

Applying to join Discovery Health Medical Scheme as part of an employer group in 2027

(Fast Track Underwriting)



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. It 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**; Postal address: PO Box 784262, Sandton, 2146; Physical address: 1 Discovery Place, Sandton, 2196; Website: www.discovery.co.za.

Purpose of the form

Thank you for deciding to apply to join the Discovery Health Medical Scheme. This document is an application form for membership. The information requested in this application form is required to enable the Scheme to process your membership application and to help the administration of your membership as well as to better administer the affairs of the Scheme. This application form also contains terms and conditions applicable to your membership (see Section 13). Please make sure you read and understand these terms and conditions as well as our Privacy Statement providing information on how we will be processing your personal information. 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, under Medical Aid > Find documents and certificates

What you must do

- You can fill in the form in writing, printing clearly and using black ink, or digitally. You can view the list of approved digital signature providers on www.discovery.co.za, under Medical Aid > Find documents and certificates > Application forms.
- The main applicant must sign all the relevant sections. The main applicant must sign and date any changes.
- Please attach a copy of each applicant's identity document. We accept valid passports and birth certificates for children.
- Read and understand the terms and conditions for membership (section 13) and the Scheme Rules. The full set of Scheme Rules is available at www.discovery.co.za/medical-aid/scheme-rules.
- This form lets you give us information about you and your dependants' race. This information is needed by the Council for Medical Schemes only for statistical purposes. You do not have to fill in this information.
- You must sign sections 7, 10 and 11.
- Email the completed and signed form to application@discovery.co.za.

Once you send us your application form, here is what will happen:

- We will contact you if any details are missing or if we need more information for underwriting purposes and to process your application.
- You will get a notification and you (and your financial adviser, if you have one) will get an email to let you know when your application is considered to be complete. This date may differ from the date on which you sign the application form.
- We will send your welcome notification by **WhatsApp**. We will send the welcome letter to you and to your financial adviser (if you have one) by **encrypted email**.
- If **standard terms** of acceptance are offered (no waiting periods or late-joiner penalties), we will activate your membership.
- If there are **non-standard terms**, we will send you a **counter-offer letter showing the terms that apply** showing the terms that apply to your membership (waiting periods or late-joiner penalties). We will only activate your membership once you agree to the new terms.

If you do not hear from the Scheme within seven days after submitting your application form, please call us on **0860 100 345** or speak to your financial adviser.

When you sign this application, you confirm that you have read and understood the terms and conditions for membership (section 13 of this form), as well as the privacy statement, and that you agree to them.

1. About yourself (main applicant)

When do you want your cover to start?	<table><tr><td>D</td><td>0</td><td>D</td><td>1</td><td>M</td><td></td><td>M</td><td></td><td>Y</td><td></td><td>Y</td><td></td><td>Y</td><td></td><td>Y</td><td></td></tr></table>	D	0	D	1	M		M		Y		Y		Y		Y																			
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Surname																																			
First names (as per identity document)																																			
ID or passport number																																			
Gender	M	☐	F	☐	Date of birth	<table><tr><td>D</td><td></td><td>D</td><td></td><td>M</td><td></td><td>M</td><td></td><td>Y</td><td></td><td>Y</td><td></td><td>Y</td><td></td><td>Y</td><td></td></tr></table>	D		D		M		M		Y		Y		Y		Y														
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Race	African	☐	Coloured	☐	Indian/Asian	☐	White	☐	Other	☐	Do not want to disclose	☐																							

This information is not mandatory. The Council for Medical Schemes collects this information for statistical purposes.

Occupation																	
Tax number									Gross monthly earnings R								
Telephone (H)									Telephone (W)								
Cellphone																	
Email																	

Physical address																	
Unit/Suite number					Complex/Building												
Street number					Street name												
Suburb																	
City													Postal code				

Postal address (post collected from PO Box, suite or private bag)

Same as residential address Yes ☐ No ☐ If you do not complete a postal address, we will use your physical address for post.

