Discovery Health

**Discovery Health administers Discovery Health Medical Scheme**

# APPLICATION FOR ADDITION OF DEPENDANT(S)

**155 WEST STREET, SANDTON PO BOX 5412, RIVONIA 2128 FAX (011) 539 3000 www.discovery.co.za**

**AAD 01/08/2004**

## HOW TO COMPLETE THIS APPLICATION

Please use one block per letter, complete with black ink and print clearly.
To avoid administration delays, please ensure this application is completed in full.

## A. YOUR INTERMEDIARY DETAILS (To be completed ONLY if correspondence needs to go through the Intermediary)

Surname | Telephone
First name(s) | Fax number
Intermediary number | E-mail address
DCS branch (if applicable) | DCS contact person
Telephone | Fax number
E-mail address

## B. ABOUT YOURSELF (main applicant)

Surname | Membership number
First name(s) | Date of birth Y Y Y Y / M M / D D

## C. ADDITION OF YOUR SPOUSE (Check box and complete if you wish to add a spouse as a dependant)

When would you like the cover to start? Y Y Y Y M M **0 1**

Title | Initials | Surname
First name(s) | Previous/maiden name
Preferred name
ID number | or passport number
Country of issue
In which country do you live?
Gender M F | Date of birth | Occupation
Telephone (H) | (W)
Cellular | Fax number
E-mail address | E-mail type Home | Work
Preferred means of communicating (please tick one) E-mail | Post

**NEW MSA CHOICE**

Please take note that due to your family status changing it may be necessary for you to change your annual Medical Savings Account.

I wish to change my MSA to R per annum | I do not wish to change my MSA

**ADDITION OF SPOUSE TO EXISTING STATUS B/C EMPLOYEES (if you are joining as part of an existing employer group with more than 35 members)**

- If the addition of spouse to an existing membership under a Status B or C group, is due to marriage within the last three months, a marriage certificate must accompany the addition of dependant application to avoid underwriting. If the spouse to be included on the membership has been married to the existing member for a period of more than 3 months, full underwriting will apply.
- In order to qualify to join as a common-law spouse (including same sex partners) our criteria is as follows:
  - Co-habitation of at least six months confirmed in the form of an affidavit.
  - If there has been co-habitation of longer than 1 year, full underwriting will apply.
  - When supplying an affidavit full dates of co-habitation must be supplied.

## D. ADDITION OF A CHILD (Check box and complete if you wish to add a child as a dependant)

| | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| | adult (21+ years) ☐ or child ☐ | adult (21+ years) ☐ or child ☐ | adult (21+ years) ☐ or child ☐ | adult (21+ years) ☐ or child ☐ |
| Title | Initials | Initials | Initials | Initials |
| Surname | | | | |
| First Name(s) | | | | |
| Relationship to Principal | | | | |
| Preferred Name | | | | |
| ID Number or Passport Number (Please include copy of passport) | | | | |
| Date of Birth | Y Y Y Y M M D D Gender M F | Y Y Y Y M M D D Gender M F | Y Y Y Y M M D D Gender M F | Y Y Y Y M M D D Gender M F |
| In which country do you live? | | | | |

## E. ADDITION OF ANY ADULT DEPENDANT (Check box and complete if you wish to add an adult as a dependant)

| | 1 | 2 |
|---|---|---|
| | adult (21+ years) ☐ or child ☐ | adult (21+ years) ☐ or child ☐ |
| Title | Initials | Initials |
| Surname | | |
| First Name(s) | | |
| Relationship to Principal | | |
| Preferred Name | | |
| ID Number or Passport Number (Please include copy of passport) | | |
| Date of Birth | Y Y Y Y M M D D Gender M F | Y Y Y Y M M D D Gender M F |
| In which country do you live? | | |

1. Are any of the dependants financially dependent on the principal member? Yes ☐ No ☐
2. Does dependant receive an income, e.g. pension? Yes ☐ No ☐
3. If "YES", what is the monthly income? R

**NEW MSA CHOICE**

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☐ I wish to change my MSA to R per annum ☐ I do not wish to change my MSA

## F. OTHER

1. Have any of your dependants that are being added to your Discovery policy ever belonged to a medical scheme? Yes ☐ No ☐
   If the answer is "YES", please complete the table below, giving details of your previous medical scheme membership.
   Where you have been a member of more than two medical schemes, please attach details separately.

| | 1. | 2. |
|---|---|---|
| Membership number | | |
| Name of scheme | | |
| Date joined | Y Y Y Y M M D D | Y Y Y Y M M D D |
| Date of termination | Y Y Y Y M M D D | Y Y Y Y M M D D |
| Proof attached | Yes ☐ No ☐ | Yes ☐ No ☐ |

## F. OTHER (continued)

2. Have any of the dependants ever been refused cover, or offered cover on special terms by a life assurance company or medical scheme? Yes ☐ No ☐
3. If "YES" please state the name of the company, the policy number and the reason.

