

# Employer application to join Discovery Health Medical Scheme in 2024



## 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](http://www.discovery.co.za), PO Box 784262, Sandton, 2146, 1 Discovery Place, Sandton, 2196.

## Purpose of this form

This document is an application form for an employer group. This application form also contains terms and conditions applicable to your membership (Section 9). Please make sure you read and understand these terms and conditions. This document is valid for 90 days from date of signing it. Make reference to the footnote that indicates the expiry date of the form.

Download the latest version of all forms from [www.discovery.co.za](http://www.discovery.co.za), under Medical Aid > Find documents and certificates.

## Follow these steps to help us process your application

- Please fill in the form in black ink and print clearly, or complete the form digitally. You can access a list of the approved digital signatures from [www.discovery.co.za](http://www.discovery.co.za), under Medical Aid > Find documents and certificates > Application forms.
- Please sign all the relevant sections. Please sign and date any changes.
- Read and understand the terms and conditions for membership (Section 9) and the Scheme Rules. The full set of Scheme Rules is available on [www.discovery.co.za/medical-aid/scheme-rules](http://www.discovery.co.za/medical-aid/scheme-rules).
- Sign sections 6, 8 and 10.
- Email the completed and signed form to [application@discovery.co.za](mailto:application@discovery.co.za).

When you sign this application, you confirm that you have read and understood the terms and conditions for membership and agree to them.

### 1. About your organisation

When do you want your cover to start?	<table><tr><td>D</td><td>O</td><td>D</td><td>1</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	O	D	1	M	M	Y	Y	Y	Y
D	O	D	1	M	M	Y	Y	Y	Y		
Name of employer											
Registration number					Employer number						
VAT number					Branch number						
Legal entity, for example (Pty) Ltd, Partnership, etc											

### Physical address

Suite/Unit number		Complex name			
Street number		Street name			
Suburb			Postal code		

### Postal address (Post collected from post box, suite or private bag)

If you do not complete a postal address, we will use your physical address for the post.

<input type="checkbox"/> PO Box	<input type="checkbox"/> Private Bag	Box number		
<input type="checkbox"/> Suite	<input type="checkbox"/> Postnet Suite	Number		
Suburb			Postal code	

In what industry do you operate? Please tick the applicable block.

Mining and mining resources	<input type="checkbox"/>	Hotel/leisure/entertainment	<input type="checkbox"/>
Financial Services	<input type="checkbox"/>	Professional services	<input type="checkbox"/>
Retail	<input type="checkbox"/>	Education	<input type="checkbox"/>
Construction/building	<input type="checkbox"/>	Religious organisations	<input type="checkbox"/>
Manufacturing	<input type="checkbox"/>	IT	<input type="checkbox"/>

Other (please specify)

COVID (workman's compensation) registration number

## 2. Your organisation's contact people

### 2.1. Executive (Financial director, Senior director, Managing director)

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s) (as in identity document)	<input type="text"/>		
ID or passport number	<input type="text"/>	Date of birth	<input type="text"/>
Employee number	<input type="text"/>	Telephone (W)	<input type="text"/>
Cellphone	<input type="text"/>		
Email	<input type="text"/>		

### 2.2. Primary payroll administrator (This is the main employer contact person who is authorised to deal with us and send us financial and other changes for your employees.)

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s) (as in identity document)	<input type="text"/>		
ID or passport number	<input type="text"/>	Date of birth	<input type="text"/>
Telephone (W)	<input type="text"/>	Cellphone	<input type="text"/>
Email	<input type="text"/>		

## 3. Your organisation's medical scheme membership details

### Name of current medical scheme/s

Current scheme name/s	Employer membership number	Start date	End date if already resigned

### Previous medical scheme names

Previous scheme names	Employer membership number	Start date	End date

#### 4. Please select your billing method

Monthly bill: ☐ Advance ☐ Arrears

Send monthly bill to: ☐ Email ☐ Post

#### 5. Details of your company's employees

5.1. The total number of permanent staff your company employs

5.2. The total number of main members who will need Discovery Health Medical Scheme cover

5.3. Will this Scheme be compulsory for:

5.3.1. All employees? ☐ Yes ☐ No

5.3.2. A defined group, for example, directors, administration, blue-collar workers? ☐ Yes ☐ No

5.3.3. If compulsory for a defined group, please give more information

5.3.4. Will the Scheme be compulsory for all future employees of the employer group or the defined group listed above? ☐ Yes ☐ No

5.4. How many of your employees currently belong to a registered South African medical scheme?

#### 6. Banking details for deduction of monthly contributions (if applicable)

**Please note: We do not accept credit card details and you can only use a South African bank account.**

**Please note:** A debit order is compulsory for an employer with 15 or fewer main members.

Bank name

Branch name

Branch code

Account number

Type of account ☐ Cheque ☐ Savings

Name of account holder

We will debit your account on the first working day of the month. If your employer group is not activated in time for the debit order collection and there is an amount outstanding, we will collect that amount in the interim upon activation.

