



*LA Health Medical Scheme  
Application Form*

Join the medical scheme  
that offers good value while  
keeping you healthy.

Join LA Health.

# Your LA Health application form

You need to complete this form when you apply to join LA Health Medical Scheme.

Please tear off this section and keep it until you receive further communication from us about your application.

## Thank you for applying to join LA Health

Thank you for choosing LA Health to look after your healthcare needs.

**Before you send us this form please make sure your employer has stamped it to indicate that they are aware of your intention to join LA Health.**

## What happens next with your application?

Once you submit your application to us, the following will happen:

- We capture and check your details.
- If there is any information missing, we will contact you by phone or in writing.
- To finalise your membership we may also speak to your broker about any other requirements.

## When we have accepted your application, you will receive communication from us

- We will SMS your membership number to you when we activate your membership
- We will also send you a new member welcome pack that will include the following items:
  - a welcome letter, which confirms the Benefit Option you have chosen and all other relevant details about your membership
  - your LA Health membership card
  - car stickers with our contact details in case of an emergency
  - a Benefit Brochure, which outlines the benefits available to you.

Once you receive written notification from LA Health Medical Scheme that your application is successful, please cancel your current medical scheme membership as it is illegal to belong to two medical schemes at the same time. If you have not heard from us seven days after submitting your application, please contact your broker.

Broker name:

Accreditation number:

Telephone number:

FAIS number:



Join the medical scheme that offers good value while keeping you healthy. **Join LA Health.**

155 West Street Sandton / Knowledge Park Century City Boulevard / PO Box 652509 Benmore 2010 / Postnet Suite 116 Private Bag X19 Milnerfontein 7435  
Client Service and hospital confirmations 0860 103 933 / Emergency 0860 999 911 / Fax 011 539 7276 / [www.lahealth.co.za](http://www.lahealth.co.za) / [service@discovery.co.za](mailto:service@discovery.co.za)



FOR OFFICE USE ONLY			
OPTION:	RISK	MSA	TOTAL
EMPLOYER			
MEMBER			
TOTAL CONTRIBUTION			

Employer stamp

# LA HEALTH MEMBER APPLICATION FORM 2011

## HOW TO COMPLETE THIS APPLICATION

Please complete sections A - I as applicable.  
 Please use one letter per block, complete with black ink and print clearly.  
 To avoid administration delays, please ensure this application is completed in full.  
 This form must be completed for each applicant to LA Health Medical Scheme.  
 Please attach copy of each applicant's ID to this application form.  
 We accept valid passports and birth certificates for children.

You must give this form to your employer if you are still working.  
 If you are a pensioner please give it to your pension fund administrator.  
 To follow-up on this application, please call 0860 100 345  
 or email NBCustomsQueries@discovery.co.za

### A. ABOUT YOUR EMPLOYER

Municipality/Employer

Date of permanent employment  Y  Y  Y  M  M  D  D Depot name

Payroll number  Pensioners only Pension number

### B. ABOUT YOURSELF (main member) Please attach a copy of your ID/passport

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

Title  Surname

First name(s)  Sex  M  F Date of birth  Y  Y  Y  M  M  D  D

ID number  Marital status

Tax number  Cellphone

Telephone (H)  (W)

Email  Home  Work

Physical address  Postal address

Code   Code

Gross annual salary R  Please give us your correct address to ensure you receive your documents from us.

### C. ABOUT YOUR SPOUSE (if applying for cover) Please attach a copy of your spouse's ID/passport

Title  Surname

First name(s)  Sex  M  F Date of birth  Y  Y  Y  M  M  D  D

ID number  Cellphone

Telephone (H)  (W)

### D. ABOUT YOUR DEPENDANTS (if applying for cover) Please attach a copy of all your dependants' ID/passport/birth certificate

1	Child (up to 27 years) <input type="checkbox"/> or adult <input type="checkbox"/> Sex <input type="text"/> M <input type="text"/> F	2	Child (up to 27 years) <input type="checkbox"/> or adult <input type="checkbox"/> Sex <input type="text"/> M <input type="text"/> F
	Title <input type="text"/> Initials <input type="text"/>		Title <input type="text"/> Initials <input type="text"/>
	Surname <input type="text"/>		Surname <input type="text"/>
	First name(s) <input type="text"/>		First name(s) <input type="text"/>
	Relationship to main member <input type="text"/>		Relationship to main member <input type="text"/>
	Date of birth <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D		Date of birth <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D
	ID number <input type="text"/>		ID number <input type="text"/>
3	Child (up to 27 years) <input type="checkbox"/> or adult <input type="checkbox"/> Sex <input type="text"/> M <input type="text"/> F	4	Child (up to 27 years) <input type="checkbox"/> or adult <input type="checkbox"/> Sex <input type="text"/> M <input type="text"/> F
	Title <input type="text"/> Initials <input type="text"/>		Title <input type="text"/> Initials <input type="text"/>
	Surname <input type="text"/>		Surname <input type="text"/>
	First name(s) <input type="text"/>		First name(s) <input type="text"/>
	Relationship to main member <input type="text"/>		Relationship to main member <input type="text"/>
	Date of birth <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D		Date of birth <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D
	ID number <input type="text"/>		ID number <input type="text"/>

