Transnet Pensioners

This check list is for HR practitioners to check and ensure all the information is on the application form and all the documents that are required have been attached. It will further assist in the processing of applications and minimise delays in activation of the employees new medical scheme. The Employee Must Sign Off On The Check List.	AON			
CHECKLIST FOR APPLICATIONS **Please provide the following documentation with the application** **Please read and answer all the questions**	**Are the relevant documents attached?**			
Is an affidavit attached if registering a common law spouse or partner?	**Yes**		**No**	
Is the application signed and stamped by Transnet HR practitioner(this is to confirm that you are an employee of Transnet).?	**Yes**		**No**	
You understand that the completed applications must be scanned to transnetapps@aon.co.za or faxed to 086 726 7146?	**Yes**		**No**	
Have you answered all the questions?	**Yes**		**No**	
Are all the Birth Certificates of Children where ID is not yet available attached?	**Yes**		**No**	
Do you understand that you should not resign until you accepted at the new medical scheme?	**Yes**		**No**	
Do you understand that you have to give your existing medical scheme there notice period?	**Yes**		**No**	
Have you attached the Documentary proof in case of adopted/foster child?	**Yes**		**No**	
Have you allocated your commencement date?	**Yes**		**No**	
Have you allocated your date of employment?	**Yes**		**No**	
Have you completed the section for your banking details for the medical scheme to refund you for claims?	**Yes**		**No**	
Have you selected your option?	**Yes**		**No**	
Have you signed and dated the declaration?	**Yes**		**No**	
Have you signed on all the applicable sections?	**Yes**		**No**	
Are all the ID Documents for yourself and all your dependants attached?	**Yes**		**No**	
Have you allocated your ID number and SAP number on the application?	**Yes**		**No**	
If you altered your application, did you sign next to the alteration?	**Yes**		**No**	
If you answered yes to any questions - have you given an explanation to the questions?	**Yes**		**No**	
Is your Marriage certificate attached if you regisstering a spouse?	**Yes**		**No**	
Have you attached the Membership certificates with termination dates from your previous medical schemes?	**Yes**		**No**	
Have you allocated contact details in order to be contacted?	**Yes**		**No**	
Have you given your full Postal address with postal codes?	**Yes**		**No**	
Have you attached Proof(payslip) of your taxable income, (Income Band Options only)?	**Yes**		**No**	
Have you specified your Business Unit clearly on the application?	**Yes**		**No**	
Do you fully understand that your application will not be processed until a fully completed application is received by the medical scheme with all the supporting documents?	**Yes**		**No**	

Employee Full Name & Surname:

Date:

Employee Signature:

Applying to become a member of Discovery Health Medical Scheme in 2024

Discovery Health Medical Scheme

Broker House Name: Aon South Africa (Pty) Ltd
Broker House Code: 1004785125
Broker Code: 1020031108

Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are applying to become a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (members): 0860 99 88 77, Tel (health partners): 0860 44 55 66, www.discovery.co.za, PO Box 784262, Sandton, 2146,
1 Discovery Place, Sandton, 2196.

Purpose of the form

Thank you for deciding to apply to join the Discovery Health Medical Scheme. This document is an application form for membership.

The information requested in this application form is required to enable the Scheme to process your membership application and to help in the administration of your membership as well better administer the affairs of the Scheme.

This application form also contains terms and conditions applicable to your membership (Section 13). Please make sure you read and understand these terms and conditions. This document is valid for 90 days from date of signing it. Make reference to the footnote that indicates the expiry date of the form.

Download the latest version of all forms from www.discovery.co.za, under Medical Aid > Find documents and certificates

What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally. You can access a list of the approved digital signatures from www.discovery.co.za, under Medical Aid > Find documents and certificates > Application forms.
- All relevant sections must be signed by the main applicant. The main applicant must sign and date any changes.
- Read and understand the terms and conditions for membership (Section 13) and the Scheme Rules. The full set of Scheme Rules is available on request at www.discovery.co.za/medical-aid/scheme-rules.
- Sign section 6 (if applying to become a KeyCare member), 8, 12 and 14.
- Provision is made in this form for you and your dependants to provide information relating to your race. This information is required by the Council for Medical Scheme for statistical purposes only. You are not compelled to provide this information.
- Email the completed and signed form to **application@discovery.co.za** or fax it to **011 539 3000**.
- Please attach a copy of each applicant's identity document. We also accept valid passports and birth certificates for children.

Once you submit your application form, here is what will happen:

You will be contacted if any details are missing or if more information is required for underwriting purposes and to process your application.

- You will receive an SMS and you (and your financial adviser, if you have chosen one) will receive an email to let you know when your application is considered to have been fully and completely made. This date may differ from the date on which you sign the application form.
- If standard terms of acceptance are offered (no waiting periods or late-joiner penalties), your membership will be activated and you (or your financial adviser if you appointed one) will receive a welcome letter. For any non-standard terms, a counter-offer letter will be issued, which will indicate any conditions applicable to your membership (waiting periods and/or late-joiner penalties). You may accept the offer by signing and returning this letter to activate your membership. Once we receive your acceptance you and your financial adviser will receive a welcome letter.

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

When you sign this application, you confirm that you have read and understood the terms and conditions (Section 13 of this form) for membership and agree to them.

I consent to my spouse and/or adult dependant, that is part of this application process, acting on my behalf and providing personal information, including health information, to Discovery Health for the purpose of my application to join Discovery Health Medical Scheme Yes ☐ No ☐

1. About yourself (main applicant)

When do you want your cover to start? D 0 D 1 M M Y Y Y Y

Title | Initials

Surname

First names (according to identity document)

Gender M F

Race African Coloured Indian/Asian White Other

You do not have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Do not want to disclose race

Date of birth D D M M Y Y Y Y Occupation

Tax Number

Gross monthly earnings **R** .

ID or passport number Telephone (H)

Telephone (W) Cellphone

Email

Physical address while in South Africa

Suite/unit number Complex name

Street number Street name

Suburb Postal code

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

Same as residential address Yes No

If you do not complete a postal address, we will use your physical address for post.

PO Box Private Bag Box number

Suite PostNet Suite Number

Suburb Postal code

2. About your spouse or partner (only complete if applying for cover)

Title Initials

Surname

First name (as per identity document)

Gender M F

Race African Coloured Indian/Asian White Other

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Do not want to disclose race

Date of birth D D M M Y Y Y Y

Marital status Married Single Divorced Widowed

ID or passport number

Telephone (H) Telephone (W)

Cellphone

Email

3. About your dependants (only complete if they are also applying for cover)

Dependant 1

Title Initials

Surname

First names (according to identity document)

Gender M F

Race African Coloured Indian/Asian White Other

You do not have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Do not want to disclose race

Date of birth D D M M Y Y Y Y

ID or passport number

Relationship to main member

(For example mother or child. Where your child is not your biological child, please state your relationship, for example adopted child or foster child. Please give us legal proof of the relationship.)

