

Application to add dependants in 2010

Thank you for deciding to apply to add your dependant to your membership of the Discovery Health Medical Scheme. This document is an application form for membership.

It also contains some rules for membership. Please make sure you read and understand the rules.

What you must do

Please go through these steps:

Step 1: Fill in the form in black ink, using one letter per block. Please print clearly.

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

Step 3: Sign section 8.

Step 4: Please make sure the main applicant signs and dates any changes.

Step 5: Fax the completed and signed form to **011 539 3000** or email it to **application@discovery.co.za**

Step 6: Please attach a copy of each applicant's identity document to this application form. We also accept valid passports and birth certificates for children.

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

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

1. Main member details

Membership number

Surname

First name(s) (as per identity document)

ID or passport number Country of issue

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

PO Box Private Bag Box number

Suite Postnet Suite Number

Suburb Postal code

Physical address

Suite/Unit number Complex name

Street number Street name

Suburb Postal code

Telephone (H) (W)

Cellphone Fax

Email

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

4. Your employer warranty (additions to employer groups need to be signed by the HR or payroll contact)

Please ensure your employer completes this warranty if the member falls under an employer group.

1. We warrant that the member detailed in section 1 of this application form is an employee of our organisation.
2. The Scheme may bill us for the amount due for this dependant in the same manner as for other employees with the Scheme.

Authorised signatory(ies) 1. 2.

Name(s)

Designation(s)

5. Please select your GP (if you are joining a KeyCare Plus Plan)

	Name	GP name	Practice number	Second GP name*	Practice number
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 2 and 3 of this form.

Please note: you can only access day-to-day cover and chronic benefits through the KeyCare general practitioner(s) you chose above.

6. 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.

Spouse or partner

Scheme name	Membership number	Start date	Are you still a member?	End date if you have already resigned	Reason for leaving						
						Y	Y	M	M	D	D
			Yes <input type="checkbox"/> No <input type="checkbox"/>								
			Yes <input type="checkbox"/> No <input type="checkbox"/>								
			Yes <input type="checkbox"/> No <input type="checkbox"/>								
			Yes <input type="checkbox"/> No <input type="checkbox"/>								

Dependant name 1

Scheme name	Membership number	Start date	Are you still a member?	End date if you have already resigned	Reason for leaving						
						Y	Y	M	M	D	D
			Yes <input type="checkbox"/> No <input type="checkbox"/>								
			Yes <input type="checkbox"/> No <input type="checkbox"/>								
			Yes <input type="checkbox"/> No <input type="checkbox"/>								
			Yes <input type="checkbox"/> No <input type="checkbox"/>								

Dependant name 2

Scheme name	Membership number	Start date	Are you still a member?	End date if you have already resigned	Reason for leaving						
						Y	Y	M	M	D	D
			Yes <input type="checkbox"/> No <input type="checkbox"/>								
			Yes <input type="checkbox"/> No <input type="checkbox"/>								
			Yes <input type="checkbox"/> No <input type="checkbox"/>								
			Yes <input type="checkbox"/> No <input type="checkbox"/>								

Dependant name 3

Scheme name	Membership number	Start date	Are you still a member?	End date if you have already resigned	Reason for leaving						
						Y	Y	M	M	D	D
			Yes <input type="checkbox"/> No <input type="checkbox"/>								
			Yes <input type="checkbox"/> No <input type="checkbox"/>								
			Yes <input type="checkbox"/> No <input type="checkbox"/>								
			Yes <input type="checkbox"/> No <input type="checkbox"/>								

7. Your medical questions

7.A Only the spouse or partner and any adult dependant applying for cover need to complete Section 7.A.

Spouse or partner

How tall are you? . metres

How much do you weigh? kilograms

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?

Adult 1 (any dependant 21 years or older)

How tall are you? . metres

How much do you weigh? kilograms

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?

Adult 2 (any dependant 21 years or older)

How tall are you? . metres

How much do you weigh? kilograms

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?

7.B 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?

7.1 Cancer Yes No

Example: any form of cancer or pre-cancerous growths.

	Name:	Name:
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

7.2 Heart and circulation conditions Yes No

Example: angina, chest pain, heart failure, murmurs, rheumatic fever, high blood pressure, heart attack, raised cholesterol, previous heart surgery or palpitations.

	Name:	Name:
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

7. Your medical questions (continued)

7.3 Gynaecological conditions Yes No

Example: ovarian cysts, endometriosis, fibroids, cervical disorders, menstrual disorders or pregnancy.

	Name:								Name:							
Medical diagnosis																
Date first diagnosed	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
Date of last symptoms, consultation or hospitalisation	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
Medicines used for this condition and dosage																
Date last taken	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
Currently on treatment for this condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>								Yes <input type="checkbox"/> No <input type="checkbox"/>							

7.4 Mental health Yes No

Example: depression, anxiety, schizophrenia or bipolar disorder.

	Name:								Name:							
Medical diagnosis																
Date first diagnosed	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
Date of last symptoms, consultation or hospitalisation	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
Medicines used for this condition and dosage																
Date last taken	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
Currently on treatment for this condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>								Yes <input type="checkbox"/> No <input type="checkbox"/>							

7.5 Metabolic or endocrine conditions Yes No

Example: diabetes, thyroid disorders, growth disorders, Cushing's disease or Addison's disease.

