IFC | INDEPENDENT FINANCIAL CONSULTANTS

Fax

To: Independent Financial Consultants	From:
Att: Iracema Fonseca	Subject:
Fax to email: (086) 586-4165	# Pages: (including cover sheet):
Fax land: (021) 593-3135	Date:
Cell: (084) 334-4848 (W) (021) 593-3012	Email: admin@ifconsultants.co.za

Contact Details

Name:
Work Number:
Cell Number:
Email:

IFC is an authorized financial service provider - FSB license number: 40508. Our company offers free a consulting service on medical aid and life cover, as well as essential short term products, including gap cover.

Applying to become a member of Discovery Health Medical Scheme in 2015

Discovery Health Medical Scheme

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 these rules.

Who we are

The Discovery Health Medical Scheme (referred to as 'the Scheme'), registration number 1125, 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 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

- ☐ Fill in the form in black ink, using one letter per block. Please print clearly.
- ☐ Read and understand the rules for membership (section 13).
- ☐ Sign section 6 (if applying to become a KeyCare member) 8, 12 and 13.
- ☐ Please make sure the main applicant signs and dates any changes.
- ☐ Fax the completed and signed form to **011 539 3000** or email it to **application@discovery.co.za**
- ☐ Please attach a copy of each applicant's identity document. We also accept valid passports and birth certificates for children.

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

- If any details are missing or if we need more information for underwriting purposes, we will contact you.
- We will activate your membership and send you or your financial adviser a letter of confirmation when we are offering standard terms of acceptance (no waiting periods or late-joiner penalties). For any non-standard terms, we will issue a counter-offer letter which will indicate any conditions applicable to your membership (waiting periods and/or late-joiner penalties). You may accept the offer by signing and returning this letter for us to activate your membership.
- We will send you or your financial adviser a welcome letter, SMS or an email to let you know when your application is considered to have been fully and completely made. This date may differ from the date on which you sign the application form.
- You will then get a pack in the post.

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

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

1. About yourself (main applicant)

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

Previous or maiden name

Preferred language English ☐ Afrikaans ☐

Occupation Tax number

Total monthly earnings R

ID or passport number Country of issue

Telephone (H) (W)

Cellphone Fax

Email

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

☐ Suite ☐ Postnet Suite Number

☐ PO Box ☐ Private Bag Box number

Suburb Postal code

If your post is delivered to your street address, please complete these details under physical address.

Physical address:

Suite/Unit number Complex name

Street number Street name

Suburb Postal code

117696 GE 11.14(15)

2. About your spouse or partner (only complete if applying for cover)

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

Previous or maiden name

ID or passport number | Country of issue

Telephone (H) | (W)

Cellphone | Tax number

Email

3. About your dependants (only complete if applying for cover)

Dependant 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

ID or passport number | Country of issue

Relationship to main member (For example, mother, child etc. Where your child is not your biological child, please state relationship, ie adopted child, foster child. Please provide legal proof)

If your dependant is 21 years and older, are they: Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐ How much does your dependant earn each month? R

Dependant 2

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

ID or passport number | Country of issue

Relationship to main member (For example, mother, child etc. Where your child is not your biological child, please state relationship, ie adopted child, foster child. Please provide legal proof)

If your dependant is 21 years and older, are they: Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐ How much does your dependant earn each month? R

Dependant 3

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

ID or passport number | Country of issue

Relationship to main member (For example, mother, child etc. Where your child is not your biological child, please state relationship, ie adopted child, foster child. Please provide legal proof)

If your dependant is 21 years and older, are they: Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐ How much does your dependant earn each month? R

4. Your financial adviser's details

Financial adviser's name: Iracema Fonseca | Code: 1064996133

Intermediary house: Independant Financial Consultants | Code: 109797720

Financial adviser's telephone number (W): 021 593 30 12 | Lead number

Email: admin@ifconsultants.co.za

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

I declare that:

1. I am an accredited financial adviser in terms of the Medical Schemes Act and licensed by the FSB in terms of the FAIS Act at the date of signing this application form.
2. I am appointed by the client to provide advice about this application.
3. I have a valid contract with the Discovery Health Medical Scheme and I have made the client aware of the commission payable by Discovery Health Medical Scheme.
4. I am responsible for providing the applicant with:
   - my name, physical address, postal address and telephone number
   - impartial advice that is in his or her best interest.
5. I am accountable for any advice given to the member about completion of this application form and joining the Discovery Health Medical Scheme.

Financial adviser's signature

5. Please select your health plan

Executive Plan	Comprehensive Series	Priority Series	Saver Series	Core Series	KeyCare Series
☐ Executive	☐ Classic	☐ Classic	☐ Classic	☐ Classic	☐ KeyCare Plus
	☐ Classic Delta	☐ Essential	☐ Classic Delta	☐ Classic Delta	☐ KeyCare Access
	☐ Classic Zero MSA		☐ Essential	☐ Essential	☐ KeyCare Core
	☐ Essential		☐ Essential Delta	☐ Essential Delta	
	☐ Essential Delta		☐ Coastal	☐ Coastal	

How would you like us to refund claims from the Medical Savings Account if your plan has one? Discovery Health Rate ☐ Cost ☐

You have the right to ask for help in selecting a health plan that suits your needs. By signing this application you confirm that you are familiar with the conditions and benefits of the plan you select.

6. If you choose a KeyCare Plan

Income verification will be conducted for the lower income bands. Income is defined as: The higher of the main member or spouse's earnings, commission and rewards from employment; interest from investments; income from leasing of assets or property; distributions received from a trust, pension and/or provident fund; and financial assistance from any social assistance programme.

IMPORTANT NOTICE:

Declaring income lower than your actual income is fraud. This will lead to the immediate termination of your membership.

By signing this application form, you give your permission for us to verify your declared income using all relevant internal and external sources, as defined in 13.4.

	Main member	Spouse or partner
Total earnings over the last 12 months	R	R
Total monthly earnings	R	R

I declare that this income declaration is true and accurate.

Signature of main applicant

If the highest earner earned less than R120 000 for each year then please provide the following supporting documentation as proof of income:

- Last 3 months' (90 consecutive days) bank statements; **and**
- If employed, your last 3 months' payslips and commission schedules, or most recent tax year's IRP5 certificate
- If student, proof of enrolment at academic institution
- If self-employed, most current financial statements
- If pensioner, proof of annuity and/or employer pension and/or State Older Person's Grant
- If unemployed, UIF certificate

Please complete this if you have selected the KeyCare Plus or KeyCare Access Plan.