If your dependant is 21 years and older, are they:

Married Yes No

Financially dependant on you? Yes No

Does your dependant earn an income? Yes No

How much does your dependant earn each month? **R** .

Does your dependant's spouse earn an income? Yes No

How much does your dependant's spouse earn per month? **R** .

Dependant 2

Title Initials

Surname

First names (according to identity document)

Gender M F

Race African Coloured Indian/Asian White Other

You do not have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Do not want to disclose race

Date of birth D D M M Y Y Y Y

ID or passport number

Relationship to main member

(For example mother or child. Where your child is not your biological child, please state your relationship, for example adopted child or foster child. Please give us legal proof of the relationship.)

If your dependant is 21 years and older, are they:

Married Yes No

Financially dependant on you? Yes No

Does your dependant earn an income? Yes No

How much does your dependant earn each month **R** .

Does your dependant's spouse earn an income? Yes No

How much does your dependant's spouse earn each month **R** .

Dependant 3

Title Initials

Surname

First names (according to identity document)

Gender M F

Race African Coloured Indian/Asian White Other

You do not have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Do not want to disclose race

Date of birth D D M M Y Y Y Y

ID or passport number

Relationship to main member

(For example mother or child. Where your child is not your biological child, please state your relationship, for example adopted child or foster child. Please give us legal proof of the relationship.)

If your dependant is 21 years and older, are they:

Married ☐ Yes ☐ No

Financially dependant on you? ☐ Yes ☐ No

Does your dependant earn an income? ☐ Yes ☐ No

How much does your dependant earn each month? **R** .

Does your dependant's spouse earn an income? ☐ Yes ☐ No

How much does your dependant's spouse earn each month? **R** .

Are you applying for more than 3 Dependants? ☐ Yes ☐ No

Note: If you are applying for more than 3 dependants, please add the details on a separate page.

4. Your financial adviser's details

Do you want an adviser? Yes ☐ No ☐

Please complete this section if you already have a financial adviser

Financial adviser's name Broker House Name: Aon South Africa (Pty) Ltd Code

Intermediary house Broker House Code: 1004785125 Code

Financial adviser's telephone number (W) Broker Code: 1020031108 Lead number

Email

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

Declaration

I declare that I have read, understood and agree to the broker declaration on **www.discovery.co.za/portal/rules**.

I declare that:

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

4.2. I am appointed by the main applicant to provide advice about this application.

4.3. I have a valid contract with Discovery Health Medical Scheme and I have made the client aware of the commission payable by Discovery Health Medical Scheme.

4.4. I am responsible for providing the main applicant with:

- my name, physical address, postal address and the telephone number
- impartial advice that is in his or her best interest.

4.5. I am accountable for any advice given to the main applicant about completion of this application form and joining Discovery Healthcare Fund.

Signature of financial adviser Broker House Name: Aon South Africa (Pty) Ltd Broker House Code: 1004785125 Broker Code: 1020031108

Signature of main applicant

⚠ **Please only sign if information is true, complete and correct.**

5. Please select your health plan

Executive Plan	Comprehensive Series	Priority Series	Saver Series	Smart Series	Core Series	KeyCare Series
☐ Executive	☐ Classic	☐ Classic	☐ Classic	☐ Classic	☐ Classic	☐ KeyCare Plus
	☐ Classic Smart	☐ Essential	☐ Classic Delta	☐ Essential	☐ Classic Delta	☐ KeyCare Core
			☐ Essential	☐ Essential Dynamic	☐ Essential	☐ KeyCare Start
			☐ Essential Delta		☐ Essential Delta	☐ KeyCare Start Regional
			☐ Coastal		☐ Coastal	

I would like to select that my health plan complies with the requirements of Shariah Yes ☐ No ☐

How would you like us to refund claims from the Medical Savings Account if your plan has one? Discovery Health Rate ☐ Cost ☐

Discovery Health Rate is the medical scheme rate subject to funds available.

Cost is the full amount of the claim subject to funds available.

You have the right to ask for help in selecting a health plan that suits your needs. Whether you have requested help or made the decision on your own, by signing this application, you confirm that you are familiar with the conditions and benefits of the plan you select.

When you make a claim that is eligible for payment, the Scheme will use the money available in your Medical Savings Account (MSA) to pay for it. Your MSA is a combination of your annual MSA allocation, which is the amount of money you receive at the start of each year, and your accumulated MSA, which is the money that you didn't spend in previous years and that carried over to the current year.

6. If you choose a KeyCare plan

Please complete this section if you selected a KeyCare plan.

Income is defined as guaranteed gross monthly earnings of the main member and the spouse before deductions. If you have selected a KeyCare plan, Income Verification will be conducted for the lower income bands.

IMPORTANT NOTICE

Declaring income lower than your actual income is fraud. This may lead to the termination of your membership and criminal charges may be brought against you. If your income is not declared, your income verification status will default to the highest income band. It is your responsibility to give accurate income information, otherwise the Scheme may not be in a position to pay back the excess amount you paid.

	Main member	Spouse or partner
Gross earnings over the last 12 months	R	R
Gross monthly earnings	R	R

By signing this application form, you give your permission for us to verify your declared income using all relevant internal and external sources, indicated in 13.4 of the terms and conditions of membership (Section 13).

I declare that this income declaration is true and accurate.

Signature of main applicant

Please only sign if information is true, complete and correct.

Please complete this if you have selected the KeyCare Plus, KeyCare Start or KeyCare Start Regional Plan.

- For KeyCare Plus please select a GP on the KeyCare GP Network.
- For KeyCare Start please select a GP on the KeyCare Start GP Network.
- For KeyCare Start Regional please select a GP on the KeyCare Start Regional GP Network.
- If you have selected the KeyCare Start Regional Plan, which offers comprehensive and affordable cover in and around Polokwane, Tzaneen, Mbombela, Trichardt, Bellville and George, please make sure that you stay or work in one of these locations so that the full benefit suite is available to you.

	Name	GP name	Practice number
Main applicant			
Spouse or partner			
Dependant 1**			
Dependant 2**			
Dependant 3**			

** Please make sure that the dependant information you give above is the same as the dependant information in section 3 of this form. Please provide the details on a separate page if you are applying for more than 3 dependants.

