Discovery Health

Your Discovery Health Application Form

2008

You need to complete this form when you apply to join the Discovery Health Medical Scheme.

Please ***tear off this section*** and keep it until you receive further communication from us about your application.

Thank you for applying to join Discovery Health

Thank you for choosing Discovery Health as your partner in service and healthcare.

More about Discovery

Discovery aims to be a leader in international health and life insurance. In this, our core purpose – making people healthier and enhancing and protecting their lives – remains our guiding principle.

Discovery Health is a dynamic, innovative and financially strong healthcare funding company and is part of the Discovery Group, which is listed on the Johannesburg Securities Exchange. Discovery Health has a unique range of plan choices with varying cover and benefits to suit you and your individual circumstances.

As a Discovery Health member, you can join our unique Vitality wellness programme, which offers health, lifestyle and leisure rewards at unprecedented rates. You and your family – including your spouse, children and any adult dependants – have access to the great benefits of Vitality.

What happens next with your application?

Once you submit your application, here is what will happen:

- We capture and quality check your details.
- If there is any information missing or underwriting required, we will contact you by phone or in writing.
- We then offer you Discovery Health membership, based on certain conditions, which are outlined in a letter you will receive from us.
- 24 hours after we receive your fully completed application (and any outstanding information), your intermediary gets this letter and contacts you to discuss the conditions and answer any questions you may have.
- To finalise your membership we will liaise with your intermediary about any other requirements.
- You sign acceptance of any waiting periods or late-joiner penalties we may apply and confirm your membership start date.
- If you receive a 'standard rates decision', then you must confirm your membership starting date.
- We will SMS your membership number to you when we activate your membership.

If you have not heard from us seven days after submitting your application, please contact your intermediary or us on 0860 34 56 78.

When we have accepted your application, you will receive communication from us

After we have accepted your application, you will receive communication from us. You will get a pack in the post, which will include:

- a welcome letter, which confirms the plan you have bought
- your Discovery Health membership card
- your Health Plan Guide or an interactive DVD (depending on which you select), which gives you more information about your Health Plan
- a car sticker with our contact details in case of an emergency
- a Vitality booklet, which outlines the Vitality programme.

Please do not resign from your current medical scheme until you have received written notification from Discovery Health Medical Scheme. Once you have confirmed acceptance, please cancel your current medical scheme membership as it is illegal to belong to two medical schemes at the same time.

Discovery Health

Discovery Health Plans 2008

Discovery Health offers a range of Health Plans that will meet your needs. Why not tick the option you have chosen? That way, you will keep a reminder of the plan you are on until you get your membership information.

1 Executive Plan

The Executive Plan offers premium access to healthcare funding. This plan offers comprehensive in- and out-of-hospital cover for related accounts, eg specialists, up to 300% of the Discovery Health Rate. It also provides private ward cover, extensive chronic illness benefits, access to funding for the latest medical technology, a Medical Savings Account and an Above Threshold Benefit for medical expenses and general practitioner consultations up to R270 per consultation.

2 Classic Comprehensive

This plan offers comprehensive in-hospital cover for related accounts, eg specialists, up to 200% of the Discovery Health Rate if you don't use a specialist who charges the Premier Rate or Classic Direct Rate. It also provides extensive chronic illness benefits, access to funding for the latest medical technology, a Medical Savings Account (25% of your monthly medical scheme contribution) and an Above Threshold Benefit for day-to-day expenses and general practitioner consultations for only R120 through the Discovery GP network.

3 Essential Comprehensive

This plan offers comprehensive in-hospital cover for related accounts, eg specialists, up to 100% of the Discovery Health Rate if you don't use a specialist who charges the Premier Rate. It also provides extensive chronic illness benefits, access to funding for the latest medical technology, a Medical Savings Account (15% of your monthly medical scheme contribution) and an Above Threshold Benefit for day-to-day expenses and general practitioner consultations for only R120 through the Discovery GP network.

