



Informed Healthcare Solutions (IHS)

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FAX COVER SHEET

To:	Graham Pike of IHS	From:	
Fax:	0866 200 320	Company:	
Tel:	021 712 8866	Tel:	
Pages:		Date:	
Re:	Discovery Health Medical Aid Application		

Comments:

Instructions:

1. Print this document.
2. Fill in the application form and cover letter.
3. Fax the form to us on 0866 200 320 or scan and email it to forms@medicalaidcomparisons.co.za
4. Sit back while we do all the complicated stuff.

Save time and hassle with your medical aid application and make sure it gets the best possible chance of success

5. Your financial adviser's details

Financial adviser's name

Graham Pike

Code

1 0 3 1 5 3 3 6 0 5

Intermediary house

INFORMED HEALTHCARE SOLUTIONS PTY LTD

Code

1 0 0 4 7 4 9 2 6 1

Financial adviser's telephone number (W) **0 2 1 7 1 2 8 8 6 6**

Lead number

Email **graham@ihshealth.co.za**

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 Discovery Health Medical 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 Discovery Health Medical Scheme.

Financial adviser's signature

6. Please select your health plan

Executive Plan

Executive

Comprehensive Series

- Classic
 Classic Delta network option
 Essential
 Essential Delta network option

Priority Series

- Classic
 Essential

Saver Series

- Classic
 Classic Delta network option
 Essential
 Essential Delta network option
 Coastal

Core Series

- Classic
 Classic Delta network option
 Essential
 Essential Delta network option
 Coastal

KeyCare Series

- KeyCare Plus
 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.

7. If you applied for KeyCare Core or KeyCare Plus

Your KeyCare contributions depend on the higher income of you or your spouse or partner.

Income for this purpose includes, but is not limited to, average monthly earnings over the last 12 months from guaranteed earnings, guaranteed allowances, company contributions and variable pay or commissions from employment (including self-employment and informal employment); pension and annuity proceeds; interest earned on active and passive investments, including rental income from leasing properties; and distributions received from a trust.

IMPORTANT NOTICE:

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

By signing this application form, you give your permission for us to verify your declared income using all relevant internal and external sources, as defined in 14.4. If you do not complete the income section, we will assume that you earn more than R100 000 for each year.

	Main member	Spouse or partner
Total earnings over the last 12 months	R <input type="text"/>	R <input type="text"/>
Total monthly earnings	R <input type="text"/>	R <input type="text"/>
Occupation		

I declare that this income declaration is true and accurate.

Signature of main applicant

If the highest earner received less than R100 000 for each year then please provide the following supporting documentation as proof of income:

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

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.

12. Your medical questions (continued)

12.3 a. Gynaecological conditions Yes No

Example: abnormal Pap smear results, abnormal menstrual bleeding, endometriosis, polycystic ovarian syndrome.

b. Are you currently pregnant or have you been pregnant and/or had a miscarriage or termination of pregnancy? Yes No

Patient 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"/>
Currently on treatment for this condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicine 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"/>

12.4 Mental health Yes No

Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (like narcolepsy), eating disorders, Alzheimer's disease, autism, dementia, attention deficit-hyperactivity disorder.

Patient 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"/>
Currently on treatment for this condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicine 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"/>

12.5 Metabolic or endocrine conditions Yes No

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

Patient name		
Medical diagnosis		
Date first diagnosed	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"/>
Currently on treatment for this condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicine 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"/>

12.6. Liver and pancreas conditions Yes No

Example: hepatitis, cirrhosis, portal hypertension, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis.

Patient 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"/>
Currently on treatment for this condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicine 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"/>

12. Your medical questions (continued)

12.7 a. Gastrointestinal conditions Yes No

Example: GORD (heartburn), oesophageal disease, hernias, atrophic gastritis, ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis.

b. Have you had or currently have a stoma? Yes No

Patient 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"/>
Currently on treatment for this condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicine 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"/>

12.8 Brain and nerve conditions Yes No

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

Patient 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"/>
Currently on treatment for this condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicine 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"/>

12.9 Respiratory conditions Yes No

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

Patient 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"/>
Currently on treatment for this condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicine 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"/>

12.10 a. Musculoskeletal and connective tissue conditions Yes No

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

b. Have had neck/back pain symptoms, and/or treatment for a neck/back pain? Yes No

Patient 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"/>
Currently on treatment for this condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicine 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"/>

12. Your medical questions (continued)

12.11 a. Kidney or urinary conditions Yes No

Examples: kidney / renal failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence.

b. Currently receiving dialysis or had it in the past? Yes No

Patient 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"/>
Currently on treatment for this condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicine 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"/>

12.12 Blood conditions Yes No

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

Patient name		
Medical diagnosis		
Date first diagnosed	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"/>
Currently on treatment for this condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicine 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"/>

12.13 a. Breast disease Yes No

Examples: fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abnormal mammogram result.

b. Any operation(s) to your breasts? Yes No

Patient 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"/>
Currently on treatment for this condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicine 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"/>

12.14 Eye conditions Yes No

Example: cataract, keratoconus, corneal ulcer, uveitis, glaucoma, squint, ptosis, any abnormality of eyelids, retinopathy macular degeneration, cornea transplant, eye surgery.