☐ PO Box	☐ Private bag	Box number															
☐ Suite	☐ PostNet suite	Number															
Suburb																	
City													Postal code				

2. About your spouse or partner (only complete if you're also applying for cover for them)

Title					Initials											
Surname																
First names (as in identity document)																
ID or passport number																
Gender	M	☐	F	☐	Date of birth	D	D	M	M	Y	Y	Y	Y			
Race	African	☐	Coloured	☐	Indian/Asian	☐	White	☐	Other	☐	Do not want to disclose	☐				

This information is not mandatory. The Council for Medical Schemes collects this information for statistical purposes.

Marital status	Married	☐	Single	☐	Divorced	☐	Widowed	☐								
Telephone (H)					Telephone (W)											
Cellphone																
Email																

3. About your dependants (only complete if you're applying for cover for them)

Dependant 1

Title					Initials											
Surname																
First names (as in identity document)																
ID or passport number																
Gender	M	☐	F	☐	Date of birth	D	D	M	M	Y	Y	Y	Y			
Race	African	☐	Coloured	☐	Indian/Asian	☐	White	☐	Other	☐	Do not want to disclose	☐				

This information is not mandatory. The Council for Medical Schemes collects this information for statistical purposes.

Relationship to main member																
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(For example, mother or child. Where your child is not your biological child, please state your relationship, for example, adopted child or foster child. Please attach proof of this relationship to this application.)

If over 18 years, provide cellphone number

If your dependant is 21 years or older:

Are they married? Yes ☐ No ☐

Are they financially dependent on you? Yes ☐ No ☐

Do they earn an income? Yes ☐ No ☐

Does their spouse earn an income? Yes ☐ No ☐

How much does your dependant earn each month? R

How much does your dependant's spouse earn each month? R

Dependant 2

Title Initials

Surname

First names (as in identity document)

ID or passport number

Gender M ☐ F ☐ Date of birth

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Do not want to disclose ☐

This information is not mandatory. The Council for Medical Schemes collects this information for statistical purposes.

Relationship to main member

(For example, mother or child. Where your child is not your biological child, please state your relationship, for example, adopted child or foster child. Please attach proof of this relationship to this application.)

If over 18 years, provide cellphone number

If your dependant is 21 years or older:

Are they married? Yes ☐ No ☐

Are they financially dependent on you? Yes ☐ No ☐

Do they earn an income? Yes ☐ No ☐

Does their spouse earn an income? Yes ☐ No ☐

How much does your dependant earn each month? R

How much does your dependant's spouse earn each month? R

Dependant 3

Title Initials

Surname

First names (as in identity document)

ID or passport number

Gender M ☐ F ☐ Date of birth

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Do not want to disclose ☐

This information is not mandatory. The Council for Medical Schemes collects this information for statistical purposes.

Relationship to main member

(For example, mother or child. Where your child is not your biological child, please state your relationship, for example, adopted child or foster child. Please attach proof of this relationship to this application.)

If over 18 years, provide cellphone number

If your dependant is 21 years or older:

Are they married? Yes ☐ No ☐

Are they financially dependent on you? Yes ☐ No ☐

Do they earn an income? Yes ☐ No ☐

Does their spouse earn an income? Yes ☐ No ☐

How much does your dependant earn each month? R

How much does your dependant's spouse earn each month? R

Are you applying for more than three dependants? Yes ☐ No ☐

Note: If you are applying for more than three dependants, please add the details on a separate page.

4. Your financial adviser's details

Do you want an adviser? Yes ☐ No ☐

Please complete this section if you already have a financial adviser

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)

Declaration – to be completed by your financial adviser, if you have one

I declare that I have read, understood and agree to the broker declaration on www.discovery.co.za/portal/rules.

I declare that:

- 4.1. I am an accredited financial adviser in terms of the Medical Schemes Act and licensed by the Financial Sector Conduct Authority in terms of the Financial Advisory and Intermediary Services Act at the date of signing this application form.
- 4.2. I am appointed by the main applicant to give advice about this application.
- 4.3. I have a valid contract with Discovery Health Medical Scheme and I have told the client about the commission that Discovery Health Medical Scheme pays me.
- 4.4. I am responsible for giving the main applicant:
 - My name, physical address, postal address and the telephone number
 - Impartial advice that is in the main applicant's best interest.
- 4.5. I am accountable for any advice I give to the main applicant about completing this application form and joining Discovery Healthcare Fund.