7. Your employment details (only complete if your employer pays the contributions on your behalf)

7.1. **If your employer is paying your full contribution or a part of it and we need to debit their account, please complete this section:**

Name of employer **Transnet Pensioners** Employer and billing number **3655613**

Employee number Date of employment D D M M Y Y Y Y

(or PERSAL number for government employees. Please attach a clear copy of your salary slip.)

Branch name Branch number **2**

Employer warranty

Please ensure your employer completes this warranty if this application form is not submitted with an employer application form:

7.1.1 We warrant that the main applicant detailed in section 1 is an employee of our organisation.

7.1.2 Discovery Health Medical Scheme may bill us for the amount due for this member in the same way as it does for our other employees

Health Medical Scheme.

Authorised signatory

Name

Designation

7.2. **Only complete this section if you own your own business and your business will be paying your contribution:**

Name of your business

Registration number | Vat number

Telephone | Fax

8. Your banking details

8.1. Your contributions

If you will be paying your contributions in full, please complete this section:

Please note: We cannot accept credit card account details and only South African banking details are accepted.

If we are debiting a third party account, the main member must sign next to the account holder.

Bank name

Branch name | Branch code

Account number | Type of account ☐ Cheque ☐ Savings

Account holder

Account holder's physical address (own/3rd party/trust/company)

Account holder contact details

Account holder email address

If we are debiting from a third party bank account, the main member must insert the ID or passport number of the third party.

ID or passport number

If the third party bank account is a Joint account ☐ Company account ☐ or Trust account ☐

As part of Payment Association of South Africa (PASA) debit order mandate requirements you are required to supply the account holders residential address, email address and contact number. Please note that the details you supply will only be used for the PASA debit order mandate requirement and will not be used to update the contact details we have on system, if you wish to update any contact details please visit **www.discovery.co.za**.

We will debit your account on the first working day of the month. If the membership is not activated in time for the debit order collection and there is an amount outstanding Discovery Health will collect that amount in the interim, upon activation . Once your account is paid up to date, you may change your debit order date to a variable debit order date by contacting us on 0860 99 88 77.

8.2. Your claims refund

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

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. We no longer issue cheques. If no details are provided it will impact your claims payment. If we are paying a third party bank account, the main member must insert the ID or passport number of the third party.

Bank name

Branch name | Branch code

Account number | Type of account ☐ Cheque ☐ Savings

Account holder

If we are paying a third party bank account, the main member must insert the ID or passport number of the third party.

ID or passport number

If the third party bank account is a Joint account ☐ Company account ☐ or Trust account ☐

please provide proof of bank account. Refer to Annexure A at the back of the application form for the proof of bank account required.

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 and you understand that you may not transfer, assign, pledge or cede the payment or receipt of any benefit by or from the Scheme to any person and if you do or attempt to do so, the Scheme may withhold, suspend or discontinue the payment of such benefit.

Signature of account holder

Signature of main member

⚠ **Please only sign if information is true, complete and correct.**

9. Previous medical scheme details (please give us proof in the form of a membership certificate)

Please give us the details of all registered South African medical schemes that you and your dependants being added previously belonged to. **We will use this information to determine if we need to apply any late-joiner penalty fees. We may also use the information on the membership certificate to determine if we can apply waiting periods.**

Were all your dependants on the same medical scheme ☐ Yes ☐ No

If you and your dependants applying for cover belonged to different medical schemes, please complete them below:

Name	Scheme name	Start date	End date if already resigned	Are they still a member?	Reason for leaving
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

10. Moving from another medical scheme

Please make sure that you have completed section 9.

10.1. I confirm that all people named on this application:

10.1.1. have not had a break in membership of more than 90 days since resigning from the previous South African medical scheme, and

Yes ☐ No ☐

10.1.2. are currently or have been members of a South African medical scheme for at least the past 24 months

Yes ☐ No ☐

If you answered yes to the above questions, please answer the questions in 10.2.
If you answer no to any question in 10.1, you must complete all the medical questions in section 11.

10.2. For any person named on this application form:

10.2.1. Have they been admitted to hospital in the 12 months before this application?

Yes ☐ No ☐

10.2.2. Are they currently taking regular, ongoing medicine and/or treatment of a medical condition or symptom?

Yes ☐ No ☐

10.2.3. Are they planning to or reasonably expecting to be hospitalised (including for pregnancy) or expecting to receive dental or medical treatment/investigations costing more than R2 000 in the next 12 months?

Yes ☐ No ☐

If you answered yes to any questions in 10.2, we will apply a three-month general waiting period to your application and you do not have to complete Section 11.

During these three months, we will only cover claims relating to Prescribed Minimum Benefits according to the Scheme's rules. If you feel that a three-month general waiting period should not be applied and you want to give us more information, please complete section 11.

11. Your health questions

We may be able to retrieve certain previous medical information we have for you and your dependants (if applicable) from previous memberships. By signing this, you agree that we may utilise this information for the purposes noted below.

Signature

Information on symptoms, conditions or disorders (must be completed for the main applicant, spouse/partner and all dependants and must include information on conditions even if covered or not on previous memberships)

Have **you or any dependant/s** in this application **ever** experienced, been treated for, or are you currently suffering from any of the following symptoms, conditions or disorders? We have listed some examples of conditions, symptoms or disorders under each question. These are only examples and not the full list of conditions, symptoms or disorders. Please include congenital abnormalities.

We use this information only for lawful purposes, for example, enabling us and our administrator to process your application and to optimally administer your membership, to verify whether the information you provide on this application form is true and complete, to provide you with customized information relevant to your health status, to develop disease management programs for specific conditions, to review and enhance Scheme benefits, to improve Scheme's financial modeling, to assist the Scheme to better assess and mitigate its risk and other beneficial uses. A condition specific waiting period will only be imposed on your membership if you or your dependant received or were recommended any medical advice, diagnosis, care or treatment within a 12-month period ending on the date on which this application is considered to be fully and properly made.

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

Please take note that if you or any of your dependants have any symptom or condition not listed in the questions below, you should highlight and provide full details of this symptom or condition in response to question 11.18 below.

Indication of existing medical conditions on this application does not automatically enroll you/your dependants onto the Scheme's Disease Management programme. For more information with regards to the Schemes disease management enrollment visit **www.discovery.co.za.**

Please answer ALL questions by ticking "Yes" or "No".