4. Do any of the dependants have a chronic condition requiring ongoing medication? Yes ☐ No ☐
5. Is the applicant who needs to be added to the membership: (tick the appropriate block)

A blood relative ☐

Related to the principal member through marriage ☐

Neither of the above (we require proof of legal guardianship) ☐

## G. YOUR MEDICAL QUESTIONAIRE

Please complete the relevant information below. If the answer to any of the questions is "YES", please provide details. Should you have any relevant medical reports please attach copies of these to this application.

1. Please supply detail of the names, addresses and telephone numbers of doctors your dependant(s) has/have been consulting for the past five years.

Current doctor Tel Years

Previous doctor Tel Years

Current dentist Tel Years

Previous dentist Tel Years

2. a

| | Principal Member | Spouse/Partner | Adult Dependant | Adult Dependant |
|---|---|---|---|---|
| Name | | | | |
| How tall are you? (metres) | - | - | - | - |
| How much do you weigh? (kilograms) | | | | |
| Do you drink alcohol? | YES ☐ NO ☐ | YES ☐ NO ☐ | YES ☐ NO ☐ | YES ☐ NO ☐ |
| How many units of alcohol do you drink in a week? 1 unit of alcohol = measure of spirits, 1/2 pint of beer or 1 glass of wine | | | | |
| Do you smoke? | YES ☐ NO ☐ | YES ☐ NO ☐ | YES ☐ NO ☐ | YES ☐ NO ☐ |
| Type | | | | |
| Amount per day | | | | |
| If no, have you smoked in the last 12 months? | YES ☐ NO ☐ | YES ☐ NO ☐ | YES ☐ NO ☐ | YES ☐ NO ☐ |

Please state whether you or any person included in this application:

| | | YES | NO |
|---|---|---|---|
| b. Has/have experienced a weight change of more than 5 kg in the last 12 months? | | ☐ | ☐ |
| c. Has/have been advised to reduce alcohol or tobacco consumption? | | ☐ | ☐ |
| 3. Are currently undergoing any form of routinely prescribed treatment or have undertaken any form of routinely prescribed treatment in the past? | | ☐ | ☐ |
| 4. Has/have ever experienced/been treated for/or are currently suffering from any of the following conditions: | | ☐ | ☐ |
| a) Mental/emotional disorders | eg Anxiety, depression, schizophrenia, anorexia, any other eating disorder | ☐ | ☐ |
| b) Central/peripheral nervous system disorders | eg Brain and spinal cord disorders, stroke, multiple sclerosis, epilepsy | ☐ | ☐ |
| c) Eye disorders, hearing impairments or speech disorders | eg Glaucoma, retinitis, other visual disorders, hearing or speech impairments | ☐ | ☐ |
| d) Cardiovascular disorders | eg Heart conditions that have required treatment or surgery, angina (chest pain), rheumatic fever, coronary artery disease (heart attack), cardiac failure, murmurs, high blood pressure, rhythm disturbances, raised cholesterol | ☐ | ☐ |

## G. YOUR MEDICAL QUESTIONAIRE

| | | YES | NO |
|---|---|---|---|
| e) Respiratory disorders | eg Difficulty in breathing, shortness of breath, persistent cough, tuberculosis, (coughing up blood) | | |
| f) Gastro-intestinal disorders | eg Peptic ulcer, hiatus hernia, oesophagitis (heartburn), colitis, alteration of bowel habits/bleeding, disorders of the liver, gall bladder, spleen/pancreas, ascites | | |
| g) Kidney or urinary tract related disorders | eg Polycystic kidneys, haematuria (blood in the urine), nephritis, prostatism, nephrectomy, renal failure, renal stones, recurrent urinary tract infection | | |
| h) Gynaecological disorders | eg Ovarian cysts, menstrual disorders, endometriosis, fibroids or enlarged uterus, infertility disorders of the cervix | | |
| i) Lumps or growths | eg Benign or malignant growths of any type, including skin lesions | | |
| j) Blood disorders | eg Anaemia, leukaemia, bleeding disorders | | |
| k) Endocrine disorders | eg Diabetes, hyperthyroidism or hypothyroidism, growth disorders, Cushing's syndrome, Addison's syndrome | | |
| l) Connective tissue and skin disorder | eg Systemic lupus erythematosis, scleroderma, keloid or hypertrophic scars | | |
| m) Musculoskeletal disorders | eg Rheumatism, arthritis, disorders of the spinal structure, myasthenia or physical disability, any back problems, e.g. (pinched nerve) | | |
| 5. Has/have ever had, or are currently undergoing, or anticipating any special dental treatment, eg orthodontic, periodontic, prosthodontic, maxillo facial procedures or treatment for impacted wisdom teeth? | | | |
| 6. a. Has/have ever had counselling, treatment or advice for sexually transmitted diseases? | | | |
| b. Has/have been diagnosed with, or received treatment in connection with HIV or AIDS? | | | |
| 7. Has/have any congenital, hereditary or physical disabilities? | | | |
| 8. Has/have ever suffered from porphyria, cancer, mental illness, retinitis pigmentosa, diabetes, stroke, chest pain, raised cholesterol or any other hereditary disorder? | | | |
| 9. are currently pregnant? | | | |
| 10. have had advice, counselling or treatment for alcoholism or drug dependency? | | | |
| 11. participate in any hazardous sports/pursuits eg mountaineering, paragliding, bungee-jumping, scuba diving, etc? Please specifiy | | | |
| 12. Has/have undergone any surgery or hospital treatment in the recent past? | | | |