Signature of financial adviser

Signature of main applicant

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

5. Please select your health plan

Executive Plan	Comprehensive Series	Priority Series	Saver Series	Smart Saver Series	Smart Series	Core Series	KeyCare Series
Executive ☐	Classic ☐	Classic ☐	Classic ☐	Classic Smart ☐	Classic ☐	Classic ☐	KeyCare Plus ☐
	Classic Smart ☐	Essential ☐	Classic Delta ☐	Essential Smart ☐	Essential ☐	Classic Delta ☐	KeyCare Core ☐
			Essential ☐		Essential Dynamic ☐	Essential ☐	KeyCare Start ☐
			Essential Delta ☐		Active Smart ☐	Essential Delta ☐	KeyCare Start Regional ☐
			Coastal ☐			Coastal ☐	
						*Active Core ☐	

*Available from 1 January 2027 subject to approval by the Council for Medical Schemes

You have the right to ask for help in choosing a health plan that suits your needs. Whether you have had help or made the decision on your own, by signing this application you confirm that you understand the conditions and benefits of the plan you choose.

I would like to select that my health plan complies with the requirements of Shariah.

Yes ☐ No ☐

How would you like us to refund claims from the Medical Savings Account if your plan has one?

Discovery Health Rate ☐ Cost ☐

Discovery Health Rate is the medical scheme rate as long as you have funds available. **Cost** is the full amount of the claim as long as you have funds available.

When you make a claim that qualifies for payment, the Scheme will use the money available in your Medical Savings Account (MSA) to pay for it. Your MSA is a combination of your annual MSA allocation, which is the amount of money you receive at the start of each year, and your accumulated MSA, which is the money that you didn't spend in previous years and that has carried over to the current year.

Please complete this if you have selected the KeyCare Plus, KeyCare Start or KeyCare Start Regional Plan

- For KeyCare Plus, please select a GP on the KeyCare GP Network.
- For KeyCare Start, please select a GP on the KeyCare Start GP Network.
- For KeyCare Start Regional, please select a GP on the KeyCare Start Regional GP Network.
- If you have selected the KeyCare Start Regional Plan, which offers comprehensive and affordable cover in and around Polokwane, Tzaneen, Mbombela, Trichardt, Pretoria, Johannesburg, Bellville, George, Potchefstroom, Kimberley and Welkom, please make sure that you stay or work in one of these locations so that the full benefit suite is available to you.

	Name	GP name	Practice number								
Main applicant			<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								
Spouse or partner			<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								
Dependant 1**			<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								
Dependant 2**			<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								
Dependant 3**			<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								

** Please make sure that the dependant information you give above is the same as the dependant information in Section 3 of this form.

Please add the details on a separate page if you are applying for more than three dependants.

6. About your employer

Please ask your employer to complete this section.

Name of employer		Employer or billing number									
Employee number		Date of employment	<table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				
(or PERSAL number for government employees. Please attach a clear copy of your salary slip.)											
Branch name		Branch number									

Employer warranty

Please ensure your employer completes this warranty if this application form is not submitted with an employer application form:

- 6.1. We warrant that the main applicant detailed in section 1 is an employee of our organisation.
- 6.2. The Discovery Health Medical Scheme may bill us for the amount due for this member in the same way as it does for our other employees with the Discovery Health Medical Scheme.

Employer's authorised signatory	
Name	
Designation	

7. Your banking details (claim refunds)

Please note: We cannot accept credit card account details. We no longer issue cheques. If you do not give any details, it will affect your claims payment. If we are paying a third-party bank account, the main member must enter the ID or passport number of the third party.

Bank name																						
Account number	<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																			Type of account	☐ Cheque/Transmission/Transaction	☐ Savings
Account holder																						
If third-party bank details, please enter the third-party ID or passport number	<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																					
If the third-party bank account is a	☐ Joint account	☐ Company account	☐ Trust account																			

Please provide proof of bank account. Annexure A to this form explains which types of proof of bank account are needed.

By signing this application, you agree that once claims have been refunded into the bank account you have chosen, the Scheme will not be responsible in any way for the amounts refunded and authorise Discovery Health to contact the account holder provided above to verify payments made or received, if necessary.