11.1 Tumours, growths and disorders of the skin

Yes ☐ **No** ☐

Example: abnormal pap smear results, skin lesions, eczema, psoriasis, breast disease, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abscess,abnormal mammogram result, abnormal PSA (prostate specific antigen), any autoimmune conditions, any congenital conditions, any other abnormal cancer-screening or diagnostic test result/s or other skin conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.2. Heart and circulation conditions

Yes ☐ **No** ☐

Example: chest pain, palpitations, shortness of breath, coronary heart disease, angina, heart attack, arrhythmia, high blood pressure (hypertension), cardiomyopathy, valvular heart disease or heart valve replacement, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker, any autoimmune conditions, any congenital conditions, peripheral vascular disease, deep vein thrombosis, pulmonary embolus, and varicose veins.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

Discovery Health Medical Scheme, registration number 1125, is regulated by the Council for Medical Schemes and administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider.

11.3. Gynaecological and obstetrics conditions

Yes ☐ **No** ☐

Example: abnormal pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility, ectopic pregnancy, missed period, ovarian cyst, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.4. Are you or any of your dependants pregnant or undergoing treatment/investigation for pregnancy?

Yes ☐ **No** ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.5. Mental health

Yes ☐ **No** ☐

Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (like narcolepsy), eating disorders, Alzheimer's disease, dementia, attention deficit-hyperactivity disorder, drug and/or alcohol abuse or rehabilitation, suicide attempt, post traumatic stress disorders, counselling, any autoimmune conditions, any congenital conditions and any other psychological conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.6. Metabolic or endocrine conditions

Yes ☐ **No** ☐

Example: diabetes mellitus (high blood sugar), diabetes insipidus, thyroid disease, Addison's disease, Cushing's syndrome, metabolic syndrome, parathyroid disease, Paget's disease, osteoporosis, growth deficiency, metabolic disorders, Conn's syndrome, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.7. Abdominal conditions

Yes ☐ No ☐

Example: hepatitis, cirrhosis, portal hypertension, liver disease, liver failure, pancreatitis, cystic fibrosis, gall bladder/stones, GORD (reflux), heartburn, oesophageal disease, hernias, gastritis, ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis, Irritable bowel syndrome (IBS), Hemorrhoids, long standing constipation/diarrhea, ongoing abdominal pain, ascites (fluid in the abdomen) any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.8. Brain and nerve conditions

Yes ☐ No ☐

Example: stroke, epilepsy, seizures, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, other chronic headaches, cerebral palsy, Parkinson’s disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, brain shunt (VP shunt),intellectual disability, CVA, bleeding on the brain, constipation, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.9. Breathing and respiratory conditions

Yes ☐ No ☐

Example: asthma, chronic obstructive pulmonary disease, bronchiectasis, tuberculosis, bronchitis or emphysema, cystic fibrosis, sarcoidosis, pneumonia, interstitial lung disease/chronic cough > 3months, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.10. Musculoskeletal (back, bone and muscle pain)

Yes ☐ No ☐

Example: arthritis (any form), ongoing/intermittent joint or muscular pain, ankylosing spondylitis, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, neurogenic bladder, gout, injury, physical disability, prosthesis, amputation, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.11. Kidney or urinary conditions including current or past dialysis

Yes ☐ **No** ☐

Example: kidney and/or renal failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, neurogenic bladder, bladder infections, other bladder or kidney problems, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.12. Blood conditions

Yes ☐ **No** ☐

Example: deep vein thrombosis, anaemia, polycythaemia vera, blood clotting disorders/diseases, leukaemia, lymphoma, pulmonary embolus, haemophilia, haemochromatosis and other bleeding disorders, any autoimmune conditions, any congenital conditions, varicose veins.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.13. Eye conditions

Yes ☐ **No** ☐

Example: cataract, keratoconus (cross linkage), corneal ulcer, uveitis, glaucoma, squint, ptosis, retinopathy, macular degeneration, cornea transplant, eye surgery, blurred vision,eye infections, blindness (partial or full), retinal detachment, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.14. Ear, nose and throat (ENT) and dentistry conditions

Yes ☐ **No** ☐

Example: otitis media (middle ear infection), otitis externa (ear canal infection), hearing problems, hearing aid, cochlear implant, tonsillitis, adenoiditis, vertigo, deafness, sinus problem, nasal surgery, dental treatment or dental surgery, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.15. Male urogenital conditions

Yes ☐ **No** ☐

Example: prostate disorders, urogenital defects, varicocele, undescended testes, phimosis, urinary incontinence, retention, infertility, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.16. Are you or any of your dependants expecting to have medical investigations or surgery or planning hospitalisation or treatment in the next 12 months or have you been admitted to hospital/seen in casualty in the last 12 months?

Yes ☐ **No** ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.17. Have you or any of your dependants received or not yet received medical advice or treatment for symptoms, not yet diagnosed by a medical professional, in the last 12 months before this application?

Yes ☐ **No** ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

11.18. Have you or any of your dependants been diagnosed with or received treatment for, any condition/symptom not mentioned in the questions above, in the last 12 months before this application?

Yes ☐ **No** ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed /symptoms	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

HIV and AIDS

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 HIV Care Programme. Discovery Health Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before Discovery Health Medical Scheme starts paying for any general or specific medical conditions. A 12-month condition specific waiting period or a three-month general waiting period may therefore apply to this condition or any related condition. If you do not let us know about you or your dependant's HIV status within 7 days of your membership being active, we may end your Discovery Health Medical Scheme membership.

12. Our Privacy Statement – How we will process and disclose your personal information and communicate with you

When you engage with Discovery Health Medical Scheme, you are entrusting us with your personal information. We are committed to protecting your right to privacy and keeping your information safe. Our Privacy Statement tells you how we collect, use and share your personal information, including personal information about your spouse, employees, dependants, beneficiaries and life assureds, where applicable. To view and read our Privacy Statement, please follow this link: **https://www.discovery.co.za/medical-aid/about-discovery-health-medical-scheme** and scroll to, "YOUR PRIVACY IS IMPORTANT TO US" click on the **Privacy Statement** link.

Signature of main member

Date D D M M Y Y Y Y

The main applicant must sign and date any changes.

Please only sign if you have read and understand this statement

13. Terms and Conditions applicable to Discovery Health Medical Scheme membership

Definitions

The Scheme refers to Discovery Health Medical Scheme, registration number 1125, registered with the Council for Medical Schemes.

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

Do you agree that we may send you direct electronic marketing from time to time

No, thank you ☐ Yes, I agree ☐

13.1. ***Scheme rules for membership***

The rules of the Scheme record your rights and responsibilities for your membership. They may change from time to time. You may as us for a copy of these rules at any time or view these rules on **www.discovery.co.za**.