4 Classic Priority

This plan offers cost-effective, extensive in-hospital cover for related accounts, eg specialists, up to 200% of the Discovery Health Rate if you don't use a specialist who charges the Premier Rate or Classic Direct Rate . It also provides standard chronic illness cover, a Medical Savings Account (25% of your monthly medical scheme contribution) with a limited Above Threshold Benefit for day-to-day expenses and general practitioner consultations for only R120 through the Discovery GP network. Should your qualifying day-to-day expenses exceed a total amount of R25 000 per adult and R5 000 per child at the Discovery Health Rate, these expenses will be covered by the Extreme Expenses Benefit. A defined co-payment applies to specific in-hospital procedures.

5 Essential Priority

This plan offers cost-effective, extensive in-hospital cover for related accounts, eg specialists, up to 100% of the Discovery Health Rate if you don't use a specialist who charges the Premier Rate. It also provides standard chronic illness cover, a Medical Savings Account (15% of your monthly medical scheme contribution) and a limited Above Threshold Benefit for day-to-day expenses and general practitioner consultations for only R95 through the Discovery GP network. Should your qualifying day-to-day expenses exceed a total amount of R25 000 per adult and R5 000 per child at the Discovery Health Rate, these expenses will be covered by the Extreme Expenses Benefit. A defined co-payment applies to specific in-hospital procedures.

6 Classic Saver

This plan offers cost-effective, extensive in-hospital cover for related accounts, eg specialists, up to 200% of the Discovery Health Rate if you don't use a specialist who charges the Premier Rate or Classic Direct Rate. It also provides standard chronic illness cover, a Medical Savings Account (25% of your monthly medical scheme contribution) for day-to-day expenses and general practitioner consultations for only R120 through the Discovery GP network.

7 Essential Saver

This plan offers cost-effective, extensive in-hospital cover for related accounts, eg specialists, up to 100% of the Discovery Health Rate if you don't use a specialist who charges the Premier Rate. It also provides standard chronic illness cover and a Medical Savings Account (15% of your monthly medical scheme contribution) for day-to-day expenses and general practitioner consultations for only R120 through the Discovery GP network.

8 Coastal Saver

This plan offers cost-effective, extensive in-hospital cover for related accounts, eg specialists, up to 100% of the Discovery Health Rate in coastal hospitals if you don't use a specialist who charges the Premier Rate. It also provides standard chronic illness cover and a Medical Savings Account (25% of your monthly medical scheme contribution) for day-to-day expenses and general practitioner consultations for only R120 through the Discovery GP network.

9 Classic Core

This plan offers extensive in-hospital cover for related accounts, eg specialists, up to 200% of the Discovery Health Rate if you don't use a specialist who charges the Premier Rate or Classic Direct Rate, as well as standard chronic illness benefits. There is no cover for day-to-day expenses.

10 Essential Core

This plan offers extensive in-hospital cover for related accounts, eg specialists, up to 100% of the Discovery Health Rate if you don't use a specialist who charges the Premier Rate, as well as standard chronic illness benefits. There is no cover for day-to-day expenses.

11 Coastal Core

This plan offers extensive in-hospital cover for related accounts, eg specialists, up to 100% of the Discovery Health Rate in coastal hospitals if you don't use a specialist who charges the Premier Rate, as well as standard chronic illness benefits. There is no cover for day-to-day expenses.

12 KeyCare Plus

This plan provides cost-effective access to quality private healthcare for the low income market through a carefully selected national network of private healthcare professionals. It also provides access to a network of general practitioners, dentists and optometrists as well as a Specialist and Antenatal Benefit.

13 KeyCare Core

This plan provides access to affordable, quality private healthcare through a carefully selected national network of private healthcare professionals, as well as a Specialist and Antenatal Benefit. There is no cover for day-to-day expenses.

Discovery Health

Discovery Health administers the Discovery Health Medical Scheme
Discovery Health is an authorised Financial Services Provider

DISCOVERY HEALTH APPLICATION 2008

HOW TO COMPLETE THIS APPLICATION

Please use one letter per block, complete with black ink and print clearly.
To avoid administration delays, please ensure this application is completed in full.
Fax the completed and signed form to **(011) 539 3000 or email to acquisitions@discovery.co.za**
Please attach a copy of each applicant's identity document to this application form. We also accept SA driver's licences, passports and SA birth certificates for children.