### E. PREVIOUS MEDICAL SCHEME DETAILS (Please supply proof of current membership)

Name of scheme  Membership number

Date of joining  Y  Y  Y  M  M  D  D to  Y  Y  Y  M  M  D  D or currently a member

**F. OPTION SELECTION**

1. LA KeyPlus  LA Focus  LA Active  LA Core  LA Comprehensive   
 Pay Medical Savings Account claims at LA Health Rate  or Cost  (if applicable).

The Medical Savings Account is not available to LA KeyPlus members.

**Please complete if you have selected the LA KeyPlus option.**

KeyCare Primary Care Network GPs					
	Name	General Practitioner (GP)	Practice Number	Second GP Name	Practice Number
Main applicant					
Spouse/partner					
Dependant*					
Dependant*					
Dependant*					

\* Please ensure that the dependant information supplied above is the same as the dependant information in Section D of this form. 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 complete this section if you need a secondary GP allocated to you.

**Please note:** you can only access day-to-day cover and chronic benefits through the KeyCare network GP(s) chosen above.

**G. BANKING DETAILS (for claims reimbursement and/or contributions)**

Bank name  Branch   
 Account type  Branch code   
 Name of accountholder   
 Account number  Signature of accountholder

**H. HOW DID YOU JOIN US?**

How did you join LA Health? Through your broker  your employer or co-worker  on your own

**I. YOUR BROKER DETAILS**

Name of broker   
 Name of broker house   
 Signature of broker  Broker code   
 Broker's stamp

Your broker is not employed by the Scheme, but is appointed by you and acts as your representative.

**PERMISSION TO PROCESS AND DISCLOSE INFORMATION AND TO COMMUNICATE WITH YOU**

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

- We 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 we and the Scheme share the information with agrees to keep the information confidential. If we want to share your information for any reason, we will do so only with your permission.
- We and the Scheme 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 the Scheme

- When providing us and the Scheme with personal and health information about a dependant on your health information about a dependant on your health plan, you confirm that you have received appropriate permission to disclose this information to us and the Scheme.
- We and the Scheme 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.
- We and the Scheme 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.
- We and the Scheme want to keep you updated on information about any offers or new products Discovery may make available at any time. Please indicate whether you agree to receive this information from us and the Scheme.

Yes  No

Signature of main applicant

**RULES FOR MEMBERSHIP**

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

When you sign this application, you agree that you and those you apply for will be bound by the rules of the Scheme. Please speak to your broker or us if there is anything you do not understand.

**1. Acting for others**

**You confirm that 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 that you apply for in any matter relating to this application.
- You have received permission from your spouse and any dependants over the age of 21 to act for them in any matter relating to this application.

**2. Giving Information**

**You must give us true, correct and complete information**

To consider your application for membership, the Scheme must learn more about you and those you apply for. The information must be true, correct and complete. This includes the details you give us in this application form and in future dealings with us.

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

**We may get the information from other relevant sources**

To consider an application for membership or a claim for medical expenses, you agree that the Scheme can get information about you and those you apply for from other relevant sources, including medical practitioners and brokers.

**Tell us about changes right away**

If any of the information you gave to us changes between the day you sign this document and the day your membership starts, you must tell us in writing what the changes are.

**When the Scheme may cancel your membership**

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

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

**3. Sharing information and confidentiality**

**When we may share your information**

The Scheme will keep your information and the information about those you apply for confidential.

The Scheme may share this information with other relevant parties only if the following two conditions are met:

- the information is needed only to administer the Scheme and any claims
- the parties the Scheme shares the information with agree to keep the information confidential.

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

**The Scheme may record calls**

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

**4. About becoming a member**

**Resign from your current medical scheme**

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 as members of LA Health.

**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.

**5. You must repay any medical savings or other debt owing when you leave the Scheme**

When you become a member, depending on the benefit option you chose, you may have money available in advance through the Medical Savings Account to use for medical expenses during the year. If you leave the Scheme before the year is up, you must repay the proportion of medical savings you have used in advance.

Any other debt must also be paid to the Scheme.

Signed at

Date

Signature of member



*Energising your  
medical cover!*