When you sign this application, you confirm that you have read and understood these terms and conditions and you agree that you and those you apply for will be bound by these and Scheme Rules.

Where applicable you also acknowledge and confirm that you, your financial adviser, or your employer, may communicate with us on this application and your membership of the Scheme.

You give permission that the Scheme or Administrator can share your medical information and other relevant Personal Information about you and your dependant/s with your chosen financial adviser. The information will be shared so that he or she can help us if necessary while we process your membership application.

Please speak to your financial adviser or the Administrator if there is anything you do not understand.

13.2. ***Who you are applying for***

You may apply to join the Scheme on your own or together with other people – your spouse, your partner and people who are financially dependent on you as defined in the Scheme rules, as referred to above. For anyone to be treated as financially dependent for this application, you must have a responsibility to provide financially for that dependant. The Scheme or Administrator might ask you to give us proof of financial or legal responsibility.

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

13.3. ***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/partner and any dependant(s) over 18 to act for them in any matter relating to this application.

13.4. ***Giving and getting information***

You must give true, correct and complete information.

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

Information about you and those you apply for must be true, correct and complete. This includes the details you give in this application form and in future dealings with us. It is important that you tell us about any medical condition, symptom or illness relating to you or those you apply for, even if you do not consider it relevant to your application. We may ask those you apply for who are 18 and older for more information about themselves.

Your legal address

The Scheme or Administrator will send documents to you at the address you indicated as the communication channel you prefer to be contacted on. If it is 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.

The Scheme and Administrator may record telephone calls

The Scheme and Administrator 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.

The Scheme and Administrator may get information about you from other relevant sources

The Scheme and Administrator may (at any time and on an ongoing basis) obtain your personal information from other relevant sources, including medical practitioners, contracted service providers, financial advisers, credit bureaus or industry regulatory bodies ("relevant sources") and further process such information to consider your membership application, to conduct underwriting or risk assessments, or to consider a claim for medical expenses, to profile and analyse risk or to investigate fraud, waste and/or abuse (including by medical

practitioners, contracted service providers or financial advisers). We may (at any time and on an ongoing basis) verify with the relevant sources that your personal information is true, correct and complete.
You give your permission that the Scheme and Administrator may get any information that is relevant to your application from your employer.

Tell the Scheme or Administrator immediately if your information changes
You, your employer or your financial adviser must tell the Scheme or Administrator in writing if any of the information you gave, in your application for membership, changes between the day you sign this document and the day your membership starts. This includes information about your health and the health of those you apply for. We need advance notice of any administrative changes such as cancellation of membership, as we do not accept backdated changes.

When the Scheme may cancel your membership/s
The Scheme may cancel any membership if you and those you apply for:

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

Providing false information may lead to criminal charges being brought against you. You will have to pay any amount owing to the Scheme as a result of this cancellation.

Monitor for possible non-disclosure.
To exclude the possibility of non-disclosure of material information, for the first 12 months we will monitor membership in the following cases:
a) Claims of new beneficiaries with less than 24 months continuous medical scheme membership and with less than 90 days break, immediately prior to date of application.
b) When an application is made for membership or admission for a person who was not a beneficiary of a medical scheme for a period of at least 90 (ninety) days preceding the date of application.
In accordance with the Medical Schemes Act, we implore new applicants to disclose true and complete information to the Scheme. It is always better to disclose too much than too little.

Please note that if membership is subject to the above-mentioned 12-month monitor period, the Scheme may request additional medical history upon receiving a claim and/or a request for authorisation. In this case, the Scheme will only confirm benefits once it is satisfied with the additional information received.

13.5. ***About becoming a member***
The Scheme might not pay for certain expenses immediately after you become a member
The Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before the Scheme starts paying for any general or specific medical conditions. We will advise if any waiting periods apply. Please speak to your financial adviser or the Administrator with regard to any waiting periods applicable to your membership and the memberships of those you apply for.

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

You must ensure contributions are paid on time
As the main member of the Scheme, you are responsible for ensuring that your contributions and the contributions of those you apply for are paid on time every month to avoid suspension of benefits. The Scheme has the right to amend monthly contributions and benefits from time to time with prior notification.

13.6. ***Repaying money owed to the Scheme***
The Scheme has the right at any time to collect from you any amount that you owe.
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 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 allocated to an account called the 'Medical Savings Account'. If you leave the Scheme before the year is up, you must repay the portion of medical savings you have used that is more than you have paid back to the Scheme over the year.

By signing this form, you agree that any money you owe to the Scheme may be deducted from any future claim payment amounts that are due to be paid to you.You will be able to identify the debit order for the money owing to the Scheme on your bank statement, the reference number DISCSETTLE will be used.

Signature of main applicant

Date D D M M Y Y Y Y

Please only sign if information is true, complete and correct.

14. Debit order mandate

This signed authority and mandate refers to the application on the signed date (''the Agreement'')

I, the undersigned:

- Warrant that the account information I have provided above is an account in my name and that the information furnished by me/us in this Authority and Mandate is true and correct.
- Authorise Discovery Health to issue and deliver payment instructions to my bank, recorded above, for the collection by Discovery Health from the bank account (or any other bank or branch to which I may transfer my account) any amounts due under or in terms of this application on condition that the sum of such payment instructions will never exceed my obligations as framed in the agreement which shall commence on the date that cover starts as requested on the application form and shall continue until this Authority and Mandate is terminated by me by giving Discovery Health no less than 20 ordinary working days written notice thereof or immediately in the event that I instruct my bank to withdraw this Authority and Mandate.
- If the membership or change in account details is not activated in time for the debit order collection and there is an amount outstanding Discovery Health can collect that amount in the interim. If I change the date of the debit order after activation, I confirm that the payment instructions must be issued and delivered on the day that I have nominated ("payment day") and thereafter on the same day in each and every successive month. If the payment day falls on a Sunday or recognised South African public holiday, the payment day will automatically be the next working day;
- Acknowledge that my bank will treat each payment instruction to pay premiums or amounts due under this Agreement to Discovery Health as if each payment instruction came from me personally as the account holder.
- Undertake to advise Discovery Health in writing of any changes to my account details and acknowledge that Discovery Health will not be held responsible or liable for any claim, loss or harm that I or any third party may suffer as a result of me providing incorrect banking details herein or if the bank account is in the name of another person or entity or as a result of my failure to notify Discovery Health of a change in banking details or if the bank account has insufficient funds to meet my obligations under or in terms of the Agreement.
- Know and understand that the withdrawals hereby authorized will be processed through a computerized system provided by South African banks. The details of each withdrawal from my bank account will be printed on my bank statement and must show the reference number of the membership inserted in the Agreement so as to enable me to identify this membership.
- Acknowledge that although this Authority and Mandate may be terminated by me, such termination does not necessarily terminate this Agreement. In the event of such termination, I am not entitled to any refund of any premiums or amounts due that was withdrawn by Discovery Health whilst this Authority and Mandate was in force if such premiums or amounts were legally owing to Discovery Health in terms of the Agreement.
- Acknowledge that by signing this Authority and Mandate I am bound by the payment terms applicable to this Agreement.
- Acknowlegement that this Authority may be assigned to a third party if this agreement is also assigned to a third party.