A. ABOUT YOURSELF (main applicant)

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

Title | Initials | Surname

First name(s) (as per identity document)

Preferred name | Gender M F | Date of birth Y Y Y Y M M D D

Marital status

Previous/maiden name

ID or passport number

Country of issue

Telephone (H) | (W)

Cellular | Fax

Physical address | Postal address

Code | Code

Preferred language: English | Afrikaans | Preferred means of communicating: Email | Post | Email type: (H) | (W)

Email

Gross monthly salary R | Occupation

B. ABOUT YOUR SPOUSE/PARTNER (if applying for cover)

Title | Initials | Surname

First name(s) (as per identity document)

Preferred name | Gender M F | Date of birth Y Y Y Y M M D D

Marital status

Previous/maiden name

ID or passport number

Country of issue

Telephone (H) | (W)

Cellular | Fax

Email

Preferred means of communicating: Email | Post | Email type: (H) | (W) | Gross monthly salary R

Alterations must be signed and dated by main applicant.

C. ABOUT YOUR DEPENDANTS (if applying for cover)

	1	2
Is your dependant 21 years or older?	Yes ☐ No ☐	Yes ☐ No ☐
Title	Initials	Initials
Surname		
First name(s) (as per identity document)		
Preferred name		
Relationship to you		
ID or passport number		
Country of issue		
Date of birth	Y Y Y Y M M D D Gender M F	Y Y Y Y M M D D Gender M F
Does he/she receive an income eg pension?	YES ☐ NO ☐	YES ☐ NO ☐
If YES, please fill in the monthly amount	R	R
Is he/she financially dependent on you?	YES ☐ NO ☐	YES ☐ NO ☐

	3	4
Is your dependant 21 years or older?	Yes ☐ No ☐	Yes ☐ No ☐
Title	Initials	Initials
Surname		
First name(s) (as per identity document)		
Preferred name		
Relationship to you		
ID or passport number		
Country of issue		
Date of birth	Y Y Y Y M M D D Gender M F	Y Y Y Y M M D D Gender M F
Does he/she receive an income eg pension?	YES ☐ NO ☐	YES ☐ NO ☐
If YES, please fill in the monthly amount	R	R
Is he/she financially dependent on you?	YES ☐ NO ☐	YES ☐ NO ☐

D. PLEASE SELECT YOUR HEALTH PLAN

EXECUTIVE PLAN	COMPREHENSIVE PLANS	PRIORITY PLANS	SAVER PLANS	CORE PLANS	KEYCARE PLANS
Executive ☐	Classic ☐	Classic ☐	Classic ☐	Classic ☐	KeyCare Plus ☐
	Essential ☐	Essential ☐	Essential ☐	Essential ☐	KeyCare Core ☐
			Coastal ☐	Coastal ☐	

Refund Medical Savings Account claims at: Discovery Health Rate ☐ (not available on Executive Plan) or Cost ☐

The Medical Savings Account is not available on Core and KeyCare plans.

If you have selected a KeyCare Plan, we calculate your contributions using the higher of your salary or your spouse's or partner's salary – not the combination of the two.

Do you want your Health Plan information sent to you in a booklet ☐ or on an interactive DVD? ☐

Please note: If you do not select an option, we will send you the booklet.

To be completed if you have selected the KeyCare Plus Plan

	Your chosen general practitioner in the KeyCare GP network			
	Name	**General practitioner**	**Practice number**	**Telephone number**
Main applicant				
Spouse/partner				
* Dependant 1				
Dependant 2				
Dependant 3				
Dependant 4				

Please note: You can only access day-to-day cover and chronic benefits through the KeyCare GP network completed above.

* Please make sure that the dependant information supplied above is the same as the dependant information in Section C of this form.

Alterations must be signed and dated by main applicant.

E. YOUR VITALITY AND/OR KEYCLUB OPTIONS

If you want to join Vitality, KeyClub (including KeyClub Starter) or both or want a DiscoveryCard please complete this section.