	Name	GP name	Practice number	Second GP name*	Practice number
Main applicant					
Spouse or partner					
Dependant 1**					
Dependant 2**					
Dependant 3**					

* If you live far away from where you work or you often need to work in different towns or provinces, you may need a second GP. Please only choose a second GP if this applies to you.

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

7. Your employment details

7.1 If your employer is paying your full contribution or a part of it and we need to debit their account, please complete 7.1:

Name of employer | Employer or billing number

Employee number | Date of employment (Y Y Y Y M M D D)

(or PERSAL number for government employees. Please attach a clear copy of your salary slip.)

Branch name | Branch number

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

Employer warranty

1. We warrant that the main applicant detailed in section 1 is an employee of our organisation.
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.

Authorised signatory

Name

Designation

7. Your employment details *(continued)*

7.2 Only complete 7.2 if you own your own business and your business will be paying your contribution:

Name of your business

Registration number

VAT number

Telephone

Fax

Physical address

Code

Postal address

Code

8. Your banking details

8.1 Your contributions

If you will be paying your contributions in full, please complete this section:

Please note: we cannot accept credit card account details

Bank name

Branch name

Branch code – –

Account number

Type of account Cheque ☐ Savings ☐

Account holder

Please choose the date you would like us to debit your account

1st ☐ 10th ☐ 15th ☐ 20th ☐ 25th ☐

If your membership is not activated in time for the debit order date you chose above, you will have two separate debit orders in the first month you pay your contribution, because you pay your contribution in advance. The first debit order will be collected on the first day of the month for outstanding contributions and the second debit order will be collected on the actual date you have chosen in the same month. From then on we will collect your monthly contribution on the date you have chosen.

8.2 Your claims refund

Can we use the same account we deduct contributions from to refund your claims? Yes ☐ No ☐

If you do not want to use the same banking details for your contributions and claims refunds, please give us the details you would like to use:

Please note: we cannot accept credit card account details

Bank name

Branch name

Branch code – –

Account number

Type of account Cheque ☐ Savings ☐

Account holder

By signing this application, you agree that once claims have been refunded into the bank account you have chosen, the Discovery Health Medical Scheme will not be responsible in any way for the amounts refunded.

Signature of account holder

9. Previous medical scheme details

Please give us the details of all registered South African medical schemes that you previously belonged to. We will use this information to determine if we need to apply any waiting periods, late-joiner penalty fees, or both. Please give us proof in the form of a membership certificate.

Main applicant

Name	Scheme name	Start date	End date if already resigned	Are they still a member?	Reason for leaving
		Y Y Y Y M M D D	Y Y Y Y M M D D	Yes ☐ No ☐	
		Y Y Y Y M M D D	Y Y Y Y M M D D	Yes ☐ No ☐	
		Y Y Y Y M M D D	Y Y Y Y M M D D	Yes ☐ No ☐	
		Y Y Y Y M M D D	Y Y Y Y M M D D	Yes ☐ No ☐	

If all dependants were on the same medical scheme(s) as completed above, please tick here to confirm this. ☐

If any of your dependants applying for cover belonged to different medical schemes, please complete them below:

Dependant name	Scheme name	Start date	End date if already resigned	Are they still a member?	Reason for leaving
		Y Y Y Y M M D D	Y Y Y Y M M D D	Yes ☐ No ☐	
		Y Y Y Y M M D D	Y Y Y Y M M D D	Yes ☐ No ☐	
		Y Y Y Y M M D D	Y Y Y Y M M D D	Yes ☐ No ☐	
		Y Y Y Y M M D D	Y Y Y Y M M D D	Yes ☐ No ☐	

10. Moving from another medical scheme

Please make sure that you have completed section 10.

10.1 I confirm that all people named on this application:

1. have not had a break in membership of more than 90 days since resigning from that South African medical scheme, and Yes ☐ No ☐
2. are currently or have been members of a South African medical scheme for at least the past 24 months. Yes ☐ No ☐

If you answered **yes** to the above questions, please answer the questions in **10.2.**

If you answer no to any question in 10.1, you must complete all the medical questions in section 11.

10.2 For any person named on this application form:

1. Have you or any of your dependants been admitted to hospital in the 12 months before this application? Yes ☐ No ☐
2. Are you or any of your dependants currently taking regular, ongoing medicine for a medical condition? Yes ☐ No ☐
3. Are you or any of your dependants planning to or reasonably expecting to be hospitalised (including for pregnancy) or expecting to receive dental or medical treatment costing more than R2 000 in the next 12 months? Yes ☐ No ☐

If you answered **no** to **all** questions in **10.2**, we will not apply any waiting periods and you **do not** have to complete **section 11**.

If you answered **yes** to **any** questions in **10.2**, we will apply a three-month general waiting period to your application and you **do not have to complete Section 11.** If you feel that a three-month general waiting period should not be applied and you want to give us more information, please complete section 11.

During these three months, we will only cover claims relating to Prescribed Minimum Benefits according to the Scheme's rules.

11. Your health questions

Treating healthcare professional's name

Telephone

The main applicant, spouse or partner and all dependants applying for cover needs to complete section 11.

Main applicant

How tall are you? ☐ . ☐☐ metres How much do you weigh? ☐☐☐ kilograms

Your blood type Your allergies

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week?

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day

If **no**, have you smoked in the last 24 months? Yes ☐ No ☐ If **yes**, amount each day

If you stopped smoking, what was your reason for stopping?

Spouse or partner

How tall are you? ☐ . ☐☐ metres How much do you weigh? ☐☐☐ kilograms

Your blood type Your allergies

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week?

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day

If **no**, have you smoked in the last 24 months? Yes ☐ No ☐ If **yes**, amount each day

If you stopped smoking, what was your reason for stopping?

Dependant 1 Name

How tall are you? ☐ . ☐☐ metres How much do you weigh? ☐☐☐ kilograms

Your blood type Your allergies

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week?

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day

If **no**, have you smoked in the last 24 months? Yes ☐ No ☐ If **yes**, amount each day

If you stopped smoking, what was your reason for stopping?

Dependant 2 Name

How tall are you? ☐ . ☐☐ metres How much do you weigh? ☐☐☐ kilograms

Your blood type Your allergies

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week?

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day

If **no**, have you smoked in the last 24 months? Yes ☐ No ☐ If **yes**, amount each day

If you stopped smoking, what was your reason for stopping?

