Application to change the main member on the Discovery Health Medical Scheme 2017

Broker House Name: Aon South Africa (Pty) Ltd

Broker House Code: 1004785125

Broker Code: 1020031108

Contact us

Tel (Members): 0860 99 88 77, Tel (Health partner): 0860 44 55 66, PO Box 784262, Sandton, 2146, www.discovery.co.za

Who we are

The Discovery Health Medical Scheme (referred to as 'the Scheme'), registration number 1125, is the medical scheme. This is a non-profit organisation, registered with the Council for Medical Schemes and administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider.

This document is an application form to change the main member on an existing Discovery Health Medical Scheme 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 three steps:

Step 1: Fill in the form

Step 2: Read and understand the rules for membership

Step 3: Sign section 7 and 8.

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 what will happen next.

How to complete this application form

- This form must be completed by the person applying to be the main member.
- Please complete with black ink and print clearly.
- To avoid administrative delays, please ensure this application is completed in full.
- Once completed, please email to **healthinfo@discovery.co.za**

1. About your employer

Employer name _____ Date of employment Y Y Y Y M M D D

Employee number _____

Branch name _____ Branch number _____

2. About the new main member

Date membership of new main member starts Y Y Y Y M M D D Membership number _____

Title _____ Initials _____ Surname _____

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

Preferred name _____ Sex ☐ M ☐ F Date of birth Y Y Y Y M M D D

Marital status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Previous or maiden name (where applicable) _____

Tax number _____ Occupation _____

Total monthly earnings R _____

ID or passport number _____ Country of issue _____

Telephone (H) _____ _____ Telephone (W) _____ _____

Cellphone _____ _____ Fax _____

Email _____

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

☐ PO Box ☐ Private Bag Box number _____

☐ Suite ☐ Postnet Suite 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 _____

Occupation _____ Tax number _____

3. If you have a KeyCare Plan

Income verification will be conducted for the lower income bands. Income is considered as: The higher of the main member's or registered spouse or partner'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; receipt of any financial assistance in terms of any statutory social assistance programme.

IMPORTANT NOTICE:

Declaring income lower than your actual income constitutes fraud. This will lead to the termination of your membership and criminal charges may be brought against you.

By signing this application form, you give your permission to verify your declared income using all relevant internal and external sources, as per 8.3.

	Main member	Spouse or partner
Total earning over the last 12 months	**R**	**R**
Occupation		

I declare that this income declaration is true and accurate.

Signature of main applicant _____

If the highest earner earns less than R137 000 each year, please provide the following supporting documents as proof of income:

3.1. Last 3 months' bank statements; and
3.2. If employed, your last 3 months' payslips and commission schedules, or most recent tax year's IRP5 certificate
3.3. If student, proof of enrolment at academic institution
3.4. If self-employed, most current financial statements
3.5. If pensioner, proof of annuity or employer pension or state older person's grant
3.6. If unemployed, UIF certificate.

Please complete this if you have a KeyCare Plus or KeyCare Access Plan. Please select a GP on the KeyCare GP Network.

	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 our records.

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

4. Details of previous main member (if applying for cover)

If you need to change the main member due to the death of the previous main member, please attach a certified copy of the death certificate.

Title _____ Initials _____ Surname _____

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

Preferred name _____ Sex ☐ M ☐ F Date of birth Y Y Y Y M M D D

Marital status ☐ Married ☐ Single ☐ Divorced ☐ Widowed Preferred language ☐ English ☐ Afrikaans

ID or passport number _____ Country of issue _____

Telephone (H) _____ _____ Telephone (W) _____ _____

Cellphone _____ _____ Fax _____

Email _____

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

Are you financially dependent on the new main member? ☐ Yes ☐ No

Please specify your monthly income R _____

Are you disabled? ☐ Yes ☐ No Are you a full-time student? ☐ Yes ☐ No

5. Your banking details

5.1. **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 Accountholder _____

Your banking details *(continued)*

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 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.

