Discovery Health

Contact us

Tel: 0860 99 88 77, PO Box 784262, Sandton, 2146, www.discovery.co.za

Application for addition of dependant(s)

Thank you for deciding to apply to join the Discovery Health Medical Scheme. This document is an application form for membership. It also contains some rules for membership. Please make sure you read and understand the rules.

Who we are

The Discovery Health Medical Scheme (referred to as 'the scheme') is the medical scheme that you are applying to become a member of. This is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to 'we' 'us' and 'our' or as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the scheme.

What you must do

Please go through these three steps:

Step 1: Fill in the form

Step 2: Read and understand the rules for membership (Section 8)

Step 3: Sign the application

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

If you have any questions, please let us or your financial adviser know. Once we have assessed your application, we will let you know if you have been accepted and what will happen next.

How to complete this application form

- Please use one letter per block, complete with black ink and print clearly.
- Fax the completed and signed form to **011 539 3000** or email it to **applications@discovery.co.za**
- Please attach a copy of the ID documents of your dependant(s). We also accept SA driver's licences, passports and SA birth certficates for children.
- To avoid administration delays, please ensure this application is completed in full by you and your employer.

1. Contact details (person who will receive correspondence about this application)

Contact name Job title

Address

Code

Telephone Cellphone

Fax

Email address

Preferred means of communicating (please tick one) Email ☐ Post ☐ Fax ☐

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2. About yourself (main member)

Surname ______ Membership number ______

First name(s) (as per identity document) ______ Date of birth Y Y Y Y M M D D

Telephone (H) ______ (W) ______

Cellphone ______ Fax ______

Employer name ______ Employer number ______

3. About your spouse/partner (if applying for cover)

When do you want your cover to start? 2 0 Y Y M M 0 1

Title ______ Initials ______ Surname ______

First name(s) (as per identity document) ______

Preferred name ______ Sex M F Date of birth Y Y Y Y M M D D

Marital status Married ☐ Single ☐ Divorced ☐ Widowed ☐

Previous/maiden name ______

ID or passport number ______

Country of issue ______

Telephone (H) ______ (W) ______

Cellular ______ Fax ______

Email ______

Date of marriage to main applicant (where applicable). Please attach a copy of an official certificate. Y Y Y Y M M D D

Addition of spouse to an existing membership
If addition of spouse to an existing membership is:

- due to legal and registered marriage within the last three months, an official certificate must accompany this application form to avoid underwriting
- for a spouse married for a period of more than three months, full underwriting will apply.

4. About your dependant(s) (if applying for cover)

Dependant 1

Title ______ Initials ______ Surname ______

First name(s) (as per identity document) ______

Preferred name ______

Relationship to main member ______ Sex M F Date of birth Y Y Y Y M M D D

ID or passport number ______ Country of issue ______

Do you receive an income for example pension? Yes ☐ No ☐ If **yes**, please fill in the monthly amount. R ______

Is your dependant your biological child? Yes ☐ No ☐ Is your dependant your adopted child? Please supply proof of adoption Yes ☐ No ☐

We need to get the following information according to Section 18 of the Income Tax Act 1962.

Is your dependant married? Yes ☐ No ☐

Is your dependant financially dependent on you? Yes ☐ No ☐ Monthly income R ______

Is your dependant disabled? Yes ☐ No ☐ Is your dependant a full-time student? Yes ☐ No ☐

4. About your dependants (if applying for cover) *(continued)*

Dependant 2

Title ☐☐☐☐ Initials ☐☐☐☐☐☐ Surname ☐

First name(s) (as per identity document) ☐

Preferred name ☐

Relationship to main member ☐ Sex M F Date of birth Y Y Y Y M M D D

ID or passport number ☐ Country of issue ☐

Do you receive an income for example pension? Yes ☐ No ☐ If **yes**, please fill in the monthly amount. R ☐

Is your dependant your biological child? Yes ☐ No ☐ Is your dependant your adopted child? Please supply proof of adoption Yes ☐ No ☐

We need to get the following information according to Section 18 of the Income Tax Act 1962.

Is your dependant married? Yes ☐ No ☐

Is your dependant financially dependent on you? Yes ☐ No ☐ Monthly income R ☐

Is your dependant disabled? Yes ☐ No ☐ Is your dependant a full-time student? Yes ☐ No ☐

Dependant 3

Title ☐☐☐☐ Initials ☐☐☐☐☐☐ Surname ☐

First name(s) (as per identity document) ☐

Preferred name ☐

Relationship to main member ☐ Sex M F Date of birth Y Y Y Y M M D D

ID or passport number ☐ Country of issue ☐

Do you receive an income for example pension? Yes ☐ No ☐ If **yes**, please fill in the monthly amount. R ☐

Is your dependant your biological child? Yes ☐ No ☐ Is your dependant your adopted child? Please supply proof of adoption Yes ☐ No ☐

We need to get the following information according to Section 18 of the Income Tax Act 1962.

