Contact details
Tel: 0860 103 933 • PO Box 652509, Benmore 2010 • www.lahealth.co.za

Application to add dependants (with underwriting)

Complete this form if you want to add dependant/s to your membership of LA Health Medical Scheme.

Who we are
LA Health Medical Scheme (referred to as "the Scheme"), registration number 1145 is the Scheme that your dependant/s are applying to become a member of. This is a non-profit organisation, registered with the Council for Medical Schemes.
Discovery Health (Pty) Ltd (referred to "we" "us" and "our" or as "the administrator") is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

Please follow these steps to help us process your application:

- Please use one letter per block, complete with black ink and print clearly and remember to sign the form.
- When filling in this form, read and understand the rules for membership (Section 11).
- Fax the completed and signed form to 011 539 3000 or email it to application@discovery.co.za
- Please attach a copy of the identity documents of your dependant/s. We also accept SA driver's licences, passports and SA birth certficates for children.
- To avoid administration delays, please make sure this application is completed in full by you and your employer.

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

- Discovery Health (Pty) Ltd will capture and check your details.
- If any details are missing, or if we need more information for underwriting purposes, Discovery Health (Pty) Ltd will contact you.
- Discovery Health (Pty) Ltd will send you a letter, SMS or an email to let you know when the application is considered to have been fully and completely made. This date may differ from the date on which you sign the application form.
- After accepting your dependant/s application to join LA Health Medical Scheme, we will send you an SMS and an email letter confirming acceptance. The SMS and email will advise you of when your dependant/s membership will start. Depending on your circumstances, it may also indicate any conditions applicable to their membership, such as waiting periods or late-joiner penalties.
- You have to sign this letter in the appropriate place and return it to Discovery Health (Pty) Ltd. When you do so, you confirm your dependant/s membership start date and acceptance of any conditions applicable to their membership of LA Health Medical Scheme.
- We will then send amended membership cards to you via the post.

If you do not hear from Discovery Health (Pty) Ltd seven days after sending us your application form, please call Discovery Health (Pty) Ltd on **0860 100 345.**

When you sign this application, you confirm that you have read and understood the rules for membership and agree to them.

1. Contact details (person who will receive correspondence about this application)

Contact name | Job title
Address
Code
Telephone | Fax
Cellphone
Email address

Preferred means of communication: (please tick one) Email ☐ Post ☐ Fax ☐

2. About yourself (main member)

Surname | Membership number
First names | Date of birth (Y Y Y Y M M D D)
Address details
Code
Telephone (H) | (W)
Cellphone | Fax
Employer name | Employer number

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3. About your spouse or partner (if applying for cover)

When do you want your cover to start? 2 0 Y Y M M 0 1

Title | Initials | Surname

First names

Preferred names | Sex M F | Date of birth Y Y Y Y M M D D

Marital status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Previous or maiden name

ID or passport number

Country of issue

Telephone (H) | (W)

Cellphone | Fax

Email

Date of marriage to main applicant (where applicable). Please attach a copy of an official marriage certificate. Y Y Y Y M M D D

Addition of spouse to an existing membership
If addition of spouse to an existing membership is:
- As a result of legal and registered marriage within the last 60 days, an official marriage certificate must accompany this application form;
- For a spouse married for more than 60 days, full underwriting will apply ;
- As a result of a long-standing relationship or in terms of common-law practice, the partnership declaration must be completed and signed.

Partnership declaration
If you are not legally married and you cannot give us a marriage certificate, you have to complete the following section in full.
We declare we are in a long-term, committed relationship that is like a marriage. We understand that by signing this declaration, we agree to tell the Scheme about any change to the status of our relationship. We further understand that if the information we give about our relationship is false in any way, the Scheme reserves the right to end both our memberships.

If both parties have not signed and dated the below section, we will halt the application process until we receive the section signed and dated by both parties.

Since when have you and your partner been in this relationship that is like a marriage? Y Y M M

I confirm the information is accurate and complete.

Signature of main applicant | Signature of partner

Date Y Y Y Y M M D D | Date Y Y Y Y M M D D

4. About your dependants (if applying for cover)

When do you want your cover to start? 2 0 Y Y M M 0 1

Dependant 1

Title | Initials | Surname

First names

Preferred name | Sex M F | Date of birth Y Y Y Y M M D D

ID or passport number | Country of issue

Relationship to main member (for example, mother, child. If the child is not your biological child, please state relationship, for example adopted child, foster child. Please give legal proof)

If your dependant is 21 years and older, are they: Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐ Disabled? Yes ☐ No ☐

Full-time student? Yes ☐ No ☐ Does your dependant earn an income? Yes ☐ No ☐

How much does your dependant earn each month? R

LAHNB03

4. About your dependants (if applying for cover) (continued)

Dependant 2

Title Initials Surname

First names

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

ID or passport number Country of issue

Relationship to main member (for example, mother, child. If the child is not your biological child, please state relationship, for example adopted child, foster child. Please give legal proof)

If your dependant is 21 years and older, are they: Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐ Disabled? Yes ☐ No ☐

Full-time student? Yes ☐ No ☐ Does your dependant earn an income? Yes ☐ No ☐ How much does your dependant earn each month? R

Dependant 3

Title Initials Surname

First names

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

ID or passport number Country of issue

Relationship to main member (for example, mother, child. If the child is not your biological child, please state relationship, for example adopted child, foster child. Please give legal proof)

If your dependant is 21 years and older, are they: Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐ Disabled? Yes ☐ No ☐

Full-time student? Yes ☐ No ☐ Does your dependant earn an income? Yes ☐ No ☐ How much does your dependant earn each month? R

Dependant 4

Title Initials Surname

First names

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

ID or passport number Country of issue

Relationship to main member (for example, mother, child. If the child is not your biological child, please state relationship, for example adopted child, foster child. Please give legal proof)

If your dependant is 21 years and older, are they: Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐ Disabled? Yes ☐ No ☐

Full-time student? Yes ☐ No ☐ Does your dependant earn an income? Yes ☐ No ☐ How much does your dependant earn each month? R

5. Your employer warranty (where relevant)

Please make sure your employer completes this section of the application form.

1. We warrant that the member detailed in section 2 of this application form is an employee of our organisation.
2. LA Health Medical Scheme may bill us for the amount due in respect of this dependant in the same manner as for other LA Health Medical Scheme members employed by our Organisation.

Authorised signatories

Names

Designation

Department name

Employer stamp

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6. Please select a GP

Please complete if you have selected the LA KeyPlus Option

	Name	General practitioner (GP)	Practice number	Second GP name	Practice number
Spouse or partner					
Dependant					
Dependant					
Dependant					

If your dependant/s live far away from where they work or often need to work in different towns or provinces, they may need a second GP. Please complete the relevant section if they need a second GP allocated to them. **Please note:** The dependant can only access day-to-day cover and chronic benefits through the KeyCare network GPs they have indicated on this form.

7. Previous medical scheme details

Please give us the details of all registered South African medical schemes that your dependant/s applying for cover previously belonged to. We will use this information to determine if we need to apply any waiting periods, late-joiner penalty fees, or both. Please give us proof in the form of a membership certificate.

	Scheme name	**Membership number**	**Start date**	**End date or are you still a member?**		**Reasons for leaving**
Spouse or partner						
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
Dependant 1						
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
Dependant 2						
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
Dependant 3						
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
Dependant 