMMDD	Yes ☐ No ☐	YYYYMMDD	
		YYYYMMDD	Yes ☐ No ☐	YYYYMMDD	
		YYYYMMDD	Yes ☐ No ☐	YYYYMMDD	

11. Moving from another medical scheme

Please make sure that you have completed section 10.

11.1 I confirm that all people named on this application:

1. are currently or have been members of a South African medical scheme for at least the past 24 months, and — Yes ☐ No ☐
2. have not had a break in membership of more than 90 days since resigning from that South African medical scheme. — Yes ☐ No ☐

If you answered **yes** to the above questions, please answer the questions in **11.2.**

If you answer no to any question in 11.1, you must complete all the medical questions in section 12.

11.2 For any person named on this application form:

1. Have you/they been admitted to hospital in the 12 months before this application? — Yes ☐ No ☐
2. Are you/they currently taking regular, ongoing medicine for a medical condition? — Yes ☐ No ☐
3. Are you/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 **11.2**, we will not apply any waiting periods and you **do not** have to complete section 12.

If you answered **yes** to **any** questions in **11.2**, we will apply a three-month general waiting period to your application and you **do not have to complete Section 12.** If you feel that a three-month general waiting period should not be applied and you want to give us more information, please complete section 12.

During these three months, Discovery Health Medical Scheme will only cover claims relating to Prescribed Minimum Benefits according to the Scheme's rules.

12. Your health questions

Treating healthcare professional's name

Practice number

Telephone

Email

The main applicant, spouse or partner and all dependants applying for cover needs to complete section 12.

Main applicant

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

12. Your health questions *(continued)*

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?

Spouse or partner
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 you or **any dependant** in this application ever experienced, been treated 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 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 12.19 below.

12.1 Are you or any of your dependants pregnant? Yes ☐ No ☐

Patient name		

12.2 Cancer Yes ☐ No ☐
Example: abnormal pap smear results, pre-cancerous skin lesions, breast disease, breast lump, abnormal PSA (prostate specific antigen) result.

Patient name		
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

12. Your health questions *(continued)*

12.3 Heart and circulation conditions **Yes** ☐ **No** ☐

Example: chest pain, palpitations, shortness of breath, coronary heart disease, angina, heart attack, arrhythmia, high blood pressure, 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	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

12.4 Gynaecological and obstetrics conditions **Yes** ☐ **No** ☐

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

Patient name		
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

12.5 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.

Patient name		
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

12.6 Metabolic or endocrine conditions **Yes** ☐ **No** ☐

Example: diabetes, 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	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

12. Your health questions *(continued)*

12.7 Liver and pancreas conditions Yes ☐ No ☐

Example: hepatitis, cirrhosis, portal hypertension, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis.

Patient name		
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

12.8 Gastrointestinal conditions including temporary or permanent stoma Yes ☐ No ☐

Example: GORD (heartburn), oesophageal disease, hernias, atrophic gastritis, ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis.

Patient name		
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

12.9 Brain and nerve conditions Yes ☐ No ☐

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

Patient name		
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

12.10 Respiratory conditions Yes ☐ No ☐

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

Patient name		
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

12. Your health questions *(continued)*

12.11 Musculoskeletal and connective tissue conditions including symptoms and treatment of back 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.

Patient name		
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

12.12 Kidney or urinary conditions including current or past dialysis **Yes** ☐ **No** ☐

Example: kidney/renal failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence.

Patient name		
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

12.13 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	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

12.14 Breast disease or any breast operations (male and female) **Yes** ☐ **No** ☐

Example: fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abnormal mammogram result.

Patient name		
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

12. Your health questions *(continued)*

12.15 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.

Patient name		
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

12.16 Ear, nose and throat (ENT) conditions Yes ☐ No ☐
Example: chronic otitis media (middle ear infection), chronic otitis externa, hearing problems, hearing aid, cochlear implant, tonsillitis, adenoiditis, vertigo.