11. Your health questions *(continued)*

Dependant 3 Name

How tall are you? . metres How much do you weigh? kilograms

Your blood type Your allergies

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week?
1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day

If **no**, have you smoked in the last 24 months? Yes ☐ No ☐ If **yes**, amount each day

If you stopped smoking, what was your reason for stopping?

Have you or **any dependant** in this application ever experienced, been treated 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 include congenital abnormalities.

Please take note that if you have any 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 11.18 below.

11.1 Tumours and growths **Yes** ☐ **No** ☐

Example: abnormal pap smear results, pre-cancerous skin lesions, breast disease, breast lumps, non-cancerous tumors, cancerous tumors, fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abnormal mammogram result, abnormal PSA (prostate specific antigen) result.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

11.2 Heart and 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, congenital heart disease, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

11.3 Gynaecological and obstetrics conditions **Yes** ☐ **No** ☐

Example: abnormal pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

11.4 Are any of your dependants pregnant? **Yes** ☐ **No** ☐

Patient name		

11.5 Mental health **Yes** ☐ **No** ☐

Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (like narcolepsy), eating disorders, Alzheimer's disease, autism, dementia, attention deficit-hyperactivity disorder, drug and/or alcohol rehabilitation, suicide attempt, counselling, bulimia and any other psychological conditions.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

11.6 Metabolic or endocrine conditions **Yes** ☐ **No** ☐

Example: diabetes (high blood sugar), thyroid disease, Addison's disease, Cushing's syndrome, metabolic syndrome, parathyroid disease, Paget's disease, osteoporosis, growth deficiency, metabolic disorders, Conn's syndrome.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

11.7 Abdominal conditions **Yes** ☐ **No** ☐

Example: hepatitis, cirrhosis, portal hypertension, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis, gall bladder, gall stones, GORD (heartburn), oesophageal disease, hernias, atrophic gastritis, ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

11. Your health questions *(continued)*

11.8 Brain and nerve conditions **Yes** ☐ **No** ☐

Example: stroke, epilepsy, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, cerebral palsy, Parkinson's disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, mental retardation and CVA.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

11.9 Breathing and respiratory conditions **Yes** ☐ **No** ☐

Example: asthma, chronic obstructive pulmonary disease, bronchiectasis, tuberculosis, bronchitis or emphysema, cystic fibrosis, sarcoidosis, pneumonia.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

11.10 Musculoskeletal (back, bone and muscle pain) **Yes** ☐ **No** ☐

Example: arthritis (any form), ongoing back pain, ankylosing spondylitis, lupus, Sjögren's syndrome, scleroderma, polymyositis, dermatomyositis, polyarteritis nodosa, Wegener's granulomatosis, sarcoidosis, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, gout, fractures, physical disability.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

11.11 Kidney or urinary conditions including current or past dialysis **Yes** ☐ **No** ☐

Example: kidney and orrenal failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, bladder infections, other bladder or kidney problems.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

11.12 Blood conditions **Yes** ☐ **No** ☐

Example: deep vein thrombosis, anaemia, ITP (platelet deficiency), polycythaemia vera, blood clotting diseases, leukaemia, lymphoma, pulmonary embolus, haemophilia and other bleeding disorders.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

11.13 Eye conditions **Yes** ☐ **No** ☐

Example: cataract, keratoconus, corneal ulcer, uveitis, glaucoma, squint, ptosis, any abnormality of eyelids, retinopathy, macular degeneration, cornea transplant, eye surgery, blurry vision, blindness (partial or full), retinal detachment.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

11.14 Ear, nose and throat (ENT) and dentistry conditions **Yes** ☐ **No** ☐

Example: chronic otitis media (middle ear infection), chronic otitis externa, hearing problems, hearing aid, cochlear implant, tonsillitis, adenoiditis, vertigo, deafness, sinus problem, nasal surgery, dental treatment or dental surgery.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

11.15 Male urogenital conditions **Yes** ☐ **No** ☐

Example: prostate disorders, urogenital defects, varicocele, tumours, undescended testes, phimosis, urinary incontinence.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

11. Your health questions *(continued)*

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

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

11.17 Have you or any of your dependants received medical advice or treatment for symptoms, not yet diagnosed by a medical professional, in the last 12 months before this application? Yes ☐ No ☐

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

11.18 Have you or any of your dependants been diagnosed with or received treatment for, any condition not mentioned in the questions above, in the last 12 months before this application? Yes ☐ No ☐

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

HIV and AIDS

You do not need to disclose the HIV status of you or your dependant(s) on this form if you do not feel comfortable doing so. However, if you, or one or more of your dependants, are HIV-positive, you or they must call us on **0860 99 88 77** within seven working days from the date we activate your Discovery Health Medical Scheme membership. We treat this information in the strictest confidence. If you, or one or more of your dependants, are HIV-positive, it is in your interest to register on the HIV*Care* Programme. A 12-month condition specific waiting period may apply to this condition. If you do not let us know about your HIV status within 7 days of your membership being active, we may end your Discovery Health Medical Scheme membership.

12. Fair Collection Notice – how we will process and disclose your Personal Information and communicate with you

1. This Fair Collection Notice ("Notice") explains how we obtain, use, disclose and otherwise process personal information, which may include health and financial information ("Personal Information"), as required by the Protection of Personal Information Act ("POPIA").
2. Acceptance of these terms and conditions is voluntary, but is a requirement for activation and servicing of your medical scheme membership. If you do not accept these terms and conditions, we cannot activate and service your membership.
3. Please note:
   a. We may amend this Notice from time to time. Please check our website periodically to inform yourself of any changes;
   b. You have the right to object to the processing of your Personal Information;
   c. Should you believe that we have utilised your Personal Information contrary to applicable law, you will first resolve any concerns with us. If you are not satisfied with such process, you have the right to lodge a complaint with the Information Regulator, once established.
4. Discovery Health Medical Scheme and Discovery Health (Pty) Ltd (we/us) will keep any information, including Personal Information relating to yourself and your dependants and/or beneficiaries, supplied to us in this application or collected from other sources ("Your Personal Information") confidential.
   You confirm that when you provide us with your Personal Information, your dependants and/or beneficiaries have provided you with the appropriate permission to disclose their Personal Information to us for the purposes set out below and any other related purposes.
   You agree to us processing and disclosing your Personal Information in the following manner:
5. We may collect, collate, process, store and disclose your Personal Information:
   a. For the administration of your health plan;
   b. For providing managed care services to you or any dependant/s on your health plan;
   c. For providing relevant information to a contracted third party who requires this information to provide a healthcare service to you or any dependant/s on your health plan;
   d. To profile and analyse risk;
   e. For academic research conducted by any company within the Discovery Group and/or contracted research and survey providers in South Africa as well as outside the borders of the Republic.

