

Discovery Health is an authorised Financial Services Provider and administers LA Health Medical Scheme

APPLICATION FOR ADDITION OF DEPENDANT(S)

To follow-up on this application, please phone 0860 100 345 or email NBCUSTOMS_QUERIES@discovery.co.za

Please fax the completed and signed form to 011 539 2331 or email it to healthplan@discovery.co.za

HOW TO COMPLETE THIS APPLICATION

Please use one letter per block, complete with black ink and print clearly.

To avoid administration delays, please ensure this application is completed in full.

Please attach a copy of your dependant(s) identity document. We also accept SA driver's licences, passports and SA birth certificates for children.

A. ABOUT YOUR EMPLOYER WARRANTY (Additions to employer groups need to be signed by the HR/Payroll contact)

Please ensure your employer completes this section of the application form if the member falls under an employer group.

1. We warrant that the principal member detailed in section D of this application form is an employee of our organisation.
2. LA Health may bill us for the amount due in respect of this dependant in the same manner as is done for other LA Health members employed by our organisation.

Authorised signatory(ies)

Name(s)

Designation(s)

B. CONTACT DETAILS (Person who will receive correspondence regarding this application)

Contact name

Designation

Telephone

Cellular

Fax

Email address

Preferred means of communicating (please tick one)

Email

Post

Fax

C. ABOUT THE PRINCIPAL MEMBER

Surname

Membership number

First name(s) (as per identity document)

Date of birth

Telephone (H)

(W)

Cellular

Fax

Employee number

Email

D. ABOUT YOUR SPOUSE/PARTNER (if applying for cover)

When would you like the cover to start?

Title

Initials

Surname

First name(s) (as per identity document)

Preferred name

Gender

Date of birth

Marital status

Previous/maiden name

D. ABOUT YOUR SPOUSE/PARTNER (if applying for cover) (continued)

ID or passport number

Country of issue

Telephone (H) (W)

Cellular Fax

Preferred means of communicating Email Post Email type (H) (W)

Email address

If addition of spouse to an existing membership

- is due to marriage within the last three months, a marriage certificate must accompany this application form to avoid underwriting.
- is for a spouse married for a period of more than 3 months, full underwriting will apply.

E. ABOUT YOUR DEPENDANTS (if applying for cover)

When would you like the cover to start?

1 Adult (27+ years) or child

Title Initials

Surname

First name(s) (as per identity document)

Preferred name

Relationship to main applicant

ID or passport number

Country of issue

Date of birth Sex M F

Does the dependant receive an income eg pension? YES NO

Is the dependant financially dependent on the main applicant? YES NO

If YES, please fill in the monthly income

2 Adult (27+ years) or child

Title Initials

Surname

First name(s) (as per identity document)

Preferred name

Relationship to main applicant

ID or passport number

Country of issue

Date of birth Sex M F

Does the dependant receive an income eg pension? YES NO

Is the dependant financially dependent on the main applicant? YES NO

If YES, please fill in the monthly income

3 Adult (27+ years) or child

Title Initials

Surname

First name(s) (as per identity document)

Preferred name

Relationship to main applicant

ID or passport number

Country of issue

Date of birth Sex M F

Does the dependant receive an income eg pension? YES NO

Is the dependant financially dependent on the main applicant? YES NO

If YES, please fill in the monthly income

4 Adult (27+ years) or child

Title Initials

Surname

First name(s) (as per identity document)

Preferred name

Relationship to main applicant

ID or passport number

Country of issue

Date of birth Sex M F

Does the dependant receive an income eg pension? YES NO

Is the dependant financially dependent on the main applicant? YES NO

If YES, please fill in the monthly income

1. If any of your dependants are over the age of 27 and are currently studying, please provide us with proof of studies (registration form, student card etc.)
2. If any of your dependants are over the age of 27 and have a permanent physical and/or mental disability, please provide us with proof thereof (ie a letter from their treating doctor).