Patient name		
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

12.17 Male urogenital conditions Yes ☐ No ☐
Example: prostate disorders, urogenital defects, varicocele, tumours, undescended testes, phymosis, urinary incontinence.

Patient name		
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

12.18 Are you or 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	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

12.19 Have you or any of your dependants had any symptoms, not yet diagnosed by a medical professional, in the last 12 months before this application? Yes ☐ No ☐

Patient name		
Symptoms		
Date symptoms first appeared or were noticed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for these symptoms	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for these symptoms and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

12. Your health questions *(continued)*

12.20 Have you or any of your dependants 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		
Date symptoms first noticed or appeared	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for these symptoms	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for these symptoms and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

12.21 Have you or 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 symptoms first noticed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation and/or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition	Yes ☐ No ☐	Yes ☐ No ☐
Medicine used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D

HIV and AIDS

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 HIV*Care* Programme. A 12-month condition specific waiting period may apply to this condition. When you call in to register on the HIV*Care* Programme, please confirm these details. 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.

13. Permission to process and disclose information and to communicate with you

Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider administers the Discovery Health Medical Scheme, registration number 1125.
Discovery Health Medical Scheme and Discovery Health (Pty) Ltd will keep your information and the information about those you apply for confidential. You agree to Discovery Health Medical Scheme and Discovery Health (Pty) Ltd processing and disclosing your information in the following manner:

1. Discovery Health Medical Scheme and Discovery Health (Pty) Ltd may collect, collate, process, store and disclose your and all your dependants' personal information, as provided in this application and any information we get about you and your dependant/s:
   - for the administration of your health plan,
   - for providing managed care services to you or any dependant/s on your health plan,
   - 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; and
   - to profile and analyse risk.
2. Discovery Health Medical Scheme and Discovery Health (Pty) Ltd will only share your personal and health information or the information of any dependant/s on your health plan if it is requested by a third party who you have already given your consent to for the disclosure of this information.
3. We will provide your personal and health information to any other entity within the Discovery Group where you or your dependant/s already has a relationship with or where you or your dependant's have applied for a product or benefit. This information will be provided for the administration of your or your dependant's products or benefits.
4. If we want to share your information for any other reason, we will do so only with your permission.
5. When providing Discovery Health Medical Scheme and Discovery Health (Pty) Ltd with personal and health information about a dependant on your health plan, you confirm that you have received appropriate permission to disclose this information to Discovery Health Medical Scheme and Discovery Health (Pty) Ltd.
6. Discovery Health Medical Scheme and Discovery Health (Pty) Ltd may provide any credit bureau or credit providers industry association with any information about your consumer credit record, including and not limited to information about your credit history, financial history, personal information and judgement or default history.
7. Discovery Health Medical Scheme and Discovery Health (Pty) Ltd will communicate 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.
8. Discovery Health Medical Scheme, Discovery Health (Pty) Ltd and any entity within the Discovery Group of companies 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 direct marketing information from us.

Signature of main applicant

14. Discovery Health Medical Scheme rules for membership

14.1 Rules for membership

The rules of the Discovery Health Medical Scheme records your rights and responsibilities for your membership of the Discovery Health Medical Scheme. They may change from time to time. You may ask Discovery Health (Pty) Ltd 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 Discovery Health Medical Scheme and Discovery Health (Pty) Ltd 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 Discovery Health (Pty) Ltd 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.

14.2 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 legal responsibility to provide financially for that dependant. Discovery Health (Pty) Ltd 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.

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

14.4 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 Discovery Health Medical Scheme and Discovery Health (Pty) Ltd. It is important that you tell Discovery Health Medical Scheme and Discovery Health (Pty) Ltd 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.

Discovery Health (Pty) Ltd may ask those you apply for who are 18 and older for information and this will be treated as if Discovery Health Medical Scheme had asked you in your role as main member.

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 Discovery Health (Pty) Ltd 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 Discovery Health (Pty) Ltd and the Discovery Health Medical Scheme 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. Discovery Health (Pty) Ltd 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 the Discovery Health Medical Scheme and Discovery Health (Pty) Ltd may get any information that is relevant to your application from your employer.