Examples of how this will happen includes:

   a. Sharing your Personal Information with your chosen financial adviser during the application process to help Discovery Health (Pty) Ltd, if necessary, while we process your membership application;
   b. Getting your Personal Information from other relevant sources, including any entity that is part of Discovery Limited, medical practitioners, contracted service providers, financial advisers, credit bureaus or industry regulatory bodies ("Sources"), and further processing of such information to consider your membership application, to conduct underwriting or risk assessments, or to consider a claim for medical expenses. We may (at any time and on an ongoing basis) verify with the Sources that your Personal Information is true, correct and complete;
   c. Getting and sharing any information that is relevant to your application from or with your employer, if you have joined as a member of an employer group;
   d. Communicating with you about any changes in your health plan, including your contributions or changes and enhancements to the benefits you are entitled to on the health plan you have chosen;
   e. Transferring your Personal Information outside the borders of ` the Republic of South Africa where appropriate, for example to administer the ISOS and Africa Benefit, if you provide an email address which is hosted outside the borders of South Africa, or for processing, storage or academic research. We will ensure that anyone to whom we pass your Personal Information agrees to treat your information with the same level of protection as we are obliged to;
   f. Making use of external health specialists to assess or evaluate certain clinical information. Your Personal Information will be shared with such specialist/s in the event that you or your dependants are subject to such a clinical assessment.

12. Fair Collection Notice – how we will process and disclose your Personal Information and communicate with you *(continued)*

6. If asked to do so, we will share your Personal Information with a third party if you have already given your consent for the disclosure of this information to such third party or if a contractual relationship exists in terms of which we are obliged to provide the information to such third party.
7. We will provide your Personal Information to any other entity within the Discovery Group with whom you or your dependant/s already have a relationship or where you or your dependants have applied for a product or benefit from such entity. This information will be provided for the administration of your or your dependant's products or benefits with other entities within the Discovery Group.
8. We may provide any credit bureau or credit providers industry association with any information about your consumer credit record, including personal information about any judgement or default history.
9. We and any entity within the Discovery Group will keep you updated on information about any offers or new products Discovery may make available at any time. Please contact us if you do not wish to receive any telephonic direct marketing information from us.
10. If we want to share your information for any other reason, we will do so only with your permission.
11. You have the right to request a copy of the Personal Information we hold about you. To do this, simply complete the 'Data Subject Request Form' on www.discovery.co.za/legal and specify what information you would like. We will take all reasonable steps to confirm your identity before providing details of your Personal Information.

Please note that any such Data Subject Request may be subject to a payment of a legally allowable fee.

12. You have the right to contact and ask us to update, correct or delete your Personal Information.
13. You agree that we may retain your Personal Information until such time as you request us to destroy them (unless we are obliged by law to retain it, regardless of such request)
14. If the Scheme, Discovery Health (Pty) Ltd or Discovery (Ltd) becomes involved in a proposed or actual merger, acquisition or any form of sale of some or all its assets, we may use and disclose your Personal Information to third parties in connection with the evaluation of the transaction. The surviving company, or the acquiring company in the case of a sale of assets, would have access to your Personal Information which would continue to be subject to this Notice.
15. Discovery Health Medical Scheme and Discovery Health (Pty) Ltd are required to collect and retain information in terms of the following legislation (amongst others):
    - 15.1 The Medical Schemes Act, 1998
    - 15.2 The Consumer Protection Act, 2008
    - 15.3 The Protection of Personal Information Act, 2013
    - 15.4 Electronic Communications and Transactions Act, 2002
    - 15.5 Promotion of Access to Information Act, 2000

    Legislation specific to Discovery Health (Pty) Ltd only:
    - 15.6 Financial Advisory and Intermediary Services Act, 2002

Signature of main applicant

13. Discovery Health Medical Scheme rules for membership

13.1 Rules for membership

The rules of the Discovery Health Medical Scheme records your rights and responsibilities for your membership of the Discovery Health Medical Scheme. They may change from time to time. You may ask Discovery Health (Pty) Ltd 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.

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

You give permission that Discovery Health Medical Scheme and Discovery Health (Pty) Ltd 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 he or she can help Discovery Health (Pty) Ltd if necessary while we process your membership application.

Please speak to your financial adviser or Discovery Health (Pty) Ltd if there is anything you do not understand.

13.2 Who you are applying for

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

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

13.3 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 18 to act for them in any matter relating to this application.

13.4 Giving and getting information

You must give true, correct and complete information

To consider your application for membership, the Discovery Health Medical 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 Discovery Health Medical Scheme and Discovery Health (Pty) Ltd. It is important that you tell Discovery Health Medical Scheme and Discovery Health (Pty) Ltd 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.

Discovery Health (Pty) Ltd may ask those you apply for who are 18 and older for information and this will be treated as if Discovery Health Medical Scheme had asked you in your role as main member.

Your legal address

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

Discovery Health (Pty) Ltd and the Discovery Health Medical Scheme may record telephone calls

Discovery Health (Pty) Ltd and the Discovery Health Medical 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.

Discovery Health Medical Scheme and Discovery Health (Pty) Ltd may get information about you from other relevant sources

To consider your application for membership, conduct underwriting or risk assessments or to consider a claim for medical expenses, you agree that Discovery Health (Pty) Ltd and the Discovery Health Medical Scheme can get information about you and those you apply for from other relevant sources. These include any entity that is part of Discovery Limited, medical practitioners, financial advisers, credit bureaus or industry regulatory bodies. Discovery Health (Pty) Ltd and the Discovery Health Medical Scheme may (at any time and on an ongoing basis) verify with the parties mentioned in this section that the information you give on this application and in respect of any matter pertaining to or that arose during your membership of the Discovery Health Medical Scheme, is true, correct and complete.

You give your permission that the Discovery Health Medical Scheme and Discovery Health (Pty) Ltd may get any information that is relevant to your application from your employer.

Tell Discovery Health Medical Scheme or Discovery Health immediately if your information changes

You, your employer or your financial adviser must tell Discovery Health Medical Scheme or Discovery Health (Pty) Ltd 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.