You understand that you may not transfer, assign, pledge or cede the payment or receipt of any benefit by or from the Scheme to any person. If you do or attempt to do so, the Scheme may withhold, suspend or discontinue the payment of the benefit.

Signature of account holder		Date	<table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				

Signature of main applicant

Date

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

8. Previous medical scheme details (please give us proof in the form of a membership certificate)

Please give us the details of all the registered South African medical schemes that you and your dependants who are being added belonged to previously. We will use this information to decide if we need to apply late-joiner penalty fees. We may also use the information on the membership certificate to decide if we can apply the waiting periods. However, it is still your obligation to disclose the relevant information that we have asked for.

Were all your dependants on the same medical scheme? Yes ☐ No ☐

If you and your dependants who are applying for the cover belonged to different medical schemes, please fill in the information below:

Name	Scheme name	Start date	End date	Reason for leaving

9. Your health questions

Information on symptoms, conditions or disorders (must be completed for the main applicant, spouse/partner and all dependants and must include information on conditions even if covered or not on previous memberships)

We use this information only for lawful purposes, for example, enabling us and our administrator to process your application and to optimally administer your membership, to verify whether the information you provide on this application form is true and complete, to provide you with customized information relevant to your health status, to develop disease management programs for specific conditions, to review and enhance Scheme benefits, to improve Scheme's financial modeling, to assist the Scheme to better assess and mitigate its risk (which includes whether to impose a waiting period on your membership) and any other relevant uses.

Please note that the Council for Medical Schemes has oversight over any irregular use of your or your dependant's health information.

Please also note that the Medical Schemes Act restricts the ability of the Scheme to impose waiting periods. A condition specific waiting period cannot be imposed on you or any of your dependants relating to any condition that you disclose in this application except if you or your dependant received or were recommended any medical advice, diagnosis, care or treatment in respect of such a condition within a 12-month period ending on the date on which this application is considered to be fully and properly made.

Information disclosed by you relating to health conditions prior to the preceding 12 months can serve as a basis for the Scheme requiring that you undergo a medical examination, at the Scheme's cost. Should that medical examination reveal a current health condition, waiting periods may be applied in respect of such current condition.

Below we require you to advise us about whether **you or any dependant/s** specified in this application **at any time** have experienced, been treated/investigated for, or are you currently suffering from any of the following symptoms, conditions or disorders? We have listed some examples of conditions, symptoms or disorders under each question. These are only examples and not the full list of conditions, symptoms or disorders.

Please take note that if you or any of your dependants have any disorder, symptom or condition not listed in the questions below, you should highlight and provide full details of this symptom or condition in response to question 9.6 below.

Please also note that you must tell us in writing if any of the information you gave, in **this** application for membership, changes between the day you sign this document and the day your membership starts. This includes information about your health and the health of those you apply for.

Please take note further that any indication of existing medical conditions on this application does not automatically enrol you/your dependants onto the Scheme's Disease Management programme. For more information with regards to the Schemes disease management enrollment visit www.discovery.co.za.

Please answer ALL questions by ticking "Yes" or "No". If you answered 'Yes', please provide full details in the sections provided.

9.1 Do you or any dependants have any heart or circulation conditions?Yes ☐ No ☐

Example: chest pain, palpitations, shortness of breath, coronary heart disease, angina, heart attack, arrhythmia, high blood pressure (hypertension), cardiomyopathy, valvular heart disease or heart valve replacement, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker, any autoimmune conditions, any congenital conditions, peripheral vascular disease, deep vein thrombosis, pulmonary embolus, varicose veins

Patient name	Symptoms/Medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine or surgical procedure/intervention used for this condition and dosage	Date of last treatment within the last 12 months

9.2 Do you or any dependants have any metabolic or endocrine conditions?Yes ☐ No ☐

Example: diabetes mellitus (high blood sugar), diabetes insipidus, thyroid disease, Addison's disease, Cushing's syndrome, metabolic syndrome, parathyroid disease, Paget's disease, osteoporosis, growth deficiency, overweight, obesity, unexplained weight-loss, metabolic disorders, Conn's syndrome, any autoimmune conditions, any congenital conditions