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

You, your employer or your financial adviser must tell Discovery Health Medical Scheme or Discovery Health (Pty) Ltd 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 memberships immediately and keep any contributions paid, if you and those you apply for:

- do not give Discovery Health Medical Scheme and Discovery Health (Pty) Ltd information that later turns out to be relevant to this application.
- give Discovery Health Medical Scheme and Discovery Health (Pty) Ltd any information that is not true, correct and complete.
- do not tell Discovery Health Medical Scheme and Discovery Health (Pty) Ltd 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.

14.5 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 Discovery Health (Pty) Ltd 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.

Discovery Health (Pty) Ltd and the Discovery Health Medical Scheme may record telephone calls

Discovery Health (Pty) Ltd and the Discovery Health Medical Scheme 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.

14.6 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 2 0 Y Y M M D D

The main applicant must sign and date any changes

15. What happens after sending your application to us

Once you send Discovery Health (Pty) Ltd your application form, here is what will happen:

- Discovery Health (Pty) Ltd will capture and check your details.
- If any details are missing or if we need more information for underwriting purposes, Discovery Health (Pty) Ltd will contact you.
- Discovery Health (Pty) Ltd will send you or your financial adviser a 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.
- After accepting your application to join Discovery Health Medical Scheme, we will send you or your financial adviser a SMS and an email letter confirming acceptance. The SMS and email will advise you of when your membership will commence. Depending on your circumstances, it may also indicate any conditions applicable to your membership such as waiting periods or late joiner penalties.
- You will be required to sign this letter at the appropriate place and return it to Discovery Health (Pty) Ltd. When you do so, you confirm your start date and acceptance of any conditions applicable to your membership.
- You will then get a pack in the post. This will contain details about your plan and all you need to get started.

If you do not hear from Discovery Health (Pty) Ltd seven days after sending us your application form, please contact Discovery Health (Pty) Ltd on 0860 100 345 or your financial adviser.

Application to join Vitality or KeyFIT or both

Contact us

Tel: 0860 99 88 77, PO Box 653574, Benmore 2010, www.discovery.co.za

Please complete this form and submit it to us by email at vitalitysales@discovery.co.za or by fax to (011) 539 2509.

Please make sure that you sign this application

Main applicant's name and surname

Main applicant's ID number

Please choose one of the following options:

☐ Vitality ☐ KeyFIT ☐ Vitality and KeyFIT

Only members with a KeyCare Health Plan can join KeyFIT without joining Vitality as well.

1. Banking details and payment date

If you are paying your own Vitality contribution, please complete this section.

Bank name

Branch name Branch number – –

Account number Type of account Cheque ☐ Savings ☐

Accountholder

Accountholder's signature Signature of main applicant

Please note: If you are using someone else's bank account, the accountholder must sign above to confirm and consent to this.

Please note that if your activation request reaches Vitality between the 1st and 15th of the month, the policy will be effective from the first of the current month. If you activate Vitality between the 16th and last day of the month, the policy will be effective from the first of the following month.

Please choose the date you would like us to debit your account (if you are not a government employee):

1st ☐ 10th ☐ 15th ☐ 20th ☐ 25th ☐

If your membership is not activated in time for the debit order date you chose above, you will have two separate debit orders in the first month you pay your contribution, because you pay your contribution in advance. The first debit order will be collected on the first day of the month and the second debit order will be collected on the actual date you have chosen in the same month. From then on we, will collect your monthly contribution on the date you have chosen.

If you are a government employee on the PERSAL payroll system, please tick the box below to tell us which day of the month you want us to debit your account.

1st ☐ 5th ☐ 8th ☐ 21st ☐ 26th ☐

2. The DiscoveryCard

The DiscoveryCard is a Visa credit card. Vitality members can get cash back, travel savings and a world of convenience through our DiscoveryCard partners.

Would you like to apply for a DiscoveryCard? Yes ☐ No ☐

Please note: When assessing your DiscoveryCard application, a credit check will be done. An accredited consultant will phone you to complete the application. A DiscoveryCard will only be issued if you meet the credit approval criteria.

