

Transfer to individual capacity form 2021



Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (members): 0860 99 88 77, Tel (health partners): 0860 44 55 66, www.discovery.co.za, PO Box 784262, Sandton, 2146,
1 Discovery Place, Sandton, 2196.

Purpose of the form

This form is to transfer a membership from an employer group to an individual capacity.

What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally.
- You must physically sign all relevant sections, you cannot sign it digitally. The main applicant must sign and date any changes.
- To avoid administrative delays, please make sure you complete this form in full.
- Once it is complete, please email it to administration@discovery.co.za.
- You need to submit the following with this form:
 - Copy of ID or passport (of the main member and the account holder if the main member is not the account holder)
 - Bank statement or a letter of confirmation from the bank (not older than three months).

When you sign this application, you confirm that the information given is true and correct.

1. Main member details

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First names (according to ID)	<input type="text"/>		
ID or passport number	<input type="text"/>		
Membership number	<input type="text"/>		

2. New account details for contribution collection or refunds — Account holder details

Please note that we cannot accept credit card account details.

When should we start using the new banking details?	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Bank name	<input type="text"/>								
Branch name	<input type="text"/>	Branch Code	<input type="text"/>						
Account number	<input type="text"/>	Type of account	<input type="checkbox"/> Cheque	<input type="checkbox"/> Savings					
Account holder	<input type="text"/>								
Account holder's physical address (own/3rd party/company/trust)	<input type="text"/>								
Account holder contact number	<input type="text"/>	-	<input type="text"/>						
Account holder email address	<input type="text"/>								

As part of Payment Association of South Africa (PASA) debit order mandate requirements you are required to supply the account holders residential address, email address and contact number. Please note that the details you supply will only be used for the PASA debit order mandate requirement and will not be used to update the contact details we have on system, if you wish to update any contact details please visit www.discovery.co.za > Medical aid > manage your health plan.

3. New account details for claims payments (if we do not have claims payment banking details on system or if we need to update the claims payment banking details)

You can update your claims payment details by visiting www.discovery.co.za > Medical Aid > Manage your health plan.

Tick here if we must use the same details as we have for contribution collection and refunds

When should we start using the new banking details?

D	D	-	M	M	-	Y	Y	Y	Y
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Please note that we cannot accept credit card details.

Bank name			
Branch name		Branch Code	
Account number		Type of account	<input type="checkbox"/> Cheque <input type="checkbox"/> Savings
Account holder			
Account holder physical address			
Account holder contact number			
Account holder email address			

We can only change your banking details if:

- 3.1. You have filled in all the relevant fields on this request form.
- 3.2. The main member has signed the request.
- 3.3. Documents needed in the "What you must do" section accompany this form.

I, (first and last name),
as the main member, give Discovery Health Medical Scheme permission to change my banking details.

Signed at (town or city)

D	D	-	M	M	-	Y	Y	Y	Y
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Signature of main member



Please only sign if information is true, complete and correct.

4. Accountholder declaration (this section must be signed by the person whose bank account we will debit)

1. I confirm that I have the right to give Discovery Health Medical Scheme the authority to debit the account monthly, and that this bank account belongs to me. Furthermore, I will be liable for any claims, losses or damages of any nature arising out of debits Discovery Health Medical Scheme made from the account listed above. This is if this account has insufficient funds, is incorrect or if it is held in the name of any other person.
2. I hereby authorise Discovery Health Medical Scheme to verify the banking details as given above to set up the debit order.
3. I confirm that the account listed above is active and has not been de-activated due to non-compliance with verification procedures according to the Financial Intelligence Centre Act 38 of 2001 ("FICA"), as amended.

Signature of bank
account holder

D	D	-	M	M	-	Y	Y	Y	Y
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Please only sign if information is true, complete and correct.