Authorised signatory or signatories on behalf of the employer and employees:

Name and surname

Name and surname

Designation

Designation

#### 7. Your financial adviser's details (to be completed by your financial adviser)

This employer nominates this financial adviser to act exclusively on behalf of this employer group

Financial adviser's name

Code

Intermediary house

Code

Financial adviser's telephone number (W)

Lead number

Email

Bank reference number (if applicable)

(Mandatory for all ABSA and FNB financial advisers)

#### I declare that:

7.1. I am an accredited financial adviser in terms of the Medical Schemes Act 131 of 1998 and licensed by the Financial Services Board in terms of the Financial Advisory and Intermediary Services Act 37 at the date of signing this application form

7.2. I am appointed by the employer to provide advice about this application.

7.3. I have a valid contract with Discovery Health Medical Scheme and I have made the client aware of the commission I receive from Discovery Health Medical Scheme.

7.4. I am responsible for providing the employer with:

- my name, physical address, postal address and telephone number
- impartial advice that is in its best interest.

7.5. I am accountable for any advice I give to the employer and main applicant about the completion of this application form and joining Discovery Health Medical Scheme.

Signature of financial adviser

Date 

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

## 8. Our Privacy Statement – How we will process and disclose your personal information and communicate with you

When you engage with Discovery Health Medical Scheme, you are entrusting us with your personal information. We are committed to protecting your right to privacy and keeping your information safe. Our Privacy Statement tells you how we collect, use and share your personal information, including personal information about your spouse, employees, dependants, beneficiaries and life assureds, where applicable. To view and read our Privacy Statement, please follow this link: <https://www.discovery.co.za/medical-aid/about-discovery-health-medical-scheme> and scroll to, "YOUR PRIVACY IS IMPORTANT TO US" click on the **Privacy Statement** link.

Signature of main member

Date 

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 you have read and understand this statement

## 9. Terms and Conditions applicable to Discovery Health Medical Scheme membership

**The Scheme** refers to Discovery Health Medical Scheme, registration number 1125, registered with the Council for Medical Schemes.

**Administrator** refers to Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider, the administrator and managed care organisation for Discovery Health Medical Scheme and a subsidiary of the Discovery Group.

### You and your employees

In your role as an employer, you are applying for membership of the Scheme for your employees. In this document and future communication, you are referred to as 'you' and 'your' or as 'the employer'. Your employees might be able to add their spouse or partner, and people who are financially dependent on them to their health plan. Please speak to us to find out if this applies to your organisation.

### 9.1. Scheme rules for membership

The rules of the Scheme records the rights and responsibilities for your employees' membership. The rules may change from time to time.

You may ask us for a copy of these rules at any time or view them on our website at [www.discovery.co.za](http://www.discovery.co.za).

When you sign this application form, you confirm that you have read and understood these terms and conditions relevant to this application. You also confirm that the contracted financial adviser you appointed may communicate with the Scheme or Administrator on all matters relating to this application and membership of your employees to the Scheme. Your employees need to give permission that the Scheme or Administrator can share their medical information and other relevant personal information about them and their dependants with the contracted financial adviser. We will share the information so that the financial adviser can help us if necessary while we process your employees' membership applications. Please speak to your financial adviser or the Administrator if there is anything you do not understand.

### 9.2. Giving and getting information

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

For the Scheme to consider the application for your employees' membership, the Scheme must learn more about you, your employees and those they join with. Information about you, your employees and those they join with must be true, correct and complete. This includes the details you give in this document and future information given to us by anyone in your organisation or a financial adviser acting for you. Even if you or your employees do not consider a medical condition, symptom or illness relating to your employees and those they apply for to be relevant to this application, it is important to tell the Scheme about it during the application process. We may ask your employees and those that they apply for who are 18 years or older for more information about themselves.