Patient 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"/>
Currently on treatment for this condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicine 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"/>

12. Your medical questions (continued)

12.15 Ear, nose and throat (ENT) conditions Yes No

Example: chronic otitis media (middle ear infection), chronic otitis externa, hearing problems, hearing aid, cochlear implant, tonsillitis, adenoiditis, vertigo.

Patient 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"/>
Currently on treatment for this condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicine 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"/>

12.16 Male urogenital conditions Yes No

Examples: prostate disorders, urogenital defects, varicocele, tumours, undescended testes, phymosis, urinary incontinence.

Patient 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"/>
Currently on treatment for this condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicine 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"/>

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

Patient name		
Medical diagnosis		
Date first diagnosed	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"/>
Currently on treatment for this condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicine 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"/>

12.18 Do you or any of your dependants have any symptoms, or have you received medical advice or treatment for symptoms not yet diagnosed by a medical professional for a symptom or condition not mentioned in questions above in the 12 months before this application? Yes No

Patient 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"/>
Currently on treatment for this condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicine 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"/>

HIV and AIDS

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

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

Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider administers the Discovery Health Medical Scheme, registration number 1125.

Discovery Health Medical Scheme and Discovery Health (Pty) Ltd will keep your information and the information about those you apply for confidential. You agree to Discovery Health Medical Scheme and Discovery Health (Pty) Ltd processing and disclosing your information in the following manner:

1. Discovery Health Medical Scheme and Discovery Health (Pty) Ltd will only share your personal and health information or the information of any dependant on your health plan if it is requested by a third party who you have already given your consent to for the disclosure of this information. The party that Discovery Health Medical Scheme and Discovery Health (Pty) Ltd 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.
2. Discovery Health Medical Scheme and Discovery Health (Pty) Ltd may collect, collate, process and store your and all your dependants' personal information, including health information, as provided in this application and any information we get about you and your dependants:
 - for the administration of your health plan,
 - for providing any managed care services that you or any dependant on your health plan may require,
 - for providing relevant information to a contracted third party who requires information to provide a healthcare service to you or any dependant on your health plan; and
 - to profile and analyse any risk to Discovery Health Medical Scheme.
3. When providing Discovery Health Medical Scheme and Discovery Health (Pty) Ltd with personal and health information about a dependant on your health plan, you confirm that you have received appropriate permission to disclose this information to Discovery Health Medical Scheme and Discovery Health (Pty) Ltd.
4. Discovery Health Medical Scheme and Discovery Health (Pty) Ltd may provide any credit bureau or credit providers industry association with any information about your consumer credit record, including and not limited to information about your credit history, financial history, personal information and judgment or default history.
5. Discovery Health Medical Scheme and Discovery Health (Pty) Ltd may communicate with you about any changes in your health plan, including any changes in your contributions or changes and enhancements to the benefits you are entitled to on the health plan you have chosen.
6. Discovery Health Medical Scheme and Discovery Health (Pty) Ltd want to keep you updated on information about any offers or new products Discovery may make available at any time. Please indicate if you do not wish to receive this information from Discovery Health Medical Scheme and Discovery Health (Pty) Ltd. No

Signature of main applicant

14. Discovery Health Medical Scheme rules for membership

14.1 Rules for membership

Rules for membership are 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 appoint your employer's contracted financial adviser for all matters relating to your membership of the Discovery Health Medical Scheme. I give permission that Discovery Health Medical Scheme and Discovery Health (Pty) Ltd can share my medical information and other relevant personal information about me and my dependants with my chosen financial adviser. The information will be shared so that he or she can help me whenever I need help during the application process.

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

14.2 Who you are applying for

You may apply to join the Discovery Health Medical Scheme on your own or together with other people – your spouse, your partner and people who are financially dependent on you as defined in the Discovery Health Medical Scheme rules. To be treated as financially dependent for this application, a dependant must earn an income of less than what is stated in the Discovery Health Medical Scheme rules, or you must have a legal responsibility to provide financially for them. Discovery Health (Pty) Ltd 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.

14.3 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.

14.4 Giving information

You must give Discovery Health (Pty) Ltd true, correct and complete information

To consider your application for membership, the Discovery Health Medical Scheme must learn more about you and those you apply for. Information about you and those you apply for must be true, correct and complete. This includes the details you give in this application form and in future dealings with Discovery Health (Pty) Ltd. It is important that you tell

Discovery Health (Pty) Ltd about any medical condition, symptom or illness relating to you or those you apply for, even if you do not consider it relevant to your application.

Discovery Health (Pty) Ltd may ask those you apply for who are 21 and older for information and it will be treated as if Discovery Health (Pty) Ltd had asked you in your role as main member.

Your legal address

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

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

I give my permission that the Discovery Health Medical Scheme may get any information that is relevant to my application from my employer.