5. Debit order mandate

The signed authority and mandate refers to the application on the signed date ("the Agreement")

I, the undersigned:

- Warrant that the account information I have provided above is an account in my name and that the information furnished by me/us in this Authority and Mandate is true and correct;
- Authorise Discovery Health Medical Scheme to issue and deliver payment instructions to my bank, recorded above, for the collection by Discovery Health Medical Scheme from the bank account (or any bank or branch to which I may transfer my account) any amounts due under or in terms of this application on condition that the sum of such payment instructions will never exceed my obligations as framed in the Agreement which shall commence on the date that cover starts as requested on the application form and shall continue until this Authority and Mandate is terminated by me by giving Discovery Health Medical Scheme no less than 20 ordinary working days written notice thereof or immediately in the event that I instruct my bank to withdraw this Authority and Mandate.
- Confirm that the payment instructions mentioned above must be issued on the first working day of the month. If the membership is not activated in time for the debit order collection and there is an amount outstanding Discovery Health Medical Scheme can collect that amount in the interim, upon activation. If I change the date of the debit order after activation, I confirm that the payment instructions must be issued and delivered on the day that I have nominated ("payment day") and thereafter on the same day in each and every successive month. If the payment day falls on a Sunday or recognised South African public holiday, the payment day will automatically be the next working day;
- Authorise Discovery Health Medical Scheme to track my bank account and re-present the payment instruction referred to above in the event that there are insufficient funds in my bank account to meet my obligations under or in terms of this Agreement.
- Acknowledge that my bank account will treat each payment instruction to pay contributions or amounts due under this Agreement to Discovery Health Medical Scheme as if each payment instruction came from me personally as the account holder.
- Undertake to advise Discovery Health Medical Scheme in writing of any changes to my account details and acknowledge that Discovery Health Medical Scheme will not be held responsible or liable for any claim, loss or harm that I or any third party may suffer as a result of me providing incorrect banking details herein or if the bank account is in the name of another person or entity or as a result of my failure to notify Discovery Health Medical Scheme of a change in banking details or if the bank account has insufficient funds to meet my obligations or in terms of the Agreement.
- Know and understand that the withdrawals hereby authorized will be processed through a computerized system provided by South African banks. The details of each withdrawal from my bank account will be printed on my bank statement and must show the reference number of the membership inserted in the Agreement so as to enable me to identify this membership;
- Acknowledge that although this Authority and Mandate may be terminated by me, such termination does not necessarily terminate this Agreement. In the event of such termination I am not entitled to any refund of any contributions or amounts due that was withdrawn by Discovery Health Medical Scheme whilst this Authority and Mandate was in force if such contributions or amounts were legally owing to Discovery Health Medical Scheme in terms of the Agreement;
- Acknowledge that by signing this Authority and Mandate I am bound by the payment terms applicable to this Agreement.

A. Reference number

This Agreement reference number is DISCPREM/ DISCSETTLE

Signature of main applicant

D	D	-	M	M	-	Y	Y	Y	Y
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The main applicant must sign and date any changes.



Please only sign if information is true, complete and correct.

6. Intermediary details

Please note that the below section is compulsory. We will not be able to complete the transfer if the below section is not completed.

Note: The selection will not impact the monthly contributions

Please choose from one of the below options:

I choose to remain with the current intermediary from the previous employer

I would like to choose a new intermediary

Please complete the section below with the new intermediary details, if the second option is selected above.

Intermediary name	<input type="text"/>
Intermediary code	<input type="text"/>
Intermediary contact details	<input type="text"/>
Intermediary email address	<input type="text"/>

Should you not wish to appoint an intermediary, please accept the intermediary waiver below

Intermediary waiver: I select to continue without financial advice from any financial adviser and understand that this decision will have no impact on my monthly contribution

Accept intermediary waiver

7. Authorisation

I,

am duly authorised to appoint the financial adviser and intermediary house mentioned above, I also give the Discovery companies consent to share with my appointed adviser all policy information, including personal and underwriting information necessary to ensure the efficient administration, assessing of claims and to ensure that Discovery complies with all relevant legislation on an ongoing basis. I understand and accept that this consent can be revoked at any time failing which Discovery shall be entitled to continue sharing such information with the appointed individuals until termination of such policy.

Signature of main applicant

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Please only sign if information is true, correct and complete.

8. Adviser's details (if applicable)

I, , have been appointed as the principal adviser on record for

(client's name) , Policy Number(s)

from this day, the of 20

In terms of the provisions made in Section 7 (4) of the Financial Sector Conduct Authority General Code of Conduct for Authorised Financial Services . Providers and Representatives, I confirm that I will complete a review of the above client's portfolio at policy annual review date as set out in this agreement.

NB: Principal adviser must sign the form and declaration.

Adviser's signature

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Please only sign if information is true, correct and complete.