Signature of accountholder _____

5.2. **Your claims refund**

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

Please attach a copy of ID and original bank statement or letter of confirmation from the bank for all claims refund banking details whether different to contributions banking details or not. 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 Accountholder _____

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

6. Your financial adviser's details (if you are appointing a new financial adviser)

Financial adviser's name _____ Code _____

Intermediary house _____ Code _____

Financial adviser's contact details:

Telephone (H) _____ _____ Cellphone _____ _____

Lead number _____

Email _____

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

Declaration

I declare that:

6.1. I am an accredited financial adviser in terms of the Medical Schemes Act and licensed by the Financial Services Board in terms of the Financial Advisory and Intermediary Services Act at the date of signing this application form.

6.2. I am appointed by the client to provide advice about this application.

6.3. 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.

6.4. I am responsible for providing the applicant with:

6.4.1. my name, physical address, postal address and telephone number

6.4.2. impartial advice that is in his or her best interest.

6.5. I am accountable for any advice given to the member about completion of this application form and joining Discovery Health Medical Scheme.

6.6. I will abide by the Financial Services Board's license requirements and the Code of Conduct.

Financial advisor's signature _____

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

7.1. 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 ("POPI").

7.2. 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.

7.3. Please note:

7.3.1. We may amend this Notice from time to time. Please check our website periodically to inform yourself of any changes;

7.3.2. You have the right to object to the processing of your Personal Information;

7.3.3. If you believe that we have used your personal information contrary to applicable law, you must first attempt to resolve any concerns with us in terms of our complaints or disputes process. If you are not satisfied with such process, you have the right to lodge a complaint with the Information Regulator, under POPI.

7.4. Discovery Health Medical Scheme and the administrator (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. In the event of you providing information and signing consent on behalf of a minor (person younger than 18 years old) you confirm that you are a competent person and authorised to do so on their behalf.

7.5. You agree to us processing and disclosing your Personal Information in the following manner:
We may collect, collate, process, store and disclose your Personal Information:

7.5.1. For the administration of your health plan;

7.5.2. For providing managed care services to you or any dependant/s on your health plan;

7.5.3. 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;

7.5.4. To profile and analyse risk;

7.5.5. 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:

7.5.6. Sharing your Personal Information with your chosen financial adviser during the application process to help the administrator, if necessary, while we process your membership application;

7.5.7. Getting your Personal Information from other relevant sources, including medical practitioners, contracted service providers, financial advisers, credit bureaus, entities that are part of Discovery Limited 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;

7.5.8. 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;

7.5.9. 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;

7.5.10. 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;

7.5.11. 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.

7.6. 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.

7.7. 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.

7.8. 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.

7.9. 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.

7.10. If we want to share your information for any other reason, we will do so only with your permission.

7.11. 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.

7.12. You have the right to contact and ask us to update, correct or delete your Personal Information.

7.13. 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).

7.14. If the Scheme, the administrator or Discovery (Ltd), as the holding company of the administrator, 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.

7.15. Discovery Health Medical Scheme and the administrator are required to collect and retain information in terms of the following legislation (amongst others):

7.15.1. The Medical Schemes Act, 1998

7.15.2. The Consumer Protection Act, 2008

7.15.3. The Protection of Personal Information Act, 2013

7.15.4. Electronic Communications and Transactions Act, 2002

7.15.5. Promotion of Access to Information Act, 2000 Legislation specific to the administrator only:

7.15.6. Financial Advisory and Intermediary Services Act, 2002.

Signature of main applicant _____ ⚠ Please do not sign incomplete forms.

8. Rules for membership

8.1. **Who "we" are**

Discovery Health Medical Scheme, registration no 1125, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, the administrator and managed care organisation for Discovery Health Medical Scheme, an authorised financial services provider and a subsidiary of Discovery Limited.