CHOOSING YOUR HEALTH CARE PROVIDER ON THE LA KEYPLUS OPTION

To be completed if you have selected the LA KeyPlus Option

KeyCare Primary Care Network				
	Name	General practitioner	Practice number	Telephone number
Spouse/partner	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dependant*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dependant*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dependant*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please note: You can only access day-to-day cover and chronic benefits through the KeyCare Primary Care general practitioner detailed above.

* Please ensure that the dependant information supplied above corresponds with the dependant information in section E of this form.

G. PREVIOUS MEDICAL SCHEME DETAILS

Please give us the details of all registered South African medical schemes that you and your dependants previously belonged to. We will use this information to determine if we need to apply any waiting periods, late joiner penalty fees or both.

Scheme name	Membership number	Start date	End date or are you still a member?	Reasons for leaving
Main applicant	<input type="text"/>	<input type="text"/>	<input type="text"/> YES <input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> YES <input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> YES <input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> YES <input type="checkbox"/>	<input type="text"/>
Spouse/partner – Are these medical scheme details the same as the main applicant's? YES <input type="checkbox"/> NO <input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> YES <input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> YES <input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> YES <input type="checkbox"/>	<input type="text"/>
Dependant 1 – Name <input type="text"/>				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> YES <input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> YES <input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> YES <input type="checkbox"/>	<input type="text"/>
Dependant 2 – Name <input type="text"/>				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> YES <input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> YES <input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> YES <input type="checkbox"/>	<input type="text"/>
Dependant 3 – Name <input type="text"/>				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> YES <input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> YES <input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> YES <input type="checkbox"/>	<input type="text"/>
Dependant 4 – Name <input type="text"/>				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> YES <input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> YES <input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> YES <input type="checkbox"/>	<input type="text"/>

H. YOUR DEPENDANT'S MEDICAL QUESTIONS (continued)

- Please give full medical details of **all dependants to be covered**.
- You are required by law to make a full and proper disclosure of any medical information.
- By completing this section, you consent to the disclosure of medical information for risk management and underwriting purposes.

A.	Spouse/partner	Adult dependant	Adult dependant	Adult dependant
Name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
How tall are you? (metres)	<input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/>
How much do you weigh? (kilograms)	<input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/>
Do you drink alcohol?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
How many units of alcohol do you drink in a week? <small>1 unit of alcohol = 1 measure of spirits, 1/2 pint of beer or 1 glass of wine</small>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Do you smoke?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Type (eg a pipe, cigars, cigarettes)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Amount per day	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
If no, have you smoked in the last 24 months?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Amount per day	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

B. Have any of your dependants included in this application ever experienced, been treated for, or are currently suffering from any of the following symptoms or conditions?

1. Blood disorders YES <input type="checkbox"/> NO <input type="checkbox"/> eg anaemia <input type="checkbox"/> leukaemia <input type="checkbox"/> bleeding disorders <input type="checkbox"/> haemophilia <input type="checkbox"/> lymphoma <input type="checkbox"/> deep vein thrombosis (blood clots) <input type="checkbox"/> pulmonary embolism <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
2. Brain and nerve disorders YES <input type="checkbox"/> NO <input type="checkbox"/> eg stroke <input type="checkbox"/> multiple sclerosis <input type="checkbox"/> epilepsy <input type="checkbox"/> migraine <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> quadriplegia <input type="checkbox"/> paraplegia <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. Cancer YES <input type="checkbox"/> NO <input type="checkbox"/> eg any form of cancer <input type="checkbox"/> or pre-cancerous growth/s <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		