The above questions are prompts and are not exhaustive. Should any of your dependant(s) have any condition and symptoms which are not directly covered by these questions, but which is material to our consideration of the risk, you are nonetheless obliged to disclose it. Are you aware of any such condition?

If any question is answered "YES" please supply full details below. If the space is not sufficient, please attach additionalinformation to the application.

| Question no | Name | Diagnosis | Date first diagnosed | Currently on treatment for this condition YES | NO | Date of last consultation, hospitalisation or medication taken for this disorder | Treating practitioner's name and telephone number |
|---|---|---|---|---|---|---|---|
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## H. YOUR LEGAL DECLARATION

1. I apply for my dependant(s) to join the Discovery Health Medical Scheme ("Scheme") administered by Discovery Health Limited (referred to as "Discovery Health", and agree to abide by and to familiarise myself with the rules of the Scheme.
2. Any breach of any warranty or non-disclosure of any information by myself or my dependant(s) relevant to the assessment of this application will render any contracts to which this application relates null and void, and all contributions paid by me will be forfeited to the Scheme. In such events Discovery Health will be entitled to reclaim any amounts which they may have paid to me or any person on behalf of me or my dependant(s) behalf under such contracts.
3. I will notify Discovery Health should any alteration, in any circumstances on which the assessment of their risk is based, occur after the date of this application and before the date of Discovery Health's acceptance of the risk. I acknowledge that failure to do so will render any contracts to which this application relates null and void, and in such event Discovery Health will be entitled to reclaim any amounts which they have paid to me or any person on behalf of me or my dependant(s) under such contracts.
4. I will notify Discovery Health should I or any of my dependant(s) require hospitalisation for a non-emergency event and acknowledge that failure to do so will result in a reduction of the benefits payable by Discovery Health for any procedure undertaken.
5. No benefit will be payable by Discovery Health unless they are satisfied as to the validity of a claim and have received all the information which they may deem necessary, including but not limited to the results of any medical examinations and tests which they may require my dependant(s) to undertake.
6. I consent to Discovery Health addressing any request for information, tests or examinations directly to any dependant of mine over the age of 21 (twenty one), with the same legal consequences as if the request had been addressed to me in my capacity as a principal member.
7. 7.1 I authorise Discovery Health to obtain from any person any necessary information which they may require in their sole and absolute discretion concerning any dependant of mine in assessing any risk or claim relating to this application;
   7.2 I direct the person concerned to provide Discovery Health with such information on request.
8. It is my sole responsibility as a member to ensure that the monthly premium is received by Discovery Health.
9. On termination of my membership from the Scheme:
   9.1 I will repay the Scheme and/or Discovery Health any amount owing by me from my Medical Savings Account
   9.2 I understand that should contributions to my Medical Savings Account exceed claims paid from this account the excess will be paid to me.
10. I consent to all conversations between myself and Discovery Health being recorded and all information obtained through these conversations forming part of Discovery Health's records. I further consent to all of these recordings remaining the sole property of Discovery Health.
11. I undertake to obtain the necessary consent from any dependant of mine to whom these conditions may apply and indemnify Discovery Health against any claim which may arise as a result of my failure to do so.
12. I warrant that the contents of this application are true and correct and complete.
13. I acknowledge that should this application be submitted via the Internet it is solely for the purposes of convenience and neither I nor Discovery Health (subject to its sole discretion) will rely on the information herein contained without my first providing Discovery Health with a signed hard copy of this application. I further agree that the hard copy submitted pursuant to an Internet application will constitute an offer on my part for membership of the Scheme.
14. I will notify Discovery Health if any of my dependants are living with HIV/AIDS. I acknowledge and accept that Discovery Health will not be liable to pay any claims related to HIV/AIDS in the first twelve months of my dependants' membership of Discovery Health.

Signed at _____ on Y Y Y Y M M D D

Signature of principal member _____