Please only choose one of the below options:

Vitality	KeyClub	KeyClub Starter*	Vitality and KeyClub	KeyClub and KeyClub Starter*

*KeyClub Starter gives main members on KeyCare, earning less than R6 800, an additional R5 000 funeral cover for R1 per month.

The DiscoveryCard

The DiscoveryCard is a VISA credit card. As a Vitality member with a DiscoveryCard, you can get cash back, travel savings and a world of convenience through our DiscoveryCard partners.

Would you like to apply for your DiscoveryCard? YES NO Required limit R

Please note that when assessing your DiscoveryCard application, a credit check will be done. This application form is not a sale of the DiscoveryCard. An accredited consultant will phone you to complete the process.

F. BANKING DETAILS FOR VITALITY, KEYCLUB OR BOTH

If your employer is <u>not</u> paying for Vitality, KeyClub or both please complete this section. You can only use a South African bank account.

Bank name

Branch name

Branch code – –

Account number

Type of account Cheque Transmission Savings

Name of account holder

Signature of account holder

Signature of main applicant

Please note: If you are using someone else's bank account, the account holder must sign above to confirm this.

If you are a government employee on the PERSAL payroll system, please tick the box below to tell us which day of the month you want us to debit your account.

1st 5th 8th 21st 26th

G. BANKING DETAILS FOR CLAIMS REFUNDS

If we do not have banking details, we will send you a cheque. You can only use a South African bank account.

Same as in Section F YES NO

Bank name

Branch name

Branch code – –

Account number

Type of account Cheque Transmission Savings

Name of account holder

Signature of account holder

Signature of main applicant

Please note: If you are using someone else's bank account, the account holder must sign above to confirm this.

By signing above, you acknowledge that once claims have been refunded into the bank account you have chosen, the Scheme will no longer be liable in any way for the amounts refunded.

Alterations must be signed and dated by main applicant.

H. YOUR CONTRIBUTIONS

H1. If you or your own business will be paying the contribution in full, please complete this section.

Paying your own contribution YES NO

Your own business is paying contributions YES NO

Name of your business

Registration no VAT no

Telephone Fax

Physical address Postal address

Code Code

You can only use a South African bank account.

Bank name

Branch name

Branch code

Account number

Type of account Cheque Transmission Savings

Name of account holder

Signature of account holder

Signature of main applicant

Please note: If you are using someone else's bank account, the account holder must sign above to confirm this.

H2. If your employer is paying your full contribution or a portion of it, please complete this section.

Name of employer Employer/billing number

Employee number Date of employment Y Y Y Y M M D D

Branch name Branch number

1. Employer contact person 2. Employer contact person

Telephone Telephone

Email Email

EMPLOYER WARRANTY

Please ensure your employer completes this warranty if this application form is **not** submitted together with an employer application form.

1. We warrant that the main applicant detailed in **Section A** is an employee of our organisation.
2. The Scheme may bill us for the amount due in respect of this member in the same way as it does for our other employees with the Scheme.

Authorised signatory(ies) **1** **2**

Name(s)

Designation(s)

If you are a government employee on the PERSAL payroll system, please complete this section.

PERSAL number (please attach a clear copy of your salary advice)

I. YOUR INTERMEDIARY'S DETAILS

Intermediary Code

Intermediary house Code

Intermediary's contact details:

Tel (W) Cellular

Email

Lead number

Bank reference number (if applicable) (Mandatory for all ABSA and FNB intermediaries)

Signature of intermediary(ies)

You or your representative (your employer) appoints intermediaries.

Alterations must be signed and dated by main applicant.

J. PREVIOUS MEDICAL SCHEME DETAILS

Please give us the details of all registered South African medical schemes that you and your dependants 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
Main applicant			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	
			Y Y M M D D	Y Y M M D D YES	
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 – Name					
			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 – Name					
			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 – Name					
			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 – Name					
			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	

K. YOUR MEDICAL QUESTIONS

- Please give full medical details of the main applicant **and all dependants in this application form.**
- You are required by law to make a full and proper disclosure of all medical information.