Is your dependant married? Yes ☐ No ☐

Is your dependant financially dependent on you? Yes ☐ No ☐ Monthly income R ☐

Is your dependant disabled? Yes ☐ No ☐ Is your dependant a full-time student? Yes ☐ No ☐

Dependant 4

Title ☐☐☐☐ Initials ☐☐☐☐☐☐ Surname ☐

First name(s) (as per identity document) ☐

Preferred name ☐

Relationship to main member ☐ Sex M F Date of birth Y Y Y Y M M D D

ID or passport number ☐ Country of issue ☐

Do you receive an income for example pension? Yes ☐ No ☐ If **yes**, please fill in the monthly amount. R ☐

Is your dependant your biological child? Yes ☐ No ☐ Is your dependant your adopted child? Please supply proof of adoption Yes ☐ No ☐

We need to get the following information according to Section 18 of the Income Tax Act 1962.

Is your dependant married? Yes ☐ No ☐

Is your dependant financially dependent on you? Yes ☐ No ☐ Monthly income R ☐

Is your dependant disabled? Yes ☐ No ☐ Is your dependant a full-time student? Yes ☐ No ☐

5. Your employer warranty (additions to employer groups need to be signed by the HR/Payroll contact)

Please ensure your employer completes this section of the application form if the member falls under an employer group.

1. We warrant that the member detailed in section 2 of this application form is an employee of our organisation.
2. Discovery Health may bill us for the amount due in respect of this dependant in the same manner as for other Discovery members employed by our organisation.

Authorised signatory(ies)		
Name(s)		
Designation(s)		

6. Please select your GP

Please complete this if you have selected the KeyCare Plus Plan

	Please fill in the details of your chosen general practitioner in the KeyCare GP network			
	Name	**General practitioner**	**Practice number**	**Telephone number**
Main applicant				
Spouse or partner				
Dependant*				
Dependant*				
Dependant*				
Dependant*				

Please note: you can only access day-to-day cover and chronic benefits through the KeyCare general practitioner you chose above.
*Please make sure that the dependant information you give above is the same as the dependant information in section 4 of this form.

7. Previous medical scheme details

Please give us the details of all registered South African medical schemes that your dependant(s) applying for cover previously belonged to.
We will use this information to determine if we need to apply any waiting periods, late joiner penalty fees, or both.

	Scheme name	**Membership number**	**Start date**	**End date or are you still a member?**		**Reasons for leaving**
Spouse/partner – Are these medical scheme details the same as the main applicant's? Yes ☐ No ☐						
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
Dependant 1 – Are these medical scheme details the same as the main applicant's? Yes ☐ No ☐						
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
Dependant 2 – Are these medical scheme details the same as the main applicant's? Yes ☐ No ☐						
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
Dependant 3 – Are these medical scheme details the same as the main applicant's? Yes ☐ No ☐						
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
Dependant 4 – Are these medical scheme details the same as the main applicant's? Yes ☐ No ☐						
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	

7. Your spouse/partner/dependants' medical questions

Please give full medical details of all dependants in this application form.

	Name	How tall are you? (metres)	How much do you weigh? (kilograms)	Do you drink alcohol?	Do you smoke?
Spouse/ partner		☐ – ☐☐	☐☐☐☐	Yes ☐ No ☐ How many units per week? ☐☐☐☐	Yes ☐ No ☐ Amount per day ☐☐ Have you smoked in the last 24 months? Yes ☐ No ☐ If yes, quantity ☐☐ Reason for stopping? ☐☐☐☐☐☐☐☐☐☐☐☐☐
Dependant 1		☐ – ☐☐	☐☐☐☐	Yes ☐ No ☐ How many units per week? ☐☐☐☐	Yes ☐ No ☐ Amount per day ☐☐ Have you smoked in the last 24 months? Yes ☐ No ☐ If yes, quantity ☐☐ Reason for stopping? ☐☐☐☐☐☐☐☐☐☐☐☐☐
Dependant 2		☐ – ☐☐	☐☐☐☐	Yes ☐ No ☐ How many units per week? ☐☐☐☐	Yes ☐ No ☐ Amount per day ☐☐ Have you smoked in the last 24 months? Yes ☐ No ☐ If yes, quantity ☐☐ Reason for stopping? ☐☐☐☐☐☐☐☐☐☐☐☐☐
Dependant 3		☐ – ☐☐	☐☐☐☐	Yes ☐ No ☐ How many units per week? ☐☐☐☐	Yes ☐ No ☐ Amount per day ☐☐ Have you smoked in the last 24 months? Yes ☐ No ☐ If yes, quantity ☐☐ Reason for stopping? ☐☐☐☐☐☐☐☐☐☐☐☐☐
Dependant 4		☐ – ☐☐	☐☐☐☐	Yes ☐ No ☐ How many units per week? ☐☐☐☐	Yes ☐ No ☐ Amount per day ☐☐ Have you smoked in the last 24 months? Yes ☐ No ☐ If yes, quantity ☐☐ Reason for stopping? ☐☐☐☐☐☐☐☐☐☐☐☐☐

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7. Your spouse/partner/dependants' medical questions *(continued)*

B. Have any dependants in this application ever experienced, been treated for, or are you currently suffering from any of the following symptoms, conditions or disorders?