13. Discovery Health Medical Scheme rules for membership

When the Discovery Health Medical Scheme may cancel your membership/s

The Discovery Health Medical Scheme may cancel any memberships immediately, if you and those you apply for:

- do not give Discovery Health Medical Scheme and Discovery Health (Pty) Ltd information that later turns out to be relevant to this application.
- give Discovery Health Medical Scheme and Discovery Health (Pty) Ltd any information that is not true, correct and complete.
- do not tell Discovery Health Medical Scheme and Discovery Health (Pty) Ltd 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.

13.5 About becoming a member

Discovery Health Medical Scheme might not pay for certain expenses immediately after you become a member

Discovery Health Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before the Discovery Health Medical Scheme starts paying for any general or specific medical conditions. Please speak to your financial adviser or Discovery Health (Pty) Ltd 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 Discovery Health Medical 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 Discovery Health Medical Scheme, you are responsible for ensuring 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 amend monthly contributions and benefits from time to time.

13.6 Repaying money owed to the Scheme

Discovery Health Medical Scheme has the right at any time to collect from you any amount that you owe to the Scheme.

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 Discovery Health Medical 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 Discovery Health Medical Scheme before the year is up, you must repay the portion of medical savings you have used that is more than you have paid back to the Discovery Health Medical 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.

Signature of main applicant

Date **2** **0** Y Y M M D D

The main applicant must sign and date any changes

Application to join Vitality or KeyFIT or both

Contact us

Tel: 0860 99 88 77, PO Box 653574, Benmore 2010, www.discovery.co.za

Please complete this form and submit it to us by email at vitalitysales@discovery.co.za or by fax to (011) 539 2509.

Please make sure that you sign this application

Main applicant's name and surname

Main applicant's ID number

Please choose one of the following options:

☐ Vitality ☐ KeyFIT ☐ Vitality and KeyFIT

Only members with a KeyCare Health Plan can join KeyFIT without joining Vitality as well.

1. Banking details and payment date

If you are paying your own Vitality contribution, please complete this section.

Bank name

Branch name Branch number – –

Account number Type of account Cheque ☐ Savings ☐

Accountholder

Accountholder's signature Signature of main applicant

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

Please note that if your activation request reaches Vitality between the 1st and 15th of the month, the policy will be effective from the first of the current month. If you activate Vitality between the 16th and last day of the month, the policy will be effective from the first of the following month.

Please choose the date you would like us to debit your account (if you are not a government employee):

1st ☐ 10th ☐ 15th ☐ 20th ☐ 25th ☐

If your membership is not activated in time for the debit order date you chose above, you will have two separate debit orders in the first month you pay your contribution, because you pay your contribution in advance. The first debit order will be collected on the first day of the month and the second debit order will be collected on the actual date you have chosen in the same month. From then on we, will collect your monthly contribution on the date you have chosen.

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 ☐

2. The DiscoveryCard

The DiscoveryCard is a Visa credit card. Vitality members can get cash back, travel savings and a world of convenience through our DiscoveryCard partners.

Would you like to apply for a DiscoveryCard? Yes ☐ No ☐

Please note: When assessing your DiscoveryCard application, a credit check will be done. An accredited consultant will phone you to complete the application. A DiscoveryCard will only be issued if you meet the credit approval criteria.

You give consent to Discovery Vitality to share information with DiscoveryCard to facilitate this application process Yes ☐ No ☐

3. Vitality contributions for 2015

	Vitality	**KeyFIT**	**Vitality and KeyFIT**
Member	R185	R40	R199
Member + spouse or dependant	R219	R49	R239
Member + 2 or more dependants	R249	R60	R275

4. Permission to process and disclose information and to communicate with you

This Fair Collection Notice ("Notice") explains how Discovery Vitality (Pty) Ltd, a company of the holding company Discovery Ltd, (we/us) obtain, use, disclose and otherwise process personal information, which may include health and financial information ("Personal Information"), as required by the Protection of Personal Information Act ("POPIA"). Acceptance of these terms and conditions is voluntary, but is a requirement for activation and servicing of your policy. If you do not accept these terms and conditions, we cannot activate and service your policy. Discovery Vitality (Pty) Ltd (we/us) will keep any information, including Personal Information relating to yourself and your dependants and/or beneficiaries, supplied to us in this application or collected from other sources ("Your Personal Information") confidential. You confirm that when you provide us with Your Personal Information, your dependants and/or beneficiaries have provided you with the appropriate permission to disclose their Personal Information to us for the purposes set out below and any other related purposes.

We may collect, collate, process, store and disclose Your Personal Information for the following purposes:

- The administration of the Vitality Programme;
- The provision of any services that you or any dependant on your Vitality policy may require;
- The provision of relevant information to a contracted third party who require such information to render a service to you or any dependant on your Vitality policy and only if such contracted third party agrees to keep the information confidential; and
- Academic research by any company within the Discovery Group and/or by contracted research and survey providers in South Africa as well as outside the borders of the Republic.

Please note:

- We may amend this Notice from time to time. Please check our website periodically to inform yourself of any changes;
- You have the right to object to the processing of Your Personal Information;
- Should you believe that we have utilised Your Personal Information contrary to applicable law, you will first resolve any concerns with us. If you are not satisfied with such process, you have the right to lodge a complaint with the Information Regulator, once established.
- We will only share Your Personal Information if it is requested by a third party to whom you have already given your consent for the disclosure of this information and the party that we share the information with agrees 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 will provide Your Personal Information to any other entity within the Discovery Group where you or your dependant/s already have a relationship, or have applied for a product or benefit from, such entity. This information will be provided for the administration of your or your dependant/s products or benefits.
- We may obtain relevant health information from Discovery Health (Pty) Ltd and the Scheme to administer the Vitality Programme.
- We may provide to any credit bureau or credit providers industry association any information relating to your creditworthiness or any consumer credit information including but not limited to credit history, financial history, and judgement or default history in accordance with the requirements of the National Credit Act and Regulations.
- We may communicate any changes in your Vitality policy to you, including any changes in your contributions or any changes/enhancements to the benefits you are entitled to.
- Discovery Vitality (Pty) Ltd and any entity within the Discovery Group as well as contracted third party service providers will keep you updated on information about any offers for new products Discovery may make available at any time. Please contact us if you do not wish to receive any telephonic direct marketing from us.
- You have the right to request a copy of the Personal Information we hold about you. To do this, simply complete the 'Data Subject Request Form' on www.discovery.co.za and specify what information you would like. We will take all reasonable steps to confirm your identity before providing details of your personal information. Please note that any such Data Subject Request may be subject to a payment of a legally allowable fee.
- You have the right to contact and ask us to update, correct or delete your personal information.
- You agree that Discovery Ltd may transfer Your Personal Information outside the borders of the Republic of South Africa if you provide an email address which is hosted outside the borders of South Africa. We may also need to transfer your personal information to another country for processing, storage or academic research. We will ensure that anyone to whom we pass your personal information agrees to treat your information with the same level of protection as we are obliged to.
- You agree that Discovery Ltd may retain Your Personal Information until such time as you request us to destroy them (unless we are obliged by law to retain it, regardless of such request) If Discovery Ltd becomes involved in a proposed or actual merger, acquisition or any form of sale of some or all its assets, we may use and disclose Your Personal Information to third parties in connection with the evaluation of the transaction.
- The surviving company, or the acquiring company in the case of a sale of assets, would have access to Your Personal Information which would continue to be subject to this Notice.
- Discovery Vitality is also required to collect and retain information in terms of the following legislation:
  - The Electronic Communications and Transactions Act (ECT)
  - The Financial Intelligence Centre Act (FICA)
  - The Financial Advisory and Intermediary Services Act (FAIS)
  - The National Credit Act (NCA)
  - The Consumer Protection Act (CPA); amongst others.