Patient name	Symptoms/Medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine or surgical procedure/intervention used for this condition and dosage	Date of last treatment within the last 12 months

9.3 Do you or any dependants have any tumours or growths (cancerous and non-cancerous) or disorders of the skin and breast?Yes ☐ No ☐

Example: skin lesions, eczema, psoriasis, breast disease, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abscess, abnormal mammogram result, abnormal PSA tests (prostate specific antigen), any autoimmune conditions, any congenital conditions or any other abnormal cancer-screening or diagnostic test result/s or other skin conditions

Patient name	Symptoms/Medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine or surgical procedure/intervention used for this condition and dosage	Date of last treatment within the last 12 months

9.4 Are you or any of your dependants pregnant or undergoing treatment/investigation to fall pregnant, trying to conceive, or undergoing fertility /reproductive treatment?Yes ☐ No ☐

Patient name	Symptoms/Medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine or surgical procedure/intervention used for this condition and dosage	Date of last treatment within the last 12 months

9.5 Are you or any dependants expecting to have medical investigations or surgery, or planning hospitalisation or treatment in the next 12 months, or have been admitted to hospital or been seen in casualty in the last 12 months?Yes ☐ No ☐

Patient name	Symptoms/Medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine or surgical procedure/intervention used for this condition and dosage	Date of last treatment within the last 12 months

9.6 Have you or any dependants had any symptoms or had any medical advice from a medical professional about a symptom or condition not yet diagnosed, or ever been diagnosed with, or received treatment for, any condition, symptoms or allergic reactions or side-effects not mentioned in the questions above, in the last 12 months?

Yes ☐ No ☐

Patient name	Symptoms/Medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine or surgical procedure/intervention used for this condition and dosage	Date of last treatment within the last 12 months

HIV and AIDS

If you or any of your dependants are HIV-positive, you or they must call us on **0860 99 88 77** within seven working days of the date we activate your Discovery Health Medical Scheme membership. We treat this information in the strictest confidence. If you or any of your dependants are, it is in your interest to register on the HIVCare Programme. Discovery Health Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set period before Discovery Health Medical Scheme starts paying for any general or specific medical conditions. A 12-month condition-specific waiting period or a 3-month general waiting period may apply to this condition or any related condition. If you do not let us know about your or your dependant's HIV status within 7 days of your membership being active, we may end your Discovery Health Medical Scheme membership.

10. 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 go to: <https://www.discovery.co.za/medical-aid/about-discovery-health-medical-scheme>. Under, **Your privacy is important to us**, click on **Privacy Statement**.

Signature of main applicant

Date

The applicant must sign and date any changes.
Please only sign if you have read and understand this statement.

11. Terms and conditions of Discovery Health Medical Scheme memberships

Definitions

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.

May the Scheme and its Administrator send you direct electronic marketing (related to the business of the Scheme) from time to time?

No, thank you ☐ Yes, I agree ☐

11.1. Scheme rules for membership

The rules of the Scheme record your rights and responsibilities for your membership. The rules may change from time to time. You may ask us for a copy of these rules at any time or view these rules at www.discovery.co.za.

When you sign this application, you confirm that you have read and understood these terms and conditions and you agree that you and those you apply for will be bound by these and by the Scheme rules.

Where applicable, you also acknowledge and confirm that you, your financial adviser or your employer may communicate with us about this application and your membership of the Scheme.

You give permission that the Scheme or Administrator can share your medical information and other relevant personal information about you and your dependants with your chosen financial adviser. The information will be shared so that they can help us if necessary while we process your membership application.

Please speak to your financial adviser or the Administrator if there is anything you do not understand.

11.2. Who you are applying for

You may apply to join the Scheme on your own or together with other people – your spouse or partner and people who are financially dependant on you as defined in the Scheme rules, as referred to above. For anyone to be treated as financially dependant for this application, you must have a responsibility to provide financially for that dependant. The Scheme or Administrator might ask you to give us proof of financial or legal responsibility.

You will be called the principal member or main member in our future communications to you.