Tell Discovery Health (Pty) Ltd about changes right away

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

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

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

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

14. Discovery Health Medical Scheme rules for membership

14.5 About becoming a member

Discovery Health (Pty) Ltd will consider your application

Discovery Health (Pty) Ltd will consider your application and any one of the following will happen:

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

Discovery Health Medical Scheme might not pay for certain expenses immediately

Discovery Health Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before the Discovery Health Medical Scheme starts paying for any general or specific medical conditions. Please speak to your financial adviser or Discovery Health (Pty) Ltd to find out if waiting periods apply to your membership and the memberships of those you apply for.

Resign from current medical schemes when accepted

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

You must ensure contributions are paid on time

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

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

Discovery Health (Pty) Ltd and the Discovery Health Medical Scheme may record telephone conversations with you and with those you apply for. The recordings and all information we get during the recordings will be processed and kept as required by law.

14.6 Repaying money owed to the Scheme

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

We will notify you if there is any amount that you owe to the Scheme.

You must repay any medical savings owing if you leave the Discovery Health Medical Scheme.

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

Signature of main applicant

Date

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The main applicant must sign and date any changes

15. What happens next with your application

Once you send Discovery Health (Pty) Ltd your application, here is what will happen:

- Discovery Health (Pty) Ltd capture and check your details.
- If any details are missing or if we need more information for underwriting purposes, Discovery Health (Pty) Ltd will contact you.
- Discovery Health (Pty) Ltd 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 Discovery Health (Pty) Ltd applies any) and return it to Discovery Health (Pty) Ltd.
- When Discovery Health (Pty) Ltd activates 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 Discovery Health (Pty) Ltd seven days after sending us your application, please contact your financial adviser or Discovery Health (Pty) Ltd on **0860 100 345**.

Application to join Vitality and KeyFIT



Contact us

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

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 KeyFIT Vitality and KeyFIT KeyClub Starter KeyFIT and KeyClub Starter

Only members with a KeyCare Health Plan can join KeyFIT without joining Vitality as well. 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 membership is not activated in time for the debit order date you chose above, you will have two separate debit orders in the first month you pay your contribution, because you pay your contribution in advance. The first debit order will be collected on the first day of the month and the second debit order will be collected on the actual date you have chosen in the same month. From then on we will collect your monthly contribution on the date you have chosen.

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

- 1st 5th 8th 21st 26th

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 if you meet credit approval criteria.

Vitality contributions for 2012

	Vitality	KeyFIT	Vitality and KeyFIT
Member	R136	R29	R145
Member + spouse or dependant	R158	R36	R172
Member + 2 or more dependants	R167	R45	R193

Permission to process and disclose information and to communicate with you

We will keep your information and the information about those you apply for confidential. You agree to us processing and disclosing your information in the following manner:

1. We will only share your personal and/or health information or the information of any dependant on your Vitality policy if it is requested by a third party who you have already given your consent to for the disclosure of this information and the party that we share the information with agrees to keep the information confidential. If we want to share your information for any other reason, we will do so only with your permission.
2. We may collect, collate, process and store your personal information, as contained in all sections of this application and any information that is provided to use after the inception of your Vitality policy:
 - For the administration of the Vitality Programme,
 - For the provision of any services that you or any dependant on your Vitality policy may require,
 - For the provision of relevant information to a contracted third party who require such information to render a service to you or any dependant on your Vitality policy and only if such contracted third party agrees to keep the information confidential.
3. When providing us with personal information about a dependant on your Vitality policy, you confirm that they have provided you with appropriate permission to disclose that information to us. This includes consent to the administration their membership to Vitality, the provision of any services to them as required, the provision of relevant information to a contracted third party who require such information to render a service to them.
4. We may obtain relevant health information from Discovery Health (Pty) Ltd and the Scheme to administer the Vitality Programme.
5. We may provide to any credit bureau or credit providers industry association any information relating to your creditworthiness or any consumer credit information including but not limited to credit history, financial history, personal information and judgment or default history.
6. We may communicate to you any changes in your Vitality policy, including any changes in your contributions or any changes/enhancements to the benefits you are entitled to.
7. We would like to keep you informed of any offers or new products Discovery might have from time to time. Please indicate if you do not wish to be notified of these offers or products? Please tick: No

Signature of main applicant

Vitality rules for membership

Discovery Vitality is separate from the Scheme and administrator

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

Rules of the Vitality programme

A full set of rules is available from Discovery Vitality on request. In the event of a conflict between what is set out here, on our website and the rules of Vitality, the rules will always apply.

Your contributions to Discovery Vitality are separate

The contributions you pay to Discovery Vitality are not part of the contributions you pay to the Scheme.

Permission to get information from the Scheme

You specifically give Discovery Vitality permission to get the relevant information from the Scheme to administer the Vitality programme and to increase our product offering to you.

Cancellation of Vitality membership

Please give notice on the first day of the month if you wish to cancel your Vitality membership in that month. Otherwise, your membership will only end on the last day of the next month.

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

Signature of main applicant

Date

2	0	y	y	M	M	D	D
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The main applicant must sign and date any changes