	Name:								Name:							
Medical diagnosis																
Date first diagnosed	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
Date of last symptoms, consultation or hospitalisation	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
Medicines used for this condition and dosage																
Date last taken	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
Currently on treatment for this condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>								Yes <input type="checkbox"/> No <input type="checkbox"/>							

7.6 Liver or pancreatic conditions Yes No

Example: hepatitis, cirrhosis, liver failure, gallstones or pancreatitis.

	Name:								Name:							
Medical diagnosis																
Date first diagnosed	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
Date of last symptoms, consultation or hospitalisation	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
Medicines used for this condition and dosage																
Date last taken	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
Currently on treatment for this condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>								Yes <input type="checkbox"/> No <input type="checkbox"/>							

7.7 Gastrointestinal conditions Yes No

Example: Crohn's disease, ulcerative colitis or bleeding ulcers.

	Name:								Name:							
Medical diagnosis																
Date first diagnosed	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
Date of last symptoms, consultation or hospitalisation	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
Medicines used for this condition and dosage																
Date last taken	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
Currently on treatment for this condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>								Yes <input type="checkbox"/> No <input type="checkbox"/>							

7. Your medical questions (continued)

7.8 Brain and nerve conditions Yes No

Example: stroke, multiple sclerosis, epilepsy, migraine, Parkinson's disease, quadriplegia, paraplegia or cerebral palsy.

	Name:	Name:
Medical diagnosis		
Date first diagnosed	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Date of last symptoms, consultation or hospitalisation	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Medicines used for this condition and dosage		
Date last taken	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Currently on treatment for this condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

7.9 Respiratory conditions Yes No

Example: asthma, emphysema, chronic bronchitis, shortness of breath, persistent cough, cystic fibrosis, chronic obstructive airways disease, any lung surgery or coughing up of blood.

	Name:	Name:
Medical diagnosis		
Date first diagnosed	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Date of last symptoms, consultation or hospitalisation	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Medicines used for this condition and dosage		
Date last taken	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Currently on treatment for this condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

7.10 Musculoskeletal conditions Yes No

Example: rheumatoid arthritis, osteoarthritis, myasthenia gravis, gout, osteoporosis, loss of limb, back problems and operations, slipped disk, back pain or any other conditions.

	Name:	Name:
Medical diagnosis		
Date first diagnosed	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Date of last symptoms, consultation or hospitalisation	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Medicines used for this condition and dosage		
Date last taken	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Currently on treatment for this condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

7.11 Kidney or urinary tract conditions Yes No

Example: kidney failure, kidney stones, recurrent infections, nephritis, prostate problems, blood or protein in urine or polycystic kidneys.

	Name:	Name:
Medical diagnosis		
Date first diagnosed	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Date of last symptoms, consultation or hospitalisation	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Medicines used for this condition and dosage		
Date last taken	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Currently on treatment for this condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

7.12 Blood conditions Yes No

Example: anaemia, leukaemia, bleeding disorders, haemophilia, lymphoma, deep vein thrombosis (blood clots) or pulmonary embolus.

	Name:	Name:
Medical diagnosis		
Date first diagnosed	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Date of last symptoms, consultation or hospitalisation	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Medicines used for this condition and dosage		
Date last taken	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Currently on treatment for this condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

7. Your medical questions (continued)

7.13 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

	Name:	Name:
Medical diagnosis		
Date first diagnosed	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Date of last symptoms, consultation or hospitalisation	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Medicines used for this condition and dosage		
Date last taken	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Currently on treatment for this condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

	Name:	Name:
Symptom or condition		
Date first diagnosed (if applicable)	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Date of last symptoms, consultation or hospitalisation	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Medicines used for this condition and dosage		
Date last taken	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Currently on treatment for this condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

7.15 Have you or any of your dependants received medical advice or treatment from a medical professional in the 12 months before this application? Yes No

	Name:	Name:
Symptom or condition		
Date first diagnosed (if applicable)	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Date of last symptoms, consultation or hospitalisation	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Medicines used for this condition and dosage		
Date last taken	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>	Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/>
Currently on treatment for this condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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 100 417** 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.

When you call to register on the HIV Care Programme, please confirm these details.

8. Rules for membership

8.1 Rules for membership

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

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

8.2 Who you are applying for

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

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

8.3 Acting for others

You confirm you have the right to act for others

By signing this document, you confirm that:

- you have the right to apply for membership and to act for those you apply for in any matter relating to this application.
- you have received permission from your spouse and any dependants over 21 to act for them in any matter relating to this application.

8.4 Giving information

You must give us true, correct and complete information

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

Information about you and those you apply for must be true, correct and complete. This includes the details you give in this application form and in future dealings with us. It is important that you tell us about any medical condition, symptom or illness relating to you or those you apply for, even if you do not consider it relevant to your application.

We may ask those you apply for who are 21 and older for information and it will be treated as if we had asked you in your role as main member.

