

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 **application@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)

When do you want your dependant's cover to start?

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	GP name	Practice number	Second GP name*	Practice number

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 note: you can only access day-to-day cover and chronic benefits through the KeyCare general practitioner(s) you choose above.

6. Banking details for Benefit Option contributions (if applicable)

If you pay your total contribution directly to the Scheme, please provide your bank details for your debit order.

Bank name Branch name
 Account type Cheque Transmission Savings Branch code - - -
 Name of account holder
 Account number Signature of account holder

7. Banking details for reimbursement of your claim (compulsory)

Claims can only be paid into a South African bank account.

Bank name Branch name
 Account type Cheque Transmission Savings Branch code - - -
 Name of account holder
 Account number Signature of account holder

By signing above, you acknowledge that once claims have been refunded into the account above, the Scheme will not be liable in any way for the amounts refunded.

8. 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: Y Y Y Y M M D D to Y Y Y Y M M D D or currently a member
 2. Name of previous medical scheme Membership number
 Date of joining: Y Y Y Y M M D D to Y Y Y Y M M D D
 3. Name of previous medical scheme Membership number
 Date of joining: Y Y Y Y M M D D to Y Y Y Y M M D D

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

1. Name of previous medical scheme Membership number
 Date of joining: Y Y Y Y M M D D to Y Y Y Y M M D D or currently a member
 2. Name of previous medical scheme Membership number
 Date of joining: Y Y Y Y M M D D to Y Y Y Y M M D D
 3. Name of previous medical scheme Membership number
 Date of joining: Y Y Y Y M M D D to Y Y Y Y M M D D

9. Your medical questionnaire (continued)

- 6. Dental disorders** Yes No
 example over/underbite problems missing/skew teeth ongoing or planned dental treatment
 ongoing or planned orthodontic treatment

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 No
 example cataracts glaucoma tinnitus hearing/visual impairment disorders of the cornea blindness

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 No
 example ovarian cysts endometriosis fibroid disorders of the cervix menstrual disorders

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 or urinary tract disorders** Yes No
 example kidney failure kidney stones recurrent infections nephritis prostate problems
 blood/protein in urine polycystic kidneys

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"/>		

- 10. Liver or pancreatic disorders** Yes No
 example hepatitis cirrhosis liver failure gallstones pancreatitis

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 or psychiatric disorders** Yes No
 example depression anxiety schizophrenia eating disorders Bipolar

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 or endocrine disorders** Yes No
 example diabetes thyroid abnormalities growth disorders Cushing's disease Addison's disease

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 No
 example rheumatoid arthritis osteo-arthritis myasthenia gravis gout osteoporosis loss of limb back problems/operations
 slipped disk backache other

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. Your medical questionnaire (continued)

14. Respiratory disorders Yes No
 example cystic fibrosis emphysema chronic bronchitis shortness of breath persistent cough asthma chronic obstructive
 airways disease any lung surgery coughing up blood

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"/>		

15. Gastro-intestinal disorders Yes No
 example 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? 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"/>		

9. Your medical questionnaire (continued)

22. HIV and AIDS

If any of your dependants are living with HIV and AIDS and would prefer not to disclose their 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"/>		

10. 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, 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 your membership

The Scheme may cancel any membership 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 or dependant registered on 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 LA Health 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.