Signature of main applicant

5. Vitality rules for membership

Discovery Vitality and KeyFIT are separate from the Scheme and administrator
Discovery Vitality is a separate company from Discovery Health (Pty) Ltd ('the administrator') and the Discovery Health Medical Scheme (referred to as 'the Scheme'). It is formally registered under the name Discovery Vitality (Pty) Ltd, (registration number 1999/007736/07) and takes care of the administration of the Vitality and KeyFIT programmes ('Discovery Vitality'), DiscoveryCard and the DiscoveryCard loyalty programme.

Rules of the Vitality programme
A full set of rules is available on www.discovery.co.za or you can call Discovery Vitality on 0860 99 88 77. In the event of a conflict between what is set out here, on our website and the rules of Vitality, the rules will always apply.

Your contributions to Discovery Vitality are separate
The contributions you pay are for Discovery Vitality and are not part of the contributions you pay to the Scheme.

Cancellation of Vitality membership
Please give notice on the first day of the month if you wish to cancel your Vitality membership in that month. Otherwise, your membership will only end on the last day of the next month. You must be a member of Vitality at the time of the *billing cycle (not the time of the transaction) in order to be eligible for your reward.

*Billing Cycle refers to the date decided by Discovery Vitality, on which your Vitality benefits are calculated on a monthly basis.

When you sign this application to join Vitality, you confirm that you have read and understood the rules for membership and you agree that you and those you apply for will be bound by them.

Signed at (town or city) on 2 0 Y Y M M D D

Signature of main applicant **The main applicant must sign and date any changes**

Application for the Medical Premium Waiver

Discovery Life

Contact us:
Tel: 0860 00 5433, PO Box 3888, Rivonia 2128, www.discovery.co.za

How to complete this application form

The Medical Premium Waiver is a Discovery Life benefit that will pay the Discovery Health Plan and Vitality contributions (if applicable) for a specific period if you die, become disabled or suffer a severe illness according to our claim definitions. If you are the only member on your Discovery Health Plan, the benefit will only pay out on disability and severe illness and not on your death.

Would you prefer Discovery Life to phone you to complete the application for the Medical Premium Waiver? Yes ☐ No ☐

If you selected "No", please complete all sections of the Medical Premium Waiver application. Otherwise please complete Section 1 and sign at the end of Section 7.

Please note: Discovery Life will share your information with Discovery Health (and vice-versa) to facilitate this application process.

1. Client details

1.1 Principal life (this person is also the main member on the Discovery Health Plan)

Surname

First name(s)
(as per identity document)

Initials Title Sex M F Date of birth Y Y Y Y M M D D

ID or passport number
(please include copy of passport)

Preferred language of communication: English ☐ Afrikaans ☐

Have you smoked in the last 12 months? Yes ☐ No ☐

1.2 Beneficiary details, whom the proceeds will be paid to on the death of the principal life (to be nominated by the principal life of the policy).
Please note that beneficiaries can only be dependants on the Discovery Health Plan

Name	Surname	ID number or passport number	Relationship to owner/ purchaser	Add up to 100%

2. Pre-existing condition exclusion and medical questions

Any injury, illness or physical defect that arose prior to the commencement or reinstatement dates of the policy that you suffered from, were aware of, or received medical treatment or advice for (the pre-existing conditions) is specifically excluded. Any injury, illness, physical defect or death arising within three years after the commencement or reinstatement dates of the policy, as a consequence of the pre-existing conditions referred to above will be excluded if such claim would, in the opinion of the medical panel of Discovery Life, have satisfied the criteria for Severity A of the Severe Illness Benefit or Category A of the Capital Disability Benefit or a death claim as the case may be.

Please note: If you answer "Yes" to any of the following questions in this section, you are not eligible for the Medical Premium Waiver.

Have you ever suffered from any of the following conditions? Yes ☐ No ☐

Cancer	Emphysema or chronic obstructive pulmonary disease
Organ transplant	HIV-positive or AIDS
Heart failure or any heart surgery	Diabetes mellitus with any form of complication
Heart attack	Psychiatric disorder (for example schizophrenia or major depression)
Liver disease	Back surgery within the last two years or ongoing severe pain
Kidney failure	Stroke or any chronic neurological disorder (for example multiple sclerosis)
Any lung surgery	Disability (for example quadriplegia, paraplegia, hearing loss, loss of vision, loss of limb or loss of speech)

Do you participate in hazardous pursuits, for example micro-lighting, motor racing? Yes ☐ No ☐

Have you ever been refused cover, offered cover on special terms or received compensation for injury, sickness, dread disease or disability or are there any circumstances that may affect the risk relating to the proposed cover? Yes ☐ No ☐

3. Bank details

Please note: The monthly premiums for the Medical Premium Waiver will be debited from the same bank account as used by Discovery Health to pay for your Discovery Health Plan contributions. If you would like a different bank account to be debited, please insert your bank details below. Please note that, even if you are going to use the same bank account as used by Discovery Health, the accountholder must still sign at the bottom of this section.