Reference number

This Agreement reference number: Your membership number

Abbreviated name

Abbreviated name as registered with the bank: DISCPREM

Deduction amount: as per your activation of membership letter

Deduction date: as per section 1 of your membership application form

Payment start date: as per section 1 of your membership application form

Account holder name

Account holder signature

Date of signature D D M M Y Y Y Y

15. Third Party Bank Details - Annexure A

Banking details for a third party

Please attach the relevant proof of bank account if you give a third party's bank account details for claim refunds and / contribution debit orders

Documents we need for a third-party bank account

(A third party can be anyone, such as your spouse, aunt, uncle, friend, father or son.)

- Proof of the account (bank statement or bank letter not older than three months)
- A copy of the third party's (accountholder) ID, passport or driving licence
- A copy of the main member's ID, passport or driving licence

Documents we need for a joint bank account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of each of the joint owners.

Documents we need for a company account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of the persons who have authority to sign on behalf of the company
- A letter of authority. The letter must:
  - State that the account can be used
  - State the membership details (including the membership or policy numbers) for which the bank account will be used
  - Include the details of the signatory
  - Be dated and signed by an authorised person on behalf of the company
- A copy of the company's certificate of registration.
- A copy of the main member's ID, passport or driving licence

Documents we need for a trust account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of each of the trustees of the account
- A copy of the certificate of registration of the trust
- A copy of the trust resolution. The resolution must:
  - Show the trustees
  - Be dated and signed by an authorised person on behalf of the trust
  - Contain the membership or policy numbers
- A copy of the main member's ID, passport or driving licence

If you are completing the request on behalf of the main member, please include proof that you have the necessary authority to do so, for example, a letter of authority or a letter of executorship.

ATTENTION:

TO WHOM IT MAY CONCERN

TENDERING OF RESIGNATION OF TRANSMED MEMBERSHIP

DATE: ____/____/_____

SURNAME: _____

FULL NAMES: _____

MEMBERSHIP NUMBER: _____

ID NUMBER: _____

CONTACT NUMBERS: _____

E-MAIL ADDRESS: _____

I would like to tender my resignation from the **TRANSMED Medical Scheme** effective immediately.

Since the rules of the scheme state I have to give **A ONE MONTH CALANDER NOTICE**, my last day on **TRANSMED Medical Scheme** will be: ____/____/_____

Kind regards

_____

Signature

PLEASE EMAIL THIS RESIGNATION TO ENQUIRIES@TRANSMED.CO.ZA BUT ATTACH THE COPY TO YOUR NEW APPLICATION.

ATTENTION:

TO WHOM IT MAY CONCERN

TENDERING OF RESIGNATION OF MEMBERSHIP

DATE: ____/____/_____

SURNAME: _____

FULL NAMES: _____

MEMBERSHIP NUMBER: _____

ID NUMBER: _____

CONTACT NUMBERS: _____

E-MAIL ADDRESS: _____

I would like to tender my resignation from the _____

Medical Scheme effective immediately.

Since the rules of the scheme state I have to give _____ days' notice, my last day on

_____ Medical

Scheme will be: ____/____/_____

Kind regards

_____

Signature

PLEASE SEND TO YOUR MEDICAL SCHEME BUT ATTACH A COPY TO YOUR APPLICATION FORM.

Benefits of appointing

Aon South Africa Healthcare as your intermediary

Aon Healthcare is committed to providing you with exceptional service at every interaction. We have a team of professional, fully accredited advisors to assist you with all your medical schemes, Gap cover and Primary care enquiries.

Our philosophy is to:

Guide:
our members in selecting the medical scheme, Gap cover insurance or Primary care options aligned to their needs.

Educate:
our members with ongoing training throughout the year, end of year medical schemes and Gap cover benefits and rate changes.

Protect:
the rights of members by applying the Medical Scheme Act and scheme rules when resolving disputes with the medical schemes on behalf of the members.

Catalogue of services and technological platform accessible to our members

- **Microsites:** Provides you with access to voice recorded Induction, Year-end renewal, Year-end launch highlight presentations, brochures, COVID-19 updates, various application forms.
- **Aon Resolution Centre:** Professional assistance with your Medical scheme, Gap cover or Primary care claim resolution, comparison or benefit explanation.
- **Year-end renewal communications:** Access to member letters providing updates on the following:
  - Alert - Provides high level summary of benefits and rates changes launched by medical scheme, Gap cover insurance as well as Primary care providers.
  - Member letter - Provides comprehensive information in relation to the benefits and rates changes implemented by Medical scheme, Gap cover or Primary care provider.
  - Guidance letter - Aon generates guidance letters for members that are under or over insured. The purpose of the guidance letter is to guide a member on selecting an appropriate option aligned to his/her needs.
- **Ad-Hoc Alerts:**
  - Ad-hoc updates pertaining to Medical schemes industry or providers specific updates.

Cost of appointing Aon

We are pleased to inform you that there is **no additional fee** charged by Aon when you appoint Aon Healthcare as your Healthcare intermediary. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme whether you have appointed Aon as broker or not. This monthly commission 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). In terms of Primary Care Insurance products we earn maximum 3%. Gap Cover Insurance products, we earn commission on a sliding scale from 5% up to 20% depending on policy holder's monthly contributions.

Connect with us

We focus on communication and engagement, across insurance retirement and health, to advise and deliver solutions that create great client impact. We partner with our client and seek solutions for their most important people and HR challenges. We have an established presence on social media to engage with our audiences on all matters related to risk and people.

