

2. About yourself (main applicant) (continued)

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

Physical address:

Suite/Unit number	<input type="text"/>	Complex name	<input type="text"/>
Street number	<input type="text"/>	Street name	<input type="text"/>
Suburb	<input type="text"/>	Postal code	<input type="text"/>
Occupation	<input type="text"/>	Tax number	<input type="text"/>

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

Title	<input type="text"/>	Initials	<input type="text"/>	Surname	<input type="text"/>
First name(s) (as per identity document)	<input type="text"/>				
Preferred name	<input type="text"/>	Sex	<input type="text"/>	Date of birth	<input type="text"/>
Previous or maiden name	<input type="text"/>				
ID or passport number	<input type="text"/>	Country of issue	<input type="text"/>		
Telephone (H)	<input type="text"/>		(W)	<input type="text"/>	<input type="text"/>
Cellphone	<input type="text"/>		Tax number	<input type="text"/>	
Email	<input type="text"/>				

4. About your dependants (if applying for cover)

Dependant 1

Title	<input type="text"/>	Initials	<input type="text"/>	Surname	<input type="text"/>
First name(s) (as per identity document)	<input type="text"/>				
Preferred name	<input type="text"/>	Sex	<input type="text"/>	Date of birth	<input type="text"/>
Relationship to main member	<small>(for example, mother, child. Where your child is not your biological child, please state relationship, for example adopted child, foster child. Please supply legal proof)</small> <input type="text"/>				
ID or passport number	<input type="text"/>	Country of issue	<input type="text"/>		
Is your dependant: married?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	financially dependent on you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			disabled?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			a full-time student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your dependant earn an income?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How much does your dependant earn each month?	R	<input type="text"/>

Dependant 2

Title	<input type="text"/>	Initials	<input type="text"/>	Surname	<input type="text"/>
First name(s) (as per identity document)	<input type="text"/>				
Preferred name	<input type="text"/>	Sex	<input type="text"/>	Date of birth	<input type="text"/>
Relationship to main member	<small>(for example, mother, child. Where your child is not your biological child, please state relationship, for example adopted child, foster child. Please supply legal proof)</small> <input type="text"/>				
ID or passport number	<input type="text"/>	Country of issue	<input type="text"/>		
Is your dependant: married?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	financially dependent on you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			disabled?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			a full-time student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your dependant earn an income?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How much does your dependant earn each month?	R	<input type="text"/>

Dependant 3

Title	<input type="text"/>	Initials	<input type="text"/>	Surname	<input type="text"/>
First name(s) (as per identity document)	<input type="text"/>				
Preferred name	<input type="text"/>	Sex	<input type="text"/>	Date of birth	<input type="text"/>
Relationship to main member	<small>(for example, mother, child. Where your child is not your biological child, please state relationship, for example adopted child, foster child. Please supply legal proof)</small> <input type="text"/>				
ID or passport number	<input type="text"/>	Country of issue	<input type="text"/>		
Is your dependant: married?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	financially dependent on you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			disabled?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			a full-time student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your dependant earn an income?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How much does your dependant earn each month?	R	<input type="text"/>

5. Your financial adviser's details

Financial adviser's name Code

Intermediary house Code

Financial adviser's telephone number (W) Lead number

Email

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

I declare that:

- 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.
- I am appointed by the client to provide advice about this application.
- I have a valid contract with the Scheme and I have made the client aware of the commission payable by Discovery Health Medical Scheme.
- 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.
- I am accountable for any advice given to the member about completion of this application form and joining the Scheme.

Financial adviser's signature

6. Please select your health plan

Executive Plan	Comprehensive Plans	Priority Plans	Saver Plans	Core Plans	KeyCare Plans
<input type="checkbox"/> Executive	<input type="checkbox"/> Classic <input type="checkbox"/> Classic Delta <input type="checkbox"/> Essential <input type="checkbox"/> Essential Delta	<input type="checkbox"/> Classic <input type="checkbox"/> Essential	<input type="checkbox"/> Classic <input type="checkbox"/> Classic Delta <input type="checkbox"/> Essential <input type="checkbox"/> Essential Delta <input type="checkbox"/> Coastal	<input type="checkbox"/> Classic <input type="checkbox"/> Classic Delta <input type="checkbox"/> Essential <input type="checkbox"/> Essential Delta <input type="checkbox"/> Coastal	<input type="checkbox"/> KeyCare Plus <input type="checkbox"/> KeyCare Core

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.

Please complete this if you selected a KeyCare Plan:

If you have selected a KeyCare Plan, we calculate your contributions using the higher of the total cost to company of the main member or spouse or partner. Total cost to company includes guaranteed earnings, guaranteed allowances, company contributions and variable pay or commissions. We do not take bonuses, for example annual 13th cheques and once-off bonuses into account. Please give us proof of income. We may ask you for updated proof of income each year.

If you don't give us proof of income, we will place you in the highest income band.

Main member R (total monthly cost to company)

Spouse or partner R (total monthly cost to company)

Please complete this if you have selected the KeyCare Plus 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 4 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.

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

(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 together with an employer application form:

Employer warranty

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

Authorised signatory(ies) 1. 2.