A.	Main applicant	Spouse/partner	Adult dependant	Adult dependant
Name				
How tall are you? (metres)	-	-	-	-
How much do you weigh? (kilograms)				
Do you drink alcohol?	YES NO	YES NO	YES NO	YES NO
How many units of alcohol do you drink in a week?				
Do you smoke?	YES NO	YES NO	YES NO	YES NO
Amount per day				
If NO, have you smoked in the last 24 months?	YES NO	YES NO	YES NO	YES NO
Quantity				
Reason for stopping smoking				

Alterations must be signed and dated by main applicant.

K. YOUR MEDICAL QUESTIONS (continued)

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

1. Blood disorders **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		

2. Brain and nerve disorders **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		

3. Cancer **YES** ☐ **NO** ☐

Example any form of cancer ☐ or pre-cancerous growth/s ☐

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		

4. Heart and circulation disorders **YES** ☐ **NO** ☐

Example angina/chest pain ☐ heart failure ☐ heart murmurs ☐ rheumatic fever ☐ high blood pressure ☐
heart attack ☐ raised cholesterol ☐ previous heart surgery ☐ rhythm disturbance (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		

5. Connective tissue disorders **YES** ☐ **NO** ☐

Example systemic lupus erythematosus ☐ scleroderma ☐ dermatomyositis/polymyositis ☐ mixed connective tissue disorder ☐

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		

Alterations must be signed and dated by main applicant.

K. YOUR MEDICAL QUESTIONS (continued)

6. Dental disorders YES ☐ NO ☐

Example recent/expected dental surgery ☐ recent/current/expected orthodontic treatment ☐

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. Eye, ear and speech disorders YES ☐ NO ☐

Example cataracts ☐ glaucoma ☐ tinnitis ☐ hearing/visual impairment ☐ disorders of the cornea ☐ blindness ☐

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		

8. Gynaecological disorders YES ☐ NO ☐

Example ovarian cysts ☐ endometriosis ☐ fibroid ☐ disorders of the cervix ☐ menstrual disorders ☐

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		

9. Kidney/urinary tract disorders 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		

10. Liver/pancreatic disorders 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		

11. Mental health/psychiatric disorders YES ☐ NO ☐

Example depression ☐ anxiety ☐ schizophrenia ☐ bipolar ☐ eating disorders

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		

Alterations must be signed and dated by main applicant.

K. YOUR MEDICAL QUESTIONS (continued)

12. Metabolic/endocrine disorders **YES** ☐ **NO** ☐

Example diabetes ☐ thyroid abnormalities ☐ 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		

13. Musculoskeletal disorders **YES** ☐ **NO** ☐

Example rheumatoid arthritis ☐ osteo-arthritis ☐ 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		

14. Respiratory disorders **YES** ☐ **NO** ☐

Example cystic fibrosis ☐ emphysema ☐ chronic bronchitis ☐ shortness of breath ☐ persistent cough ☐
asthma ☐ 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		

15. Gastro-intestinal disorders **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		

16. Are you or any of your dependants suffering from any symptoms not yet diagnosed by a medical professional, example heartburn, reflux etc? **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		

17. Do you or any of your dependants have any condition/s or symptom/s which are not directly covered by these questions? Please provide FULL medical details. **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		

Alterations must be signed and dated by main applicant.

K. YOUR MEDICAL QUESTIONS (continued)

18. Are you or any of your dependants expecting surgery ☐ or planning hospitalisation ☐ or treatment ☐ in the next 12 months? 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		

19. Have you or any of your dependants had an operation ☐ or been admitted to hospital ☐ in the last 12 months? 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		

20. Is any person in this application form pregnant? YES NO

Name(s)

21. Have you or any of your dependants been involved in a motor vehicle accident ☐ or been injured on duty ☐ or contracted a work related disease ☐ in the last 24 months? Please specify below. 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		

22. Have you or any of your dependants ever had, or are currently suffering from alcohol ☐ or drug problems ☐ ? 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		

23. HIV and AIDS YES NO

You do not need to disclose your HIV and AIDS status on this form if you do not feel comfortable to do so. However, if you are HIV-positive, you must call us on 0860 100 417 within seven working days from the date we activate your Discovery Health Medical Scheme membership. It is in your best interest 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 management programme please confirm these details.

