

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 applying to become 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 is a form to declare your health status for the reinstatement of your health membership. This form can only be used within 3 months from the date on which your membership was withdrawn.

What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally.
- All relevant sections must be signed by the main member. The main member must sign and date any changes.
- To avoid administrative delays, please ensure this form is completed in full.
- If you have any questions, please call **0860 99 88 77**.
- Once it is complete, please email the form to administration@discovery.co.za.

Declaration from main member

First name(s)

Surname

ID or passport number Membership number

I, (first name and surname)

declare that my dependants and I have not suffered any deterioration in health. We have not had any medical advice or treatment since my/our Scheme membership ended. We do not intend seeking medical advice or treatment in the next eight weeks. This declaration forms part of my application to join Discovery Health Medical Scheme and this information is true, correct and complete. I understand that any false statement or not disclosing information will make my membership invalid.

If you have had a change in health status, or sought medical advice or treatment since membership withdrawal please give complete details of any changes in your health.

Signed at (town or city) on

Signature of main member



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