Payer details

Is the payer the same person as the policy owner? Yes ☐ No ☐ If **No**, please specify the payer details below:

Surname or registered name of Company/Trust | Initials

First names | Title

Date of birth (Y Y Y Y M M D D) Sex (M F) ID/passport number/registration number

Contact number

Debit order day (monthly payment day)

Do you want the Medical Premium Waiver debit order collection grouped with other collections debited on the same day from the same account details? Yes ☐ No ☐

- It is important that you provide us with the correct banking details from which to collect the premium. Discovery Life will not be legally responsible if you supplied us with incorrect banking details.
- You must inform us if your banking details change.

Accountholder name

Bank name

Branch name | Branch code – – –

Account number (credit cards cannot be accepted) | Account type: Current ☐ Transmission ☐ Savings ☐

I, the undersigned, authorise Discovery Life:

- To debit my bank account for the full recurring premium I accepted on the payment day of each and every month commencing on the policy commencement date. In the event that the payment day falls on a Sunday or a recognised South African public holiday, the payment day will automatically be the very next business day. Further, if there are insufficient funds in the nominated account to meet the obligation, Discovery Life is entitled to track my account and represent the instruction for payment as soon as sufficient funds are available in my account.
- To issue and deliver payment instructions to my bank for collection of my premiums against my above-mentioned account (or any other bank or branch to which I may transfer my account) on condition that the sum of such payment instruction(s) will never exceed my obligations as agreed to in the policy contract. This authority shall endure until I give Discovery Life 20 days written notice of termination.
- To collect all premiums, charges and fees owed and to pay any amounts owed to me into the bank account that I have specified.
- To collect the premiums by debit order on or after the day when the premiums become due (the bank will treat every payment instruction to pay the premiums to Discovery Life as if each payment instruction came from the payer personally).

I agree to advise Discovery Life in writing of any changes that may occur. I know that Discovery Life will not be responsible for any harm or loss that I might suffer because the bank account details are incorrect or if they have changed and Discovery Life has not been notified. I warrant that the information supplied above is true and correct. I agree that I am bound by the payment terms applicable to the policy.

Signature of accountholder | Date signed (Y Y Y Y M M D D)

For additional information, please refer to the "Terms and conditions" section.

4. Premium details

The Medical Premium Waiver premium will be a percentage of your Discovery Health Plan premium. These percentages are displayed in the tables below. If your Discovery Health Plan is an Executive, Comprehensive or Priority Plan you will use the first two tables. If your Discovery Health Plan is a Classic Plan or a Core Plan you will use the second two tables.

The percentage applied depends on:

- your age at your next birthday
- whether you are a smoker or a non-smoker
- whether you have chosen a five year or 10 year benefit term
- if you are the only member of your Discovery Health Plan or whether other members are also included

Based on this information you can look up the percentage to apply to your Discovery Health Plan Premium.

Please select the benefit payment term: Five year ☐ 10 year ☐

Executive, Comprehensive and Priority Plans

Five year benefit payment term				
	Non-Smoker		**Smoker**	
Age bands (age next)	**Only member on Health Plan**	**Member and dependants on Health Plan**	**Only member on Health Plan**	**Member and dependants on Health Plan**
20 - 29	3.0%	2.5%	4.0%	3.5%
30 - 39	3.5%	3.0%	4.5%	4.0%
40 - 44	4.0%	3.5%	6.0%	5.5%
45 - 49	5.0%	4.5%	7.0%	6.5%
50 - 54	6.0%	5.5%	9.5%	9.0%

4. Premium details *(continued)*

10 year benefit payment term				
	Non-Smoker		Smoker	
Age bands (age next)	Only member on Health Plan	Member and dependants on Health Plan	Only member on Health Plan	Member and dependants on Health Plan
20 - 29	5.0%	4.5%	6.5%	6.0%
30 - 39	5.5%	5.0%	7.0%	6.5%
40 - 44	6.5%	6.0%	9.0%	8.5%
45 - 49	8.0%	7.5%	10.5%	10.0%
50 - 54	11.0%	10.5%	17.5%	17.0%

Saver and Core Plans

Five year benefit payment term				
	Non-Smoker		Smoker	
Age bands (age next)	Only member on Health Plan	Member and dependants on Health Plan	Only member on Health Plan	Member and dependants on Health Plan
20 - 29	3.25%	2.75%	4.5%	4.0%
30 - 39	3.75%	3.25%	5.0%	4.5%
40 - 44	4.25%	3.75%	6.5%	6.0%
45 - 49	5.5%	5.0%	7.5%	7.0%
50 - 54	6.5%	6.0%	10.0%	9.5%

Ten year benefit payment term				
	Non-Smoker		Smoker	
Age bands (age next)	Only member on Health Plan	Member and dependants on Health Plan	Only member on Health Plan	Member and dependants on Health Plan
20 - 29	5.5%	5.0%	7.0%	6.5%
30 - 39	6.0%	5.5%	7.5%	7.0%
40 - 44	7.0%	6.5%	10.0%	9.5%
45 - 49	8.5%	8.0%	11.5%	11.0%
50 - 54	11.5%	11%	18.5%	18.0%

Please note that the benefit will increase in line with the Discovery Health Medical Scheme premium increases. The Medical Premium Waiver premium will increase in line with Discovery Health Medical Scheme premium increases as well as an additional increase based on your age.

Commission will be paid to your financial adviser on the premium calculated above. The commission is regulated by law and initial commission will not be more than 85% of the first annual premium. The cost of commission is included in the premium. Future increases in premium that are not as a result of the contractual increase at policy anniversary will result in extra commission being paid.

5. Replacement of an existing policy

Important note: replacement of any insurance may be to the disadvantage of the proposer

Is this proposal to replace the whole or any part of your existing insurance with any assurer (whether replacement is to occur immediately or to replace an insurance discontinued within the past four months or within the next four months)? Yes ☐ No ☐

If "Yes", the financial adviser must discuss and complete the Replacement Policy Advice Record and attach it to this proposal form.

Does this proposal constitute replacement of an investment policy with a recurring premium investment or risk policy that will lead or has lead to the levying/deduction of a termination charge (causal event charges and administrative charges) of more than 15% of the replaced policy's fund value? Refer to the definitions in Part 3 of the Regulations to the Long-Term Insurance Act, 1998 (commission regulations). **(Not required if replacement policy effected as a result of the internet, telephone or direct marketing).** Yes ☐ No ☐

6. Financial adviser details

Please note: Your financial adviser for the Medical Premium Waiver must be the same as for your Discovery Health Plan and must be accredited to sell Discovery Life products.

