

## Additional dependant application form

This document is an application form for membership for any additional dependants or adult dependants you want to add to your membership after your initial joining date. It also contains some rules for membership. Please make sure you read and understand the rules.

### How to complete this application form

- 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.
- Fax the completed and signed application form to **011 539 2331** or email it to **healthplan@discovery.co.za**
- To follow-up on this application, please call 0860 100 345 or email **nb\_inhouse\_queries@discovery.co.za**

### 1. About the main member's employer

Municipality/Employer name

Date of permanent employment         Depot name

Payroll number  **Pensioners only:** Pension number

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

LA Health may bill us for the amount due in respect of this dependant in the same manner as is done for the dependants of other LA Health members.

Employer stamp  Name   
Designation

### 2. About yourself (main member)

Membership number

Title  Initials  Surname

First name(s) (as per identity document)

ID or passport number  Tax number

Telephone (H)   (W)

Cellphone   Fax

Physical address  Postal address

Code   Code

Preferred language English  Afrikaans  Preferred means of communicating Email  Post

Email type (H)  (W)

Email



**5. Please complete the section below if you are registered on the LA KeyPlus Option**

LA KeyPlus Primary Care Network				
	Name	General practitioner	Practice number	Telephone number
Spouse or partner				
Dependant*				
Dependant*				
Dependant*				
Dependant*				

\* Please ensure that the dependant information supplied above is the same as the dependant information in Section 4 of this form. In the event that 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 complete the section below if you need a secondary GP allocated to you.

Name	General practitioner	Practice number	Telephone number

Please note: you can only access day-to-day cover and chronic benefits through the KeyCare network GP(s) chosen above.

**6. Your family's previous medical scheme details (please supply proof of current membership)**

SPOUSE OR PARTNER (please complete ALL fields below if applying for cover)

1. Name of previous medical scheme  Membership number   
 Date of joining:  to  or currently a member

2. Name of previous medical scheme  Membership number   
 Date of joining:  to

3. Name of previous medical scheme  Membership number   
 Date of joining:  to

DEPENDANT 1 (please complete ALL fields below if applying for cover)

1. Name of previous medical scheme  Membership number   
 Date of joining:  to  or currently a member

2. Name of previous medical scheme  Membership number   
 Date of joining:  to

3. Name of previous medical scheme  Membership number   
 Date of joining:  to

DEPENDANT 2 (please complete ALL fields below if applying for cover)

1. Name of previous medical scheme  Membership number   
 Date of joining:  to  or currently a member

2. Name of previous medical scheme  Membership number   
 Date of joining:  to

3. Name of previous medical scheme  Membership number   
 Date of joining:  to

DEPENDANT 3 (please complete ALL fields below if applying for cover)

1. Name of previous medical scheme  Membership number   
 Date of joining:  to  or currently a member

2. Name of previous medical scheme  Membership number   
 Date of joining:  to

3. Name of previous medical scheme  Membership number   
 Date of joining:  to



## 7. Your medical questionnaire (continued)

Has any dependant in this application ever experienced, been treated for, or are you currently suffering from any of the following symptoms, conditions or disorders?

<b>1. Blood disorders</b> Yes <input type="checkbox"/> No <input type="checkbox"/> example anaemia <input type="checkbox"/> leukaemia <input type="checkbox"/> bleeding disorders <input type="checkbox"/> haemophilia <input type="checkbox"/> lymphoma <input type="checkbox"/> thrombosis (blood clots) <input type="checkbox"/> Pulmonary embolus <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition?	Date of <b>last</b> 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"/>		
<b>2. Brain and nerve disorders</b> Yes <input type="checkbox"/> No <input type="checkbox"/> example 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"/> cerebral palsy <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition?	Date of <b>last</b> 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"/>		
<b>3. Cancer</b> Yes <input type="checkbox"/> No <input type="checkbox"/> example 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 <b>last</b> 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"/>		
<b>4. Heart and circulation disorders</b> Yes <input type="checkbox"/> No <input type="checkbox"/> example angina or 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 <b>last</b> 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"/>		
<b>5. Connective tissue disorders</b> Yes <input type="checkbox"/> No <input type="checkbox"/> example 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 <b>last</b> 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"/>		
<b>6. Dental disorders</b> Yes <input type="checkbox"/> No <input type="checkbox"/> example over/underbite problems <input type="checkbox"/> missing/skew teeth <input type="checkbox"/> ongoing or planned dental treatment <input type="checkbox"/> ongoing or planned orthodontic treatment <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition?	Date of <b>last</b> 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"/>		
<b>7. Eye, ear and speech disorders</b> Yes <input type="checkbox"/> No <input type="checkbox"/> example cataracts <input type="checkbox"/> glaucoma <input type="checkbox"/> tinnitis <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 <b>last</b> 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. Your medical questionnaire (continued)