For more information from Aon Employee Benefits on healthcare, retirement benefits and a wide range of topics feel free to go to **www.aon.co.za**

http://www.facebook.com/Aonhealthcare
Click "Like" on our page (Aon healthcare)

http://twitter.com/Aon_SouthAfrica
Click "follow" on our profile

Aon Employee Benefits – Healthcare

Aon South Africa Pty Ltd, an Authorised Financial Service Provider, FSP # 20555.

http://www.aon.co.za/disclaimer
On all services provided, Aon's Terms & Conditions of Business, as amended from time to time, are applicable and can be found at http://www.aon.co.za/terms-of-trade or will be sent to you upon request.

Privacy Notice

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Disclaimer:

Although care is taken to represent the rates and benefits correctly, errors and omissions could occur. In case of any conflict, the rules of the affected medical scheme prevail. Any decisions regarding your medical scheme portfolio should be made in conjunction with your Aon Employee Benefits consultant or manager. While Aon has taken reasonable steps to ensure that the information contained in this report is relevant, accurate and current, no warranties of any kind, whether express or implied, including but not limited to the accuracy, completeness, relevance or fitness for a particular purpose are given and Aon expressly disclaims any liability for any loss or damage that may arise from the use of this report. This report is confidential and intended solely for the use of the individual or entity to whom it is addressed. If you received this report in error, you should not disseminate, distribute or copy this report and you should notify Aon if you are not the intended recipient and destroy the report. The report is copyright of Aon SA (Pty) Ltd. You may not, except with our express written permission, distribute or commercially exploit the report. Aon hereby authorizes you to copy the report for non-commercial use within your organization only.

POPIA

Protection of Personal Information Act 4 of 2013 (POPIA), Medical Schemes are requesting a signed Broker Appointment letter to make certain information available to Aon South Africa (Pty) Ltd.

14 December 2022 | V2 | DD

Contact us on: 0860 100 404, P.O. Box 78367, Sandton, 2146, www.aon.co.za
FSP number: 20555; CMS number: ORG895
Follow our website link for further information on Aon's processing of your personal information

Acknowledgement of appointment

Broker House Name: Aon South Africa (Pty) Ltd
Broker House Code: 1004785125
Broker Code: 1020031108

I acknowledge and appoint Aon South Africa (Pty) Ltd as my financial advisor for all matters related to my medical scheme membership.

My ID: _____ and membership number: _____

Signed at (Town or City): _____ on yy/mm/dd: _____

I have been informed that there is no additional fee charged by Aon for providing you with healthcare intermediary services. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme. This monthly commission is 3% of the monthly 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).

Permission to process my personal information as well as personal information of all dependents included on my membership application form and I consent to Aon South Africa (Pty) Ltd accessing information listed on the table below.

I give consent for the disclosure of information about me.

Membership number: _____ ID or passport number: _____

Title: _____ Initials: _____ Surname: _____

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

The following information should be made available to my appointed financial advisor as is necessary:

Personal examples	Benefit examples	Financial examples	Medical examples
* Name and Surname * Membership number * Date of birth * ID number * Postal Address * Physical address * E-mail Address * Telephone numbers * Cellular Number * Number of dependents	* Plan type * Medical Savings Account (MSA) * Balance Medical Scheme benefits * Spent for the year Accumulated * Medical scheme Savings Account * Medical Savings Carry over from previous year * MSA reimbursement, Scheme Rate or cost * Self-payment Gap * Above Threshold Benefit * Waiting period details * Late joiner penalty indicator * Wellness benefits	* Total Contribution * Contribution breakdown	* Chronic Indicator/ confirmation (Yes/No) * In Hospital Indicator/ confirmation (Yes/No) * Confirmation of claims paid and from what benefit * Claims transaction history * Procedures done in doctor's rooms paid from Hospital Benefit

Aon South Africa (Pty) Ltd, an Authorised Financial Services Provider, FSP # 20555

By signing this letter of appointment , I confirm that I have fully read and understood the contents of this document and provide my express consent for Aon South Africa (Pty) Ltd ("Aon") to process my Personal Information including but not limited to special personal information, as well as that of my beneficiaries and where necessary including my minor children (as defined in the Protection of Personal Information Act no 4 of 2013) for the purposes set out herein and which Personal Information may be shared and or disclosed with any party including but not limited to service providers who Aon (in it's reasonable discretion) has an obligation or requirement to share or disclose my Personal Information and that of my beneficiaries and where necessary my minor children in compliance with its obligations in law or contract.

Signed at (Town or City): _____ on yy/mm/dd: _____

Signature: _____

Aon South Africa (Pty) Ltd, an Authorised Financial Services Provider, FSP # 20555

Broker House Name: Aon South Africa (Pty) Ltd
Broker House Code: 1004785125
Broker Code: 1020031108

Financial adviser appointment form

Discovery

Contact details
Tel: 0860 345 678, PO Box 3888, Rivonia 2128 www.discovery.co.za

0 781159 833229

How to use this form

1. The purpose of this form is to change the appointed financial adviser or intermediary house on record and have access to your information held with the relevant Discovery businesses as indicated below. Only the appointed financial adviser will have access to your policies on the Financial Adviser Zone.
2. Please make sure that the authorised signature appears next to the specific product/s. Only authorised persons may sign this form – it is illegal for any other person to sign this form.
3. For Discovery to process this request quickly and correctly, please ensure that this form is legible and completed in full.
4. Where you need to make a choice between different options, please mark your selection with an X.
5. This form is only valid for three months from the date signed.
6. It is the responsibility of the newly appointed financial adviser or intermediary house to make sure that the transfer is processed within 30 days. Discovery will not backdate any changes after this period.
7. If the spaces provided are not enough, please attach a list with all relevant details. Please make sure that all additional documentation is also signed by duly authorised persons.
8. Please make sure that the rules and consequences of this request have been read and understood as set out on the rules page of this form.
9. Please email the completed form to commissions@discovery.co.za.

1. Client details

Surname | Initials | Title

First name (as per ID)

Date of birth (Y Y Y Y M M D D) | ID/passport number

Nationality of passport

Broker House Name: Aon South Africa (Pty) Ltd
Broker House Code: 1004785125
Broker Code: 1020031108

2. New financial adviser details

1. New adviser details

New adviser name	J Nel
New adviser code	1020031108
New adviser contact number	0860 100 404
New adviser email address	pr@aon.co.za
New intermediary house name	Aon SA (Pty) Ltd
New intermediary house code	1004785125
Principal adviser	☑ Percentage (%) 100

2 Secondary adviser details

Secondary adviser name	
Secondary advisery code	
Secondary adviser contact number	
Secondary adviser email address	
Secondary intermediary house name	
Secondary intermediary house code	
Principal adviser	☐ Percentage (%)

Secondary financial adviser details are only applicable to Discovery Life, Discovery Invest, Discovery Insure and Discovery Insure Commercial products.