11.3. Acting for others

You confirm 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 you apply for in any matter relating to this application.
- You have received permission from your spouse or partner and any dependants over the age of 18 to act for them in any matter relating to this application.
- You consent to your spouse or adult dependant, who is part of this application process acting on your behalf and providing personal information, including health information, to Discovery Health for the purpose of your application to join Discovery Health Medical Scheme.

- Discovery Health may be able to retrieve certain previous medical information we have for you, your spouse or partner and your dependants (if applicable) from previous memberships. However, you must still disclose any and all relevant information as asked for above.

11.4. **Giving and getting information**

You must give true, correct and complete information.

To consider your application for membership, the Scheme must learn more about you and those you apply for.

Information about you and those you apply for must be true, correct and complete. This includes the details you give in this application form and in future dealings with us. It is important that you tell us about any medical condition, symptom or illness relating to you or those you apply for, even if you do not consider it relevant to your application. We may ask those you apply for who are 18 or older for more information about themselves. All the applicants still have to disclose all relevant information as asked for above.

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 we need 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 you and with those you apply for.

The recordings and all information we get during the recordings will be processed and kept as required by law.

The Scheme and Administrator may get information about you from other relevant sources

The Scheme and Administrator may (at any time and on an ongoing basis) get your personal information from other relevant sources, including medical practitioners, contracted service providers, financial advisers, credit bureaus or industry regulatory bodies ('relevant sources'). They may process this information to consider your membership application, to conduct underwriting or risk assessments, to consider a claim for medical expenses, to profile and analyse risk or to investigate fraud, waste or abuse (including by medical practitioners, contracted service providers or financial advisers). We may (at any time and on an ongoing basis) verify with the relevant sources that your personal information is true, correct and complete. You give your permission that the Scheme and Administrator may get any information that is relevant to your application from your employer.

Tell the Scheme or Administrator immediately if your information changes

You, your employer or your financial adviser must tell the Scheme or Administrator in writing if any of the information you gave in your application for membership changes between the day you sign this document and the day your membership starts. This includes information about your health and the health of those you apply for. We need advance notice of any administrative changes such as cancellation of membership, as we do not accept backdated changes.

When the Scheme may cancel your memberships

The Scheme may cancel any membership if you and those you 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 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.

Monitor for possible non-disclosure.

To exclude the possibility of non-disclosure of material information, for the first 12 months we will monitor membership in the following cases:

In accordance with the Medical Schemes Act, all applicants are required to provide complete, accurate, and truthful information when applying for membership. It is always preferable to disclose more information rather than omit information that may be material to your application.

Failure to disclose material information, or providing false, inaccurate, or misleading information, may result in the cancellation of membership, the recovery of amounts paid by the Scheme, and/or the institution of criminal proceedings where applicable.

To ensure that all material information disclosed during the application process is accurate and complete, the Scheme may monitor your membership during the first 12 months of cover.

If additional information becomes available at a later stage, or if any information provided during the application process is found to be incomplete, incorrect, false, or misleading, the Scheme reserves the right to reassess any claim, benefit request, authorization, or membership decision.

This may result in:

- A temporary pause in the assessment or authorization of a benefit request or claim;
- A reassessment of previously approved benefits or claims;
- The withdrawal of an authorization where appropriate; and/or
- Any other action permitted in terms of the Medical Schemes Act and the Rules of the Scheme.

11.5. **About becoming a member**

The Scheme might not pay for certain expenses immediately after you become a member

The Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before the Scheme starts paying for any general or specific medical conditions. We will let you know if any waiting periods apply. Please speak to your financial adviser or the Administrator about any waiting periods that apply to your membership and the memberships of those you apply for.

Resign from current medical schemes when accepted

It is illegal to be a member of more than one medical scheme at the same time. You and those you apply for must resign from your current medical schemes when you receive notice from the Scheme by letter, email or SMS telling you that you and those you apply for have been accepted.

You must make sure contributions are paid on time

As the main member of the Scheme, you are responsible for making sure that your contributions and the contributions of those you apply for are paid on time every month to avoid suspension of benefits. The Scheme has the right to change monthly contributions and benefits from time to time with prior notification.

11.6. Repaying money owed to the Scheme

The Scheme has the right to collect from you any amount that you owe at any time. We will notify you if there is any amount that you owe to the Scheme.