H. YOUR DEPENDANT'S MEDICAL QUESTIONS (continued)

4. Heart and circulation disorders YES <input type="checkbox"/> NO <input type="checkbox"/> eg angina/chest pain <input type="checkbox"/> heart failure <input type="checkbox"/> heart murmurs <input type="checkbox"/> rheumatic fever <input type="checkbox"/> high blood pressure <input type="checkbox"/> heart attack <input type="checkbox"/> raised cholesterol <input type="checkbox"/> previous heart surgery <input type="checkbox"/> rhythm disturbance (palpitations) <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. Connective tissue disorders YES <input type="checkbox"/> NO <input type="checkbox"/> eg systemic lupus erythematosus <input type="checkbox"/> scleroderma <input type="checkbox"/> dermatomyositis/polymyositis <input type="checkbox"/> mixed connective tissue disorder <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
6. Dental disorders YES <input type="checkbox"/> NO <input type="checkbox"/> eg over/underbite problems <input type="checkbox"/> missing/skew teeth <input type="checkbox"/> ongoing or planned dental treatment <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
7. Eye, ear and speech disorders YES <input type="checkbox"/> NO <input type="checkbox"/> eg cataracts <input type="checkbox"/> glaucoma <input type="checkbox"/> tinnitus <input type="checkbox"/> hearing/visual impairment <input type="checkbox"/> disorders of the cornea <input type="checkbox"/> blindness <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
8. Gynaecological disorders YES <input type="checkbox"/> NO <input type="checkbox"/> eg ovarian cysts <input type="checkbox"/> endometriosis <input type="checkbox"/> fibroid <input type="checkbox"/> disorders of the cervix <input type="checkbox"/> menstrual disorders <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
9. Kidney/urinary tract disorders YES <input type="checkbox"/> NO <input type="checkbox"/> eg kidney failure <input type="checkbox"/> kidney stones <input type="checkbox"/> recurrent infections <input type="checkbox"/> nephritis <input type="checkbox"/> prostate problems <input type="checkbox"/> blood/protein in urine <input type="checkbox"/> polycystic kidneys <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		

H. YOUR DEPENDANT'S MEDICAL QUESTIONS (continued)

10. Liver/pancreatic disorders YES <input type="checkbox"/> NO <input type="checkbox"/> eg hepatitis <input type="checkbox"/> cirrhosis <input type="checkbox"/> liver failure <input type="checkbox"/> gallstones <input type="checkbox"/> pancreatitis <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
11. Mental health/psychiatric disorders YES <input type="checkbox"/> NO <input type="checkbox"/> eg depression <input type="checkbox"/> anxiety <input type="checkbox"/> schizophrenia <input type="checkbox"/> eating disorders <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
12. Metabolic/endocrine disorders YES <input type="checkbox"/> NO <input type="checkbox"/> eg diabetes <input type="checkbox"/> thyroid abnormalities <input type="checkbox"/> growth disorders <input type="checkbox"/> Cushing's disease <input type="checkbox"/> Addison's disease <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
13. Musculoskeletal disorders YES <input type="checkbox"/> NO <input type="checkbox"/> eg rheumatoid arthritis <input type="checkbox"/> osteoporosis <input type="checkbox"/> osteo-arthritis <input type="checkbox"/> loss of limb <input type="checkbox"/> myasthenia gravis <input type="checkbox"/> back problems/operations <input type="checkbox"/> gout <input type="checkbox"/> slipped disk <input type="checkbox"/> backache <input type="checkbox"/> other <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. Respiratory disorders YES <input type="checkbox"/> NO <input type="checkbox"/> eg asthma <input type="checkbox"/> cystic fibrosis <input type="checkbox"/> emphysema <input type="checkbox"/> chronic obstructive airways disease <input type="checkbox"/> chronic bronchitis <input type="checkbox"/> any lung surgery <input type="checkbox"/> shortness of breath <input type="checkbox"/> coughing up blood <input type="checkbox"/> persistent cough <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		

H. YOUR DEPENDANT'S MEDICAL QUESTIONS (continued)

15. Gastro-intestinal disorders YES NO
 eg Crohn's disease ulcerative colitis bleeding ulcers

Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		

16. Are any of your dependants suffering from any symptoms not yet diagnosed by a medical professional eg heartburn, reflux etc YES NO

Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		

17. If any of your dependants have any condition or symptom which is not directly covered by these questions, please provide FULL medical details. YES NO

Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		

18. Are any of your dependants expecting surgery or planning hospitalisation or treatment in the next 12 months? YES NO

Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		

19. Have any of your dependants had an operation or been admitted to hospital in the past 12 months? YES NO

Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		

20. Please detail whether any person included in this application form is pregnant. YES NO

Name

H. YOUR DEPENDANT'S MEDICAL QUESTIONS (continued)

21. If in the last 24 months, any of your dependants have been involved in a motor vehicle accident or been injured on duty or contracted a work related disease please specify below. YES NO

Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		

22. Have any of your dependants ever had or are currently suffering from alcohol or drug problems ?

Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			YES <input type="checkbox"/> NO <input type="checkbox"/>		
			YES <input type="checkbox"/> NO <input type="checkbox"/>		

23. HIV and AIDS

You do not need to disclose your HIV and AIDS status on this form if you do not feel comfortable to do so. However, if you are HIV positive, you must call us on 0860 100 417 within 7 (seven) working days from the date we activate your membership. It is in your best interest to register on the HIVCare Programme.

24. Have any of your dependants ever had a waiting period or late joiner penalty applied or been offered cover on special terms by a life insurance company or medical scheme ? YES NO

If YES, please attach previous membership certificate or state the nature of the waiting period

Name	Details	Name of medical scheme/insurance company where this was applicable

I. YOUR LEGAL DECLARATION

Rules of the Scheme

1. I apply for my dependants and myself to join LA Health Medical Scheme ("the Scheme") administered by Discovery Health (Pty) Limited (the Administrator) and agree that my dependants and I will be bound to the rules of the Scheme.

Disclosure of Information

2. Any breach of any warranty or non-disclosure of any information by myself or my dependants relevant to the assessment of this application will render my membership null and void, and all contributions paid by me will be forfeited to the Scheme.
3. I hereby consent to the disclosure by the Administrator and/or the Scheme of any information supplied to either or both of them to any third parties, provided that such parties agree to keep such information confidential at all times, and providing that the information is needed to manage Scheme benefits.
4. I consent to the Administrator addressing any request for information, tests or examinations directly to any dependant of mine over the age of 21, with the same legal consequences as if the request had been addressed to me in my capacity as a principal member.
5. I:
 - 5.1 authorise the Administrator to obtain from any person, including although not limited to my broker, any necessary information which the Administrator may require, in its sole and absolute discretion concerning myself or any dependant of mine, to assess any risk or claim relating to this application or my membership;
 - 5.2 direct the person concerned to provide Discovery with such information on request.

The Scheme's rights on termination

6. On termination of my membership from the Scheme I shall repay the Scheme and/or the Administrator any amount owing by me in respect of my Medical Savings Account or owing by me for any other reason.

Recording of Calls

7. I
 - 7.1 consent to all conversations between myself or my dependants and the Administrator being recorded and all information obtained through these conversations forming part of the Administrator's records;
 - 7.2 further consent to all of these recordings remaining the sole property of the Administrator.

Acting on behalf of dependants

8. I
 - 8.1 undertake to obtain the necessary consents from any dependant of mine to whom these terms and conditions may apply to act on their behalf with regards to any matter concerning their membership of the Scheme and I hereby indemnify both the Administrator and the Scheme against any claim which may arise as a result of my failure to do so.
 - 8.2 The Administrator reserves the right to request proof of legal liability for family care and support of a dependant (if applicable).

I. YOUR LEGAL DECLARATION (continued)

General

I understand that I must not resign from my current medical scheme until I have received written notification of acceptance from the Scheme. Once I have received notification of my acceptance from the Scheme, I will cancel my current medical scheme membership as it is illegal to belong to two medical schemes at the same time.

I warrant that the contents of this application are true, correct and complete.

I agree to inform the Administrator in writing of any change in details (including any change in my health or my dependants' health) that may occur between the date of this application form and the activation date of my membership of the Scheme.

Signed at on

Y	Y	Y	Y	M	M	D	D
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Signature of principal member

Please phone 0860 100 345 or email additionsquery@discovery should you not have heard from your intermediary or LA Health within 7 working days.

I. YOUR INTERMEDIARY DETAILS

Intermediary Code

Intermediary house Code

Intermediary's contact details:

Tel (W)

Cell

Lead number

Signature of intermediary

Broker stamp

Intermediaries are appointed by the member or his representative, being his employer.

FOR OFFICE USE ONLY	
Employer number	<input type="text"/>
Process initiator code (PIN)	<input type="text"/>