3. General

3.1 Discovery Health Medical Scheme

Employer's name

Employer's number

Branch name | Branch code –

Membership number

141673 SAD E 9137 (V12) 07.20

Discovery Life Investment Services (Pty) ltd is an authorised Financial Services provider. Registration number 2007/005969/07. Discovery Insure Ltd. Registration number: 2009/011882/06 and is an authorised financial services provider. Discovery Health (Pty) Ltd. Registration number: 1997/013480/07 and is an authorised financial services provider.

3. General *(continued)*

3.2 Flexicare

Employer's name

Employer's number

Branch name

Branch code –

Membership number

3.3 Healthy Care Company

Policy numbers 1

2

3

3.4 GAP Cover

Policy numbers 1

2

3.5 Discovery Life

Policy numbers 1

2

3

Bank reference number (PRI/BIBLIFE)

Discovery retirement optimiser Yes ☐ No ☐

3.6 Group Life

Policy numbers 1

2

3

3.7 Supplementary Gap Cover

Policy numbers 1

2

3

3.8 Discovery Invest

Investment numbers 1

2

3

3.9 Employee Benefits: Retirement Funds

Policy numbers 1

2

3

3.10 Discovery Insure

Policy numbers 1

2

3

3.11 Discovery Insure Commercial

Policy numbers 1

2

3

3.12 Discovery Funeral

Policy numbers 1

2

3

Discovery Life Investment Services (Pty) ltd is an authorised Financial Services provider. Registration number 2007/005969/07. Discovery Insure Ltd. Registration number: 2009/011882/06 and is an authorised financial services provider. Discovery Health (Pty) Ltd. Registration number: 1997/013480/07 and is an authorised financial services provider.

4. Authorisation

I, _____ , am duly authorised to appoint the financial adviser and intermediary house mentioned above. I also give the Discovery companies consent to share with my appointed adviser all policy information, including personal and underwriting information necessary to ensure the efficient administration, assessing of claims and to make sure Discovery complies with all relevant legislation on an ongoing basis.

I understand and accept that this consent can be revoked at any time, failing which Discovery will be entitled to continue sharing such information with the appointed individuals until the end of this policy.

Discovery Health Medical Scheme	Yes ☑	No ☐
Flexicare	Yes ☐	No ☐
Healthy Care Company	Yes ☐	No ☐
GAP Cover	Yes ☐	No ☐
Discovery Life	Yes ☐	No ☐
Group Life	Yes ☐	No ☐
Supplementary Gap Cover	Yes ☐	No ☐
Discovery Invest	Yes ☐	No ☐
Employee Benefits: Retirement Funds	Yes ☐	No ☐
Discovery Insure	Yes ☐	No ☐
Discovery Insure Commercial	Yes ☐	No ☐
Discovery Funeral	Yes ☐	No ☐

Client's signature _____ Dated Y Y Y Y M M D D

Adviser's declaration

I, _____, have been appointed as the principal adviser on record for (client's name) _____,

Policy Number(s) _____ from this day , the _____ of _____ 20 ___.

In terms of the provisions made in Section 7 (4) of the Financial Sector Conduct Authority General Code of Conduct for Authorised Financial Services Providers and Representatives, I confirm that I will complete a review of the above client's portfolio at policy annual review date as set out in this agreement.

NB.: Principal advisers must sign the form and declaration.

Adviser's signature

Broker House Name: Aon South Africa (Pty) Ltd
Broker House Code: 1004785125
Broker Code: 1020031108

Dated Y Y Y Y M M D D

Discovery Health Medical Scheme

Policyholder's authorised signature _____

Designation of signatory (employer) _____

The name of the designated person of employer _____

Signature of designated person of employer _____

Commission terms and conditions

Refer to the rules document on the Financial Adviser Zone (FAZ).

Discovery Health Medical Scheme

- For compulsory employer groups, please attach an original letter on the employer's letterhead. The appointment will be validated in accordance with Circular 20 of the Medical Schemes Act.
- A transfer request by branch or an employer must be on a holding company letterhead, signed by the duly authorised person.
- For non-compulsory employer groups, the individual Scheme member may appoint their own financial adviser.
- The effective date will be the 1st day of the month following the Commissions Department's receipt of this request.

Flexicare

- For compulsory employer groups, please attach an original letter on the employer's letterhead. The appointment will be validated in accordance with Circular 20 of the Medical Schemes Act.
- A transfer request by branch or an employer must be on a holding company letterhead, signed by the duly authorised person.
- For non-compulsory employer groups, the individual Scheme member may appoint their own financial adviser.
- The effective date will be the 1st day of the month following the Commissions Department's receipt of this request.

Healthy Care Company

- The effective date will be the 1st day of the month following the Commissions Department's receipt of this request.

Gap Cover

- The effective date will be the 1st day of the month following the Commissions Department's receipt of this request. The effective date cannot be backdated.

Commission terms and conditions

Discovery Life, Group Life and Supplementary Gap Cover
- Broker appointment instruction signed by a duly authorised person.
- Transfer from effective date; next anniversary.

Discovery Invest
- Broker appointment instruction signed by a duly authorised person.
- Transfer from effective date; next anniversary.

Employee Benefits: Retirement Funds
- For employer groups, please attach an original letter on the employer's letterhead authorising the appointment of the financial adviser and signed by a duly authorised person.
- A transfer request by an employer must be on a holding company letterhead, signed by the duly authorised person.
- The effective date will be the 1st day of the month following the Commissions Department's receipt of this request.
- Transfers from effective date; will be the first day of the month following the commissions department's receipt of this request and cannot be backdated.
- Broker appointment instruction signed by a duly authorised person.
- A transfer can only be done if the new intermediary has the active relevant FAIS accreditation.
- Initial and Renewal commission to remain with the intermediary that sold the benefit.

Discovery Insure and Discovery Insure Commercial
- The effective date will be the day of the Commissions Department's receipt of this request, and the effective date cannot be backdated.
- Broker appointment instruction signed by a duly authorised person.

Discovery Funeral
- Broker appointment instruction signed by a duly authorised person.
- A transfer can only be done if the new intermediary has the active relevant FAIS accreditation.
- Transfer from effective date; next anniversary.

Discovery Life Investment Services (Pty) ltd is an authorised Financial Services provider. Registration number 2007/005969/07. Discovery Insure Ltd. Registration number: 2009/011882/06 and is an authorised financial services provider. Discovery Health (Pty) Ltd. Registration number: 1997/013480/07 and is an authorised financial services provider.