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		

Alterations must be signed and dated by main applicant.

L. TERMS AND CONDITIONS

I. Rules of the Scheme

1. I apply for my dependants and me to join the Discovery Health Medical Scheme ("the Scheme"), which is administered by Discovery Health (Pty) Limited ("Discovery Health"), and agree that my dependants and I will be bound the Scheme's rules.

Disclosure of information

2. I acknowledge that if my dependants or I breach any warranty or do not disclose any information that is relevant to the assessment of this application, my membership will be null and void, in which case the Scheme will keep some of my contributions that have been paid to it.
3. I acknowledge that if I do not inform Discovery Health of any change in my health or my dependants' health that may happen between the date of this application form and the activation date of my membership, Discovery Health will be allowed to make my membership null and void, in which case the Scheme will keep some of my contributions that have been paid to it.
4. I agree to Discovery Health, the Scheme or both disclosing, any information given to one or both of them to anybody else. However, such person must have agreed to keep the information confidential at all times. Examples of information are general, medical and financial information about my dependants or me.
5. I agree that Discovery Health may, whenever it wants, disclose any information about my dependants or me, whether of a clinical or financial nature, to any entity in the Discovery Group. However, such entity must have agreed to keep the information confidential at all times and to use the information for its programmes only.
6. I agree to Discovery Health sending any request for information, tests or examinations directly to any of my dependants who are over the age of 18. I agree that doing so will have the same legal consequences as if the request had been sent to me in my capacity as the main member.
7. 7.1 I authorise Discovery Health to get from any person any information about any of my dependants or me that it, in its sole discretion, may need to assess any risk or claim relating to this application or my membership. An example of the people from whom Discovery Health may get such information is my intermediary.
   7.2 I direct the person from whom Discovery Health asks for such information to immediately give such information to Discovery Health.
8. I authorise Discovery Health and the Scheme to get any information about my dependants or me that I may have given to any entity in the Discovery Group. I also authorise them to use such information for any risk management purposes. An example of such information is medical information.

By completing this section, you consent to the disclosure of medical information for risk management and underwriting purposes.

Pre-authorisation

9. If any of my dependants or me need to be admitted to hospital for a non-emergency, I will tell Discovery Health of that fact at least 48 hours before the admission. I acknowledge that if I do not tell Discovery Health in time, the benefits payable by the Scheme for the admission will be reduced.
10. I acknowledge that the Scheme will not pay a benefit if it is not satisfied that the claim is valid and if it has not received all the information that Discovery Health may require. An example of the information that Discovery Health may require is the result of any medical examination and tests that it may need my dependants or me to undergo.

Monthly contribution

11. I acknowledge that I am responsible for ensuring that the Scheme receives the monthly contribution for my membership no later than three days after it is payable. I also acknowledge that short payment or non-payment of any of my contributions will allow the Scheme to stop paying my claims. I also acknowledge that if my contributions are short-paid or not paid for two consecutive months, my membership will be cancelled.

The Scheme's rights on termination

12. 12.1 When my membership of the Scheme ends, I will repay to the Scheme, Discovery Health or both any amount that I may owe for any other reason. An example of an amount that I might owe is an amount for my Medical Savings Account.
    12.2 I understand that when my membership of the Scheme ends, if the contributions that I have paid to my Medical Savings Account are more than the claims that have been paid from this account, the excess will be refunded to me, but strictly in accordance with the law.

Recording of calls

13. 13.1 I consent to all conversations between my dependants or me and Discovery Health being recorded and to all information obtained from the conversations forming part of Discovery Health's records.
    13.2 I also consent to all of the recordings remaining the property of Discovery Health only.

Acting on behalf of dependants

14. If these terms and conditions apply to any of my dependants, I will get their consent to act on their behalf for any matter concerning their membership of the Scheme. I indemnify Discovery Health and the Scheme against any claim that may arise if I fail to get their consent.