7.1 Cancer **Yes** ☐ **No** ☐
(example, any form of cancer ☐ or pre-cancerous growths ☐)

Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition?	Date of last symptoms ☐, consultation ☐ or hospitalisation ☐	Medicines used for this condition and date last taken
			Yes ☐ No ☐		
			Yes ☐ No ☐		

7.2 Heart and circulation conditions **Yes** ☐ **No** ☐
(example, angina ☐ chest pain ☐ heart failure ☐ murmurs ☐ rheumatic fever ☐ high blood pressure ☐ heart attack ☐ raised cholesterol ☐ previous heart surgery ☐ palpitations ☐)

Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition?	Date of last symptoms ☐, consultation ☐ or hospitalisation ☐	Medicines used for this condition and date last taken
			Yes ☐ No ☐		
			Yes ☐ No ☐		

7.3 Gynaecological conditions **Yes** ☐ **No** ☐
(example, ovarian cysts ☐ endometriosis ☐ fibroids ☐ cervical disorders ☐ menstrual disorders ☐ pregnancy ☐)

Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition?	Date of last symptoms ☐, consultation ☐ or hospitalisation ☐	Medicines used for this condition and date last taken
			Yes ☐ No ☐		
			Yes ☐ No ☐		

7.4 Mental health **Yes** ☐ **No** ☐
(example, depression ☐ anxiety ☐ schizophrenia ☐ bipolar ☐)

Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition?	Date of last symptoms ☐, consultation ☐ or hospitalisation ☐	Medicines used for this condition and date last taken
			Yes ☐ No ☐		
			Yes ☐ No ☐		

7.5 Metabolic/endocrine conditions **Yes** ☐ **No** ☐
(example, diabetes ☐ thyroid disorders ☐ growth disorders ☐ Cushing's disease ☐ Addison's disease ☐)

Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition?	Date of last symptoms ☐, consultation ☐ or hospitalisation ☐	Medicines used for this condition and date last taken
			Yes ☐ No ☐		
			Yes ☐ No ☐		

7.6 Liver/pancreatic conditions **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 ☐, consultation ☐ or hospitalisation ☐	Medicines used for this condition and date last taken
			Yes ☐ No ☐		
			Yes ☐ No ☐		

7.7 Gastrointestinal conditions **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 ☐, consultation ☐ or hospitalisation ☐	Medicines used for this condition and date last taken
			Yes ☐ No ☐		
			Yes ☐ No ☐		

7. Your spouse/partner/dependants' medical questions *(continued)*

7.8 Brain and nerve conditions **Yes** ☐ **No** ☐
(example, stroke ☐ multiple sclerosis ☐ epilepsy ☐ migraine ☐ Parkinson's disease ☐ quadriplegia ☐ paraplegia ☐ cerebral palsy ☐)

Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition?	Date of last symptoms ☐, consultation ☐ or hospitalisation ☐	Medicines used for this condition and date last taken
			Yes ☐ No ☐		
			Yes ☐ No ☐		

7.9 Respiratory conditions **Yes** ☐ **No** ☐
(example, asthma ☐ emphysema ☐ chronic bronchitis ☐ shortness of breath ☐ persistent cough ☐
cystic fibrosis ☐ 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 ☐, consultation ☐ or hospitalisation ☐	Medicines used for this condition and date last taken
			Yes ☐ No ☐		
			Yes ☐ No ☐		

7.10 Musculoskeletal conditions **Yes** ☐ **No** ☐
(example, rheumatoid arthritis ☐ osteoarthritis ☐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 ☐, consultation ☐ or hospitalisation ☐	Medicines used for this condition and date last taken
			Yes ☐ No ☐		
			Yes ☐ No ☐		

7.11 Kidney/urinary tract conditions **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 ☐, consultation ☐ or hospitalisation ☐	Medicines used for this condition and date last taken
			Yes ☐ No ☐		
			Yes ☐ No ☐		

7.12 Blood conditions **Yes** ☐ **No** ☐
(example, anaemia ☐ leukaemia ☐ bleeding disorders ☐ haemophilia ☐ lymphoma ☐ deep vein thrombosis (blood clots) ☐
pulmonary embolus ☐)

Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition?	Date of last symptoms ☐, consultation ☐ or hospitalisation ☐	Medicines used for this condition and date last taken
			Yes ☐ No ☐		
			Yes ☐ No ☐		

7.13 Are any of your dependants expecting surgery ☐ or planning hospitalisation ☐ or treatment ☐ in the next 12 months or have they been admitted to hospital in the last 12 months? ☐ **Yes** ☐ **No** ☐

Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition?	Date of last symptoms ☐, consultation ☐ or hospitalisation ☐	Medicines used for this condition and date last taken
			Yes ☐ No ☐		
			Yes ☐ No ☐		

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7. Your spouse/partner/dependants' medical questions *(continued)*

7.14 Any symptoms not yet diagnosed by a medical professional or any condition which is not covered by these questions? Yes ☐ No ☐

Name	Medical diagnosis/ symptoms	Date first diagnosed	Currently on treatment for this condition?	Date of last symptoms ☐, consultation ☐ or hospitalisation ☐	Medicines used for this condition and date last taken
			Yes ☐ No ☐		
			Yes ☐ No ☐		

7.15 Do any of your dependants have any condition/s that are not directly covered by these questions? Please provide FULL medical details Yes ☐ No ☐

Name	Medical diagnosis	Date first diagnosed experienced	Currently on treatment for this condition?	Date of last symptoms ☐, consultation ☐ or hospitalisation ☐	Medicines used for this condition and date last taken
			Yes ☐ No ☐		
			Yes ☐ No ☐		

HIV and AIDS

You do not need to disclose the HIV status of your dependant/s on this form if you do not feel comfortable doing so. However if one or more of your dependants, is HIV-positive, you or they must call us on **0860 100 417** within seven working days from the date we activate your or their Discovery Health Medical Scheme membership. We treat this information in the strictest confidence. If one or more of your dependants, is HIV-positive, it is in your dependants/s' best interests to register on the HIV*Care* Management Programme. A 12-month condition specific waiting period may apply to this condition.

When you call in to register on the HIV*Care* Management Programme please confirm these details.

8. Rules for membership

8.1 Rules for membership

Rules for membership are the rights and responsibilities for your membership of the scheme. They may change from time to time. You may ask us for a copy at any time.

When you sign this application, you confirm that you have read and understood the rules and you agree that you and those you apply for will be bound by them. Please speak to your financial adviser or us if there is anything you do not understand.

8.2 Who you are applying for

You may apply to join the scheme on your own or together with other people – your spouse, your partner, and people who are financially dependent on you. To be treated as financially dependent for this application, a dependant must earn an income of less than what is stated in the scheme rules, or you must have a legal responsibility to provide financially for them. We 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 communication to you.

8.3 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 and any dependants over 21 to act for them in any matter relating to this application.

8.4 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.

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 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 information from other relevant sources

To consider an application for membership or a claim for medical expenses, you agree that we and the scheme can get information about you and those you apply for from other relevant sources, including medical practitioners and financial advisers.

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

The scheme may cancel any memberships 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 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.

8. Rules for membership *(continued)*

8.5 Sharing information and confidentiality

When we may share your information

We and the scheme will keep your information and the information about those you apply for confidential. We and the scheme may share this information with other relevant parties only if the following two conditions are met:

1. The information is needed only to administer the scheme and any claims
2. The parties we and the scheme share 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.

We and the scheme may record calls

We and the scheme 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.

8.6 About becoming a member

We will consider your application

We will consider your application and any one of the following will happen:

- we will accept you on these terms; or
- we will send a letter with revised terms; or
- we will let you know that we need more information about you and those you apply for before your cover can start.

We might not pay for certain expenses immediately

The scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before we start paying for any general or specific medical conditions. Please speak to your financial adviser or us to find out if waiting periods 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 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.

8.7 Repaying medical savings if you leave

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

When you become a member, depending on the plan you chose, you may have money available in advance to use for medical expenses during the year. This money is made available in an account called the 'Medical Savings Account'. If you leave the scheme before the year is up, you must repay the proportion of medical savings you have used in advance.

Signed at (town or city) ____________________ on Y Y Y Y M M D D

Signature of main applicant ____________________ **The main applicant must sign and date any alterations**

9. What happens next with your application

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

- We capture and check your details.
- If any details are missing or if underwriting is needed, we will phone or write to you.
- We will send you or your financial adviser a letter, SMS or an email to let you know when we have accepted your application to join the Discovery Health Medical Scheme. This letter may contain certain conditions.
- You sign this letter to confirm your start date or acceptance of any waiting periods or late-joiner penalties (if we apply any).
- When we activate your membership, you will get an SMS from us.
- You will then get a pack in the post from us. This will contain details about your plan and all you need to get started.

If you do not hear from us seven days after sending your application, please contact your financial adviser or us on 0860 100 345.

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