You must repay any medical savings owing if you leave the Scheme

When you become a member, depending on the plan you choose, you may have money available in advance to use for medical expenses during the year. This money is allocated to an account called the 'Medical Savings Account'. If you leave the Scheme before the year ends, you must repay the portion of medical savings you have used that is more than you have paid back to the Scheme over the year.

By signing this form, you agree that any money you owe to the Scheme may be deducted from any future claim payment amounts that are due to be paid to you. You will be able to identify the debit order for the money owing to the Scheme on your bank statement by the reference number 'DISCSETTLE'.

Signature of main applicant

Date

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

This form is only a complete application when it contains all the information we need to fully process your application. We take the date on which we receive the complete application as the application date, and not the date on which you sign the form.

12. Debit order mandate

This signed Authority and Mandate refers to the application on the signed date ('the Agreement').

- Warrant that the account information provided is either in my name or that I have the authority to use this account for debit order purposes and that the information given by me in this Authority and Mandate is true and correct.
- I 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 in terms of this application. This is on condition that the sum of these payment instructions will never be higher than my obligations set out in the Agreement, which will start on the date that cover starts as requested on the application form and will continue until I end this Authority and Mandate. I can end this Authority and Mandate by giving Discovery Health at least 20 ordinary working days' written notice or, immediately, by instructing 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 afterwards on the same day 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.
- I 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.
- I undertake to tell 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 because I have given the incorrect banking details here, or if the bank account is in the name of another person or entity, or because I did not tell Discovery Health about a change in banking details, or if the bank account does not have enough funds to meet my obligations in terms of the Agreement.
- I know and understand that the withdrawals I authorise here will be processed through a computerised system offered 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 on the Agreement so I can identify this membership.
- I acknowledge that although this Authority and Mandate may be ended by me, that will not necessarily end this Agreement. If it is ended, I am not entitled to any refund of any premiums or amounts due that were withdrawn by Discovery Health while this Authority and Mandate was in force, if the premiums or amounts were legally owing to Discovery Health in terms of the Agreement.
- I acknowledge that by signing this Authority and Mandate I am bound by the payment terms applicable to this Agreement.
- I acknowledge that this Authority and Mandate may be assigned to a third party if this Agreement is also assigned to a third party.

Reference number

This Agreement reference number: System generated reference number

Abbreviated name

Abbreviated name as registered with the bank: DISCPREM

Deduction amount: As in your activation of membership letter

Deduction date: As in section 1 of your membership application form

Payment start date: As in section 1 of your membership application form

Account holder name

Signature of applicant

Date

D	D	M	M	Y	Y	Y	Y
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**The applicant must sign and date any changes.
Please only sign if information is true, complete and correct.**

This form is only a complete application when it contains all the information we need to fully process your application. We take the date on which we receive the complete application as the application date, and not the date on which you sign the form.

13. | Annexure A: Third-party bank details

Banking details for a third party

A third party can be anyone, such as your spouse, aunt, uncle, friend, parent or adult child. Please attach the relevant proof of bank account if you give a third-party's bank account details for claim refunds or contribution debit orders.

Documents we need for a third-party bank account

- Proof of the account (bank statement or bank letter not older than three months)
- A copy of the third-party's (account holder) ID, passport or driving licence
- A copy of the main member's ID, passport or driving licence

Documents we need for a joint bank account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of each of the joint owners

Documents we need for a company account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of the people who have authority to sign on behalf of the company
- A letter of authority. The letter must:
 - State that the account can be used
 - State the membership details (including the membership or policy numbers) for which the bank account will be used
 - Include the details of the signatory
 - Be dated and signed by an authorised person on behalf of the company.
- A copy of the company's certificate of registration
- A copy of the main member's ID, passport or driving licence.

Documents we need for a trust account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of each of the trustees of the account
- A copy of the certificate of registration of the trust
- A copy of the trust resolution. The resolution must:
 - Show the trustees
 - Be dated and signed by an authorised person on behalf of the trust
 - Contain the membership or policy numbers.
- A copy of the main member's ID, passport or driving licence

If you are completing the request on behalf of the main member, please include proof that you have the necessary authority to do so, for example a letter of authority or a letter of executorship.