You give consent to Discovery Vitality to share information with DiscoveryCard to facilitate this application process Yes ☐ No ☐

3. Vitality contributions for 2014

	Vitality	KeyFIT	Vitality and KeyFIT
Member	R169	R36	R179
Member + spouse or dependant	R199	R44	R215
Member + 2 or more dependants	R225	R55	R249

4. Permission to process and disclose information and to communicate with you

Discovery Vitality (Pty) Ltd hereinafter referred to as "we" will keep your information and the information about those you apply for confidential. You agree to us processing and disclosing your information in the following manner:

1. We will only share your personal and/or health information or the information of any dependant on your Vitality policy if it is requested by a third party who you have already given your consent to for the disclosure of this information and the party that we share the information with agrees to keep the information confidential. If we want to share your information for any other reason, we will do so only with your permission.
2. We may collect, collate, process, store and disclose your personal information, as contained in all sections of this application and any information that is provided to use after the inception of your Vitality policy:
   - For the administration of the Vitality Programme,
   - For the provision of any services that you or any dependant on your Vitality policy may require,
   - For the provision of relevant information to a contracted third party who require such information to render a service to you or any dependant on your Vitality policy and only if such contracted third party agrees to keep the information confidential; and
   - For academic research.
3. We will provide your personal and health information to any other entity within the Discovery Group where you or your dependant/s already have a relationship or where you or your dependant's have applied for a product or benefit. This information will be provided for the administration of your or your dependant/s products or benefits.
4. When providing us with personal information about a dependant on your Vitality policy, you confirm that they have provided you with appropriate permission to disclose that information to us. This includes consent to the administration of their membership to Vitality, the provision of any services to them as required, the provision of relevant information to a contracted third party who require such information to render a service to them.
5. We may obtain relevant health information from Discovery Health (Pty) Ltd and the Scheme to administer the Vitality Programme.
6. We may provide to any credit bureau or credit providers industry association any information relating to your creditworthiness or any consumer credit information including but not limited to credit history, financial history, personal information and judgement or default history in accordance with the requirements of the National Credit Act and regulations.
7. We may communicate to you any changes in your Vitality policy, including any changes in your contributions or any changes/enhancements to the benefits you are entitled to.
8. Discovery Vitality (Pty) Ltd and any entity within the Discovery Group of companies as well as contracted third party service providers will keep you updated on information about any offers for new products Discovery may make available at any time. Please contact us if you do not wish to receive any direct marketing information from us.

Signature of main applicant

5. Vitality rules for membership

Discovery Vitality and KeyFIT are separate from the Scheme and administrator

Discovery Vitality is a separate company from Discovery Health (Pty) Ltd ('the administrator') and the Discovery Health Medical Scheme (referred to as 'the Scheme'). It is formally registered under the name Discovery Vitality (Pty) Ltd, (registration number 1999/007736/07) and takes care of the administration of the Vitality and KeyFIT programmes ('Discovery Vitality'), DiscoveryCard and the DiscoveryCard loyalty programme.

Rules of the Vitality programme

A full set of rules is available on www.discovery.co.za or you can call Discovery Vitality on 0860 99 88 77. In the event of a conflict between what is set out here, on our website and the rules of Vitality, the rules will always apply.

Your contributions to Discovery Vitality are separate

The contributions you pay are for Discovery Vitality and are not part of the contributions you pay to the Scheme.

Cancellation of Vitality membership

Please give notice on the first day of the month if you wish to cancel your Vitality membership in that month. Otherwise, your membership will only end on the last day of the next month. You must be a member of Vitality at the time of the *billing cycle (not the time of the transaction) in order to be eligible for your reward.

*Billing Cycle refers to the date decided by Discovery Vitality, on which your Vitality benefits are calculated on a monthly basis.

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

Signed at (town or city) on 2 0 Y Y M M D D

Signature of main applicant **The main applicant must sign and date any changes**