7. Permission to process and disclose certain information and to communicate with you

7.1 Key terms used

- "You" and "your" refer to the policy owner and to the lives to be assured set out in this application form.
- "We", "us" and "our" refer to Discovery Life Limited, a public company with limited liability registered under the company laws of the Republic of South Africa, registration number 1966/003901/06. The principal place of business is 155 West Street, Sandton, Johannesburg, 2196.

7.2 We will assess your application and let you know the results of our assessment. We may do one of the following:

- Accept your application as it is; or
- Not accept your application; or
- Ask for more information about your health condition(s).

7.3 Your cover only starts when:

- we write to let you know, and
- your Discovery Health membership has been activated or confirmed (as the case may be), and
- after we have received the first premium on the date it is due or if acceptable arrangements have been made for the collection thereof.

As a result, the debit order process will be as follows:

- If the debit order date lies between the date of the Discovery Health Plan becoming active and the first of the following month, and where the Medical Premium Waiver application is processed and accepted before the 26th of the month, one premium will be charged on the debit order date in this month, for the coming month.

7. Permission to process and disclose certain information and to communicate with you *(continued)*

- Otherwise, a double debit will occur on the debit order date in the coming month to pay for the first two months of cover.

We will email your welcome pack (policy schedule and policy guide) to you. It is your responsibility to ensure that this product meets your financial needs. You may request a copy of any documentation that has been given to us during this application.

7.4 You give us permission to obtain your health and other information

To assess the risk of insuring you for cover, as well as to administer your policy and consider any claims you make, we need certain information. The information we may need includes information about your identity (including personal and contact details), health (including HIV status) and lifestyle.

By signing this application form, you authorise Discovery Life to do all of the following:

- Obtain this information about you from anyone, including Discovery Health, Discovery Health Medical Scheme and Discovery Vitality (Pty) Ltd, and any person, which could be any doctor you have consulted with. You also authorise and instruct the person with the information to give the information to Discovery Life.
- Share this and any other information in this application or in any related document with other assurers. The authority extends to sharing direct with an assurer and through any database for assurers. It may be at any time (even after your death). It may be in any form that we decide on, including detailed, abbreviated or coded forms.
- Give your financial adviser the policy information necessary to ensure the efficient administration of your policy and to ensure that we comply with all relevant legislation.

You acknowledge that this authorisation cannot be withdrawn or cancelled and that it will continue after your death.

7.5 You agree to tell us about any factors that may affect your premium while this policy remains in force

You must tell us immediately about any factors that may affect the premiums you pay. If you do not give us this information immediately, we are entitled to adjust your premiums and we may refuse to pay a claim.

7.5.1 Using tobacco: You must tell us immediately if you have started using tobacco again (for example, smoking, chewing, snuffing, etc) if you are paying premiums as if you were a non-smoker.

7.5.2 Hazardous activities: You must tell us immediately if you intend to take part in any hazardous activities. Examples of hazardous activities include scuba diving, parachuting, paragliding, motocross, etc.

7.6 If someone else pays the premiums

If someone other than you pays the premiums on your policy, you confirm that you have obtained their permission to do so. On behalf of that person, you give us permission to obtain any information relating to him or her from any one or more of the following:

- Any credit bureau;
- Any Life assurance or credit providers industry association;
- Any other association of an industry in which we operate.

This includes information related to that premium payer's creditworthiness, credit history, financial history, personal information, judgement history and default history. It is your responsibility to verify the banking details of the premium payer, for example by giving us a cancelled cheque, a bank letter or a copy of a bank statement.

7.7 You agree to receive communications electronically

You agree that we may communicate electronically in all correspondence with you. If we don't have a direct email address, we will post the correspondence to you.

7.8 Permission to process and disclose certain information and to communicate with you (we will keep your information and the information about those you apply for confidential)

7.8.1 I hereby consent to the collection, collation, processing, storage and disclosure of the information contained in all sections of this application form for any purpose relating to this and any information that is provided by me to any entity within the Discovery Group after date of this application for the purpose of:

7.8.1.1 administering this agreement and for the assessment of any claim(s) under this policy; and

7.8.1.2 enabling any entity within the Discovery Group of companies, any approved (by Discovery) third party provider, and any approved (by Discovery) financial services provider or its representative to advise me of or offer to me any enhanced benefits or new products which become available from time to time for which I may become entitled to or qualify for; and

7.8.1.3 providing relevant information to a contracted third party who requires such information to render a service to me in relation to this agreement, provided that such contracted third party agrees to keep the information confidential.

7.8.2 I confirm that when I provide Discovery with personal information about any dependent or beneficiary on this agreement, they have provided me with the appropriate permission to disclose that information to Discovery. This includes their consent for the administration and the assessment of any claim(s) under this policy, the provision of any services to them as required and the provision of relevant information to a contracted third party who requires such information to render a service to them in respect of this policy.

7.8.3 I also confirm that my personal and health information may be provided to any other entity within the Discovery Group where I or my dependant/s already have a relationship with or where I or my dependant/s have applied for a product or benefit. This information will be provided for the administration of me or my dependant/s products or benefits.

7.9 Warranty

7.9.1 I have read and understood the contents of this application form.

7.9.2 I agree to be bound by the terms and conditions of this application form, the Medical Premium Waiver Policy Guide, the policy schedule, and any servicing alteration requests, which read together, make up the contract.

7.9.3 Commissions have been explained to me by my appointed financial adviser.

7.9.4 I confirm that, to the extent that Discovery is not my appointed financial adviser, Discovery has not advised me, and as such are not responsible for any choices I have made.

7.9.5 By signing this application form, I consent to and authorise Discovery Life to do all of the following:

- View, store, access and process all the information contained in your Discovery Health Application form for the purposes of processing my Medical Premium Waiver application.

I acknowledge that this authorisation cannot be withdrawn or cancelled and that failure to provide this authorisation will result in Discovery Life being unable to accept this application for the Medical Premium Waiver product.

7.9.6 I acknowledge that Discovery will not be responsible for any failure, malfunction or delay of any networks or electronic or mechanical device or any other form of communication used in the submission, acceptance and processing of applications and/or transactions. It is my responsibility to ensure that this application form, any instructions that are part of the application form and subsequent instructions submitted electronically by fax or email to Discovery, have been received by Discovery. I acknowledge that Discovery does not consider a fax confirmation or printed copy of a sent email as proof of receiving the document or instruction.

7.9.7 I warrant that I have disclosed all material information to Discovery.

7.9.8 I understand that if I breach the warranty contained in 7.8.7 above, Discovery can declare the benefits issued to me void and I will forfeit any contributions paid.

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

Signature of principal life