Name(s)

Designation(s)

9. Previous medical scheme details (continued)

Dependant name															
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"/>	Y	Y	M	M	D	D	
		Y	Y	M	M	D	D	Yes <input type="checkbox"/> No <input type="checkbox"/>	Y	Y	M	M	D	D	
		Y	Y	M	M	D	D	Yes <input type="checkbox"/> No <input type="checkbox"/>	Y	Y	M	M	D	D	
		Y	Y	M	M	D	D	Yes <input type="checkbox"/> No <input type="checkbox"/>	Y	Y	M	M	D	D	

Dependant name															
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"/>	Y	Y	M	M	D	D	
		Y	Y	M	M	D	D	Yes <input type="checkbox"/> No <input type="checkbox"/>	Y	Y	M	M	D	D	
		Y	Y	M	M	D	D	Yes <input type="checkbox"/> No <input type="checkbox"/>	Y	Y	M	M	D	D	
		Y	Y	M	M	D	D	Yes <input type="checkbox"/> No <input type="checkbox"/>	Y	Y	M	M	D	D	

10. Moving from another medical scheme

Please make sure that you have completed section 9.

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

10.1 I confirm that all people named on this application:

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

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

If you answered **no** in **10.1** you must complete **section 11**.

10.2 For any person named on this application form:

- Have they been admitted to hospital in the 12 months before this application? Yes No
- Are they currently taking regular medicine or reasonably expecting to need medicine where the treatment costs more than R200 a month? Yes No
- Are they 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.

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

If you feel that a three-month general waiting period should not be applied and you want to give us more information, complete section 11.

11. Your medical questions

A. Only the main applicant, spouse or partner and any adult dependant applying for cover need to complete section 11.A.

Main applicant

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?

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?

11. Your medical questions (continued)

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?

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?

11.1 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"/>

11.2 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"/>

11.3 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"/>

11. Your medical questions (continued)

11.4 Mental health Yes No

Example: depression, anxiety, schizophrenia or bipolar disorder.

	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"/>

11.5 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 <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"/>

11.6 Liver or pancreatic conditions Yes No

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

	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"/>

11.7 Gastrointestinal conditions Yes No

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

	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"/>

11.8 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"/>

11. Your medical questions (continued)

11.9 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"/>

11.10 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"/>

11.11 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"/>

11.12 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"/>

11. Your medical questions (continued)

11.13 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 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"/>

11.14 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 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"/>

11.15 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 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"/>

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 HIVCare Programme. A 12-month condition specific waiting period may apply to this condition.

When you call in to register on the HIVCare Programme, please confirm these details.

12. Rules for membership

12.1 Rules for membership

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

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

12.2 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.

12.3 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.

12. Rules for membership (continued)

12.4 Giving information

You must give us true, correct and complete information

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

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

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

We may get information from other relevant sources

To consider an application for membership or a claim for medical expenses, you agree that we and the Scheme can get information about you and those you apply for from other relevant sources, including any entity that is part of Discovery Holdings Limited, medical practitioners, financial advisers, credit bureaus or industry regulatory bodies. We and the Scheme may verify on an ongoing basis, with the parties mentioned in this section, that the information you give on this application is true, correct and complete as long as your membership of the Scheme is active.

I give my permission that the Scheme may get any information that is relevant to my application from my employer. This permission ends on the day that my cover with the Scheme starts.

Tell us about changes right away

If any of the information you gave to us changes between the day you sign this document and the day your membership starts, you must tell us in writing what the changes are. This includes information about your health and the health of those you apply for.

When the Scheme may cancel

The Scheme may cancel any memberships immediately and keep any contributions paid, if you and those you apply for:

- do not give us information that later turns out to be relevant to this application.
- give us any information that is not true, correct and complete.
- do not tell us about any relevant changes (including about your health and the health of those you apply for) between the day you sign this document and the day cover starts.

12.5 Sharing information and confidentiality

When we may share your information

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

1. The information:

- is needed only to administer the Scheme and any claims; or
- is requested by a party who you have already given your consent to for the disclosure of this information.

2. The party that we and the Scheme 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 and the Scheme may record calls

We and the Scheme may record telephone conversations with you and with those you apply for.

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

12.6 About becoming a member

We will consider your application

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

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

We might not pay for certain expenses immediately

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

Resign from current medical schemes when accepted

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

You must ensure contributions are paid on time

As the main member of the Scheme, you are responsible for ensuring that your contributions and the contributions of those you apply for are paid on time every month.

12.7 Repaying medical savings if you leave

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

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

Signed at (town or city) on

Signature of main applicant

The main applicant must sign and date any changes

13. What happens next with your application

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

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

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

Application to join Vitality and KeyClub

Please make sure that you sign this application

Main applicant's surname

Main applicant's ID number

Please choose one of the following options:

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

*KeyClub Starter is available to main members under age 65 on a KeyCare Plan, who are not in the highest income band.

Banking details

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

Signature of accountholder Signature of main applicant

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

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 application is captured after the date you chose above, your first debit order will go off on the first of the month and then on the chosen date after that.

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

The Discovery credit card

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 Discovery credit card? Yes No Gross monthly salary R

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 subject to meeting credit approval criteria.