#### Your legal address

The Scheme or Administrator will send documents to you at the address you indicated as the communication channel you prefer to be contacted on. If it is necessary to send you any legal notices or summonses, our legal team will serve these at the physical address you have given, or at any other address you have given us. It is your responsibility to make sure we have the correct address for you.

#### The Scheme and Administrator may record telephone calls

The Scheme and Administrator may record telephone conversations with your employees and those they apply for. We will process and keep

the recordings and all information we get during the recordings as required by law.

### **The Scheme or administrator may get information directly from your employees**

The Scheme and Administrator can get information directly from your employees and those they join with who are over the age of 18. This includes asking them to have certain medical tests done, either before or during their membership with the Scheme.

### **Tell the Scheme or Administrator about changes right away**

If any of the information you gave as part of this application changes between the date you sign this document and the date cover starts, you must tell the Scheme or Administrator in writing what the changes are. Any changes may influence the terms the Scheme offers you and your employees. The Scheme needs advance notice of any administrative changes, such as cancellation of membership, as we do not accept backdated changes.

The Scheme may cancel membership if information is not true, correct and complete. The Scheme may cancel the membership of any of your employees, if you, your employees or those they apply for:

- Do not give us information that later turns out to be relevant to this application
- Give us any information that is not true, correct and complete
- Do not tell us about any health changes or other relevant changes between the date you sign this document and the date cover starts.

### **9.3. Payment of contributions**

You must pay monthly contributions for your employees by the payment due date. If you do not pay by the due date, you must pay within three days of the payment due date. If you do not pay within these three days, the Scheme may suspend or cancel the membership of your employees and those they join with. During any period of suspension, we will not be responsible for paying medical expenses.

You will be able to identify the debit order for your monthly contributions on your bank statement. The reference number DISC PREM will be used.

### **9.4. Conditions for cover**

#### ***Cover starts on formal acceptance***

Cover for each employee starts on the date specified on the notice of acceptance the Scheme sends to them.

#### ***Applicants must in be your employ***

Applicants for membership must be in your employ on the date cover starts. If an applicant is not in your employ on the date this contract starts, the Scheme will not give notice of acceptance to this applicant until the applicant is employed.

#### ***Resigning from current medical schemes when accepted***

It is illegal to be a member of more than one medical scheme at the same time. Your employees and those they join with must resign from their current medical schemes when they receive notice of acceptance from the Scheme.

#### ***Tell us if an employee leaves***

You must tell the Scheme or Administrator immediately when an employee leaves your company or when an employee's spouse, partner or any dependant ends their membership with the Scheme. We will then adjust the amount of contributions you must pay.

#### ***Waiting periods and late-joiner penalties***

The Scheme may impose waiting periods and late-joiner penalties on employees. Any underwriting exemption will depend on you complying with the requirements set by the Scheme from time to time.

Signature of employer contact

Date 

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**The employer contact must sign and date any changes.**



**Please only sign if you have read and understand this statement**

## 10. Debit order mandate

### Debit order mandate

This 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 to issue and deliver payment instructions to my bank, recorded above, for the collection by Discovery Health from the bank account (or any other 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 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.
- If the membership or change in account details is not activated in time for the debit order collection and there is an amount outstanding Discovery Health can collect that amount in the interim. 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;
- Acknowledge that my bank will treat each payment instruction to pay premiums or amounts due under this Agreement to Discovery Health as if each payment instruction came from me personally as the account holder.
- Undertake to advise Discovery Health in writing of any changes to my account details and acknowledge that Discovery Health 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 of a change in banking details or if the bank account has insufficient funds to meet my obligations under 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 premiums or amounts due that was withdrawn by Discovery Health whilst this Authority and Mandate was in force if such premiums or amounts were legally owing to Discovery Health in terms of the Agreement.
- Acknowledge that by signing this Authority and Mandate I am bound by the payment terms applicable to this Agreement.
- Acknowledgment that this Authority may be assigned to a third party if this agreement is also assigned to a third party.

#### Reference number

This Agreement reference number: Your membership number

#### Abbreviated name

Abbreviated name as registered with the bank: DISCPREM

Deduction amount: as per your activation of membership letter

Deduction date: as per section 1 of your membership application form

Payment start date: as per section 1 of your membership application form

Account Holder Signature

Date of signature

D	D	M	M	Y	Y	Y	Y
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