<b>8. Gynaecological disorders</b> Yes <input type="checkbox"/> No <input type="checkbox"/> example ovarian cysts endometriosis <input type="checkbox"/> fibroid disorders of the cervix <input type="checkbox"/> menstrual disorders <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	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"/>		
<b>9. Kidney or urinary tract disorders</b> Yes <input type="checkbox"/> No <input type="checkbox"/> example 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? Yes <input type="checkbox"/> No <input type="checkbox"/>	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"/>		
<b>10. Liver or pancreatic disorders</b> Yes <input type="checkbox"/> No <input type="checkbox"/> example 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? Yes <input type="checkbox"/> No <input type="checkbox"/>	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"/>		
<b>11. Mental health or psychiatric disorders</b> Yes <input type="checkbox"/> No <input type="checkbox"/> example depression <input type="checkbox"/> anxiety <input type="checkbox"/> schizophrenia <input type="checkbox"/> eating disorders <input type="checkbox"/> Bipolar					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	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"/>		
<b>12. Metabolic or endocrine disorders</b> Yes <input type="checkbox"/> No <input type="checkbox"/> example 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? Yes <input type="checkbox"/> No <input type="checkbox"/>	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"/>		
<b>13. Musculoskeletal disorders</b> Yes <input type="checkbox"/> No <input type="checkbox"/> example rheumatoid arthritis <input type="checkbox"/> osteo-arthritis <input type="checkbox"/> myasthenia gravis <input type="checkbox"/> gout <input type="checkbox"/> osteoporosis <input type="checkbox"/> loss of limb <input type="checkbox"/> back problems/operations <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? Yes <input type="checkbox"/> No <input type="checkbox"/>	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"/>		
<b>14. Respiratory disorders</b> Yes <input type="checkbox"/> No <input type="checkbox"/> example cystic fibrosis <input type="checkbox"/> emphysema <input type="checkbox"/> chronic bronchitis <input type="checkbox"/> shortness of breath <input type="checkbox"/> persistent cough <input type="checkbox"/> asthma <input type="checkbox"/> chronic obstructive airways disease <input type="checkbox"/> any lung surgery <input type="checkbox"/> coughing up blood <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	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"/>		
<b>15. Gastro-intestinal disorders</b> Yes <input type="checkbox"/> No <input type="checkbox"/> example Crohn's disease <input type="checkbox"/> ulcerative colitis <input type="checkbox"/> bleeding ulcers <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	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. Your medical questionnaire (continued)

**16. Are any of your dependants suffering from any symptoms not yet diagnosed by a medical professional?** Yes  No   
 example heartburn  reflux  etc.

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(s) which is not directly covered by these questions, please provide FULL medical details.**

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.**

Name

**21. Have any of your dependants ever had or are currently suffering from alcohol  or drug problems .** 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. HIV AND AIDS

If any of your dependants are living with HIV and AIDS and would prefer not to disclose the HIV and AIDS status on this form in the interest of confidentiality then you must call us on 0860 100 417 within 7 (seven) working days from the date we activate their LA Health membership. If any of your dependants are aware that they are HIV-positive, it would be in their interest to register on the HIVCare Programme. Should they only find out at a later stage that they are HIV-positive, please let us know as soon as possible.

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. Rules for membership

Rules for membership are the rights and responsibilities for your membership of the scheme. They may change from time to time but you may ask us for a copy of these rules at any time.

When you sign this application, you confirm that you agree that you and those you apply for will be bound by the rules of the scheme.

Please speak to your broker or us if there is anything you do not understand.

### 1. Acting for others

#### You confirm that 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 that you apply for in any matter relating to this application.
- You have received permission from your spouse and any dependants over 21 to act for them in any matter relating to this application.

### 2. Giving Information

#### You must give us true, correct and complete information

To consider your application for membership, the scheme must learn more about you and those you apply for. The information must be true, correct and complete. This includes the details you give us in this application form and in future dealings with us.

We may ask those you apply for who are 21 and older for information and it will be treated as if we had asked you in your role as main member.

#### We may get the information from other relevant sources

To consider an application for membership or a claim for medical expenses, you agree that the scheme can get information about you and those you apply for from other relevant sources, including medical practitioners and brokers.

#### Tell us about changes right away

If any of the information you gave to us changes between the day you sign this document and the day your membership starts, you must tell us in writing what the changes are. This includes information about your health and the health of those you apply for.

#### When the scheme may cancel

The scheme may cancel any memberships immediately and keep any contributions paid, if you and those you apply for:

- do not give us information that later turns out to be relevant for 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.

### 3. Sharing information and confidentiality

#### When we may share your information

The scheme will keep your information and the information about those you apply for confidential.

The scheme may share this information with other relevant parties only if the following two conditions are met:

- The information is needed only to administer the scheme and any claims
- The parties the scheme shares the information with agree to keep the information confidential.

If we want to share your information for any other reason, we will do so only with your permission.

#### The scheme may record calls

The scheme may record telephone conversations with you and those you apply for. The recordings and all information we get during the recordings will be processed and kept as required by law.

### 4. About becoming a dependant on LA Health

#### Resign from your current medical scheme

It is illegal to be a member of more than one medical scheme at the same time. Those you apply for must resign from their current medical scheme(s) when you receive notice from the scheme by letter, email or SMS telling you that they have been accepted as dependants on your LA Health membership.

#### You must ensure contributions are paid on time

As the main member of the scheme, you are responsible for ensuring that your contributions and the contributions of those you apply for are paid on time every month.

### 5. You must repay any medical savings or other debt owing when you leave the scheme

When you become a member, depending on the benefit option you chose, you may have money available in advance through the Medical Savings Account to use for medical expenses during the year. If you leave the scheme before the year is up, you must repay the proportion of medical savings you have used in advance.

Any other debt must also be paid to the scheme.

Signed at

on

Signature of applicant