Submission of application through the internet

15. 15.1 I acknowledge that even though I am allowed to send this application form through the internet, I can do so for convenience only and I must still give Discovery Health a signed hard copy of this application form;
    15.2 I acknowledge as well that if I do send this application form through the internet, Discovery Health and the Scheme will not be responsible for anything that might happen if it relies or does not rely on any information that it receives in that application form. I indemnify Discovery Health against any loss in this regard.

HIV

16. If any of my dependants or I are living with HIV and AIDS, I will tell Discovery Health of that fact within seven working days from the date my membership is activated.

Debt recovery

17. I consent to Discovery Health getting any credit and credit-related information about me whenever it wants. I also consent to Discovery Health disclosing such information to any credit bureau without telling me. I also consent to Discovery Health, the Scheme or both checking such information and making any queries about such information that it believes are necessary.

KeyCare

18. I understand that if I have chosen the KeyCare GP network on the KeyCare Plus Plan, claims for my day-to-day and chronic expenses with my chosen GP will be paid (subject to the Scheme's rules) only if my chosen GP is on the KeyCare GP network.

II. Discovery Vitality and DiscoveryCard

I acknowledge that if I have applied for Discovery Vitality, KeyClub or the DiscoveryCard, the following conditions and undertakings will apply:

The rules of Vitality and KeyClub

1. I am aware that Discovery Vitality, which is registered as Vitality HealthStyle (Pty) Limited with registration number 1999/007736/07, is a different company to Discovery Health. I am also aware that the Vitality HealthStyle programme (which in this section of this application form is called Vitality HealthStyle) is charged for separately and therefore, my contributions for Vitality HealthStyle are not part of my contributions for the Discovery Health Medical Scheme.
2. I will abide by the rules of the Vitality HealthStyle programme or KeyClub programme, whichever applies to me.

DiscoveryCard

3. If I purchase a DiscoveryCard, which is referred to in Section E, then:
   3.1 I agree to be bound by the conditions of use of the DiscoveryCard. I acknowledge that the conditions of use, the product features and the pricing guide can be obtained from www.discovery.co.za, the Discovery call centre and my intermediary. I specifically acknowledge that the conditions of use, the product features and the pricing guide might change from time to time;
   3.2 I agree that this application form as well as all other documents received from Discovery directly or through my intermediary will form the basis of my contracts with Discovery Vitality and FirstRand Bank Limited. I agree as well that no representations or undertaking that any person might make or give will be binding unless they are contained in this documentation.

Debt recovery

4. I consent to Discovery Vitality, FirstRand Bank Limited (in the case of the DiscoveryCard), or both getting any credit and credit-related information about me, my dependants or additional cardholders whenever they wish. I also consent to one or both of them disclosing such information to any credit bureau without telling me. I consent as well to Discovery Vitality, FirstRand Bank Limited or both checking such information and making any queries about such information that it believes are necessary.

Disclosure of information

5. 5.1 I consent to Discovery Health, the Scheme or both disclosing any information about my dependants or me that one or both of them might have. However, Discovery Vitality must have agreed to keep the information confidential at all times and to use the information for its programmes only. An example of the information is general, medical and financial information about my dependants or me.
   5.2 I agree that Discovery Health, the Scheme, or both (whichever is applicable) has the sole discretion to disclose information and to choose the information to be disclosed.

General

I understand that I should not resign from my current medical scheme until I have been told in writing that my application to join the Scheme has been accepted. Once I have been told, I will cancel my current medical scheme membership as it is illegal to belong to two medical schemes at the same time.

I warrant that the contents of this application are true, correct and complete.

If there are no waiting periods or late-joiner penalty fees applied to me or any of my dependants, Discovery Health may activate my membership with effect from the commencement date reflected on this application form.

I agree to inform Discovery Health and Discovery Vitality (if applicable) in writing of any change in details (including any change in my health or my dependants' health) that may occur between the date of this application form and the activation date of my membership of the Scheme and Vitality HealthStyle (if applicable).

Signed at (Town/City) _____ **on** Y Y Y Y M M D D

Signature of main applicant _____

Alterations must be signed and dated by main applicant.