8.2. **Rules for membership**

Rules of the Discovery Health Medical Scheme records the 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 all matters relating to this application and your membership of the Discovery Health Medical Scheme. Please speak to your financial adviser or us if there is anything you do not understand.

8.3. **Acting for others**

You understand that you take over the rights and responsibilities of the main member and become the main member yourself.

By signing this document, you confirm that:

8.3.1. you have received permission from your spouse and any dependants over 18 to act for them in any matter relating to this application.

8.4. **Giving information**

You agree to always give the Scheme true, correct and complete information.

We may get information 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 we and the 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 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 permission that the Discovery Health Medical Scheme may get any information that is relevant to your application from your employer.

8.5. **About becoming a main member**

You must ensure contributions are paid on time

As the new main member of the Scheme, you will now become responsible for ensuring that the contributions are paid on time every month.

Transfer of rights

When you take over the rights and responsibilities of the main member, you agree to become responsible for any debts that the previous main member may have incurred resulting from their membership of the Discovery Health Medical Scheme. By using your Medical Savings Account, you may incur certain debts or responsibilities that you will be responsible for if you end your membership with the Scheme.

If you are taking over the rights of the main member because of the death of the previous main member, these terms and conditions will apply similarly to you. Neither Discovery Health (Pty) Ltd nor the Discovery Health Medical Scheme will be responsible for any aspects relating to the deceased estate of the previous main member. By signing this application, you indemnify us against any claims from any third party resulting from the administration of the estate. This means that you agree to pay any amounts that the law says we must pay to a third party resulting from the administration of the estate.

We may record calls

We do record telephone conversations with you and with those you apply for.

The recordings will be processed and stored as required by law.

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

Signature of main applicant _____ Signature of previous main member* _____

⚠ Please do not sign incomplete forms.

* If the previous main member's signature cannot be obtained, please state the reason.

_____

_____

Discovery Health Medical Scheme is a registered medical scheme and regulated by the Council for Medical Schemes (CMS). The CMS contact details are as follows: Email: complaints@medicalschemes.com | Customer Care Centre: 0861 123 267 | website: www.medicalschemes.com

Contact us on: **0860 tel arc / 0860 835 272,** P.O. Box 1874, Parklands, 2121, www.aon.co.za
FSB number: 20555; CMS number: ORG895

Acknowledgement of appointment

I hereby authorise Aon South Africa (Pty) Ltd to be my duly appointed Broker with immediate effect.

My ID [ ] and membership number [ ]

I have also been informed that the commission due to Aon, payable by the medical scheme as part of my monthly contribution, is 3% of the contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Section 65 of the Medical Schemes Act, 131 of 1998, plus value added tax (VAT).

Signed at (town or city) [ ] on yy/mm/dd [ ]

Signature [ ]

Permission to make certain information available to Aon South Africa (Pty) Ltd

I give consent for the disclosure of information about me.

Membership number [ ]

Medical Scheme [ ] Aon Broker Code [ ]

Title [ ] Initials [ ] Surname [ ]

First name(s) (as per identity document) [ ]

ID or passport number [ ]

To clarify this, the following information will be made available:

Personal examples	Benefit examples	Financial examples	Medical examples
Membership number Date of birth ID number Postal and e-mail Address Contact details Physical address Telephone numbers	Plan type Medical Savings Account amounts available Medical Savings Account choice Scheme Rate or Cost Current Medical Savings Account spent Limits Waiting period: details Wellness benefits Self-payment Gap Above Threshold Benefit	Tax certificate and tax reports Banking details Total contribution and breakdown	Chronic indicator Chronic condition PMB Chronic condition details Confirmation of claims paid (excluding amount and paid from where) Claims transaction history Hospital procedures Procedures codes Procedures done in doctor's rooms paid from Hospital Benefit

I hereby also authorise Aon South Africa (Pty) Ltd to provide me with any products that they consider appropriate to me.

Yes [ ] No [ ]

Signed at (town or city) [ ] on yy/mm/dd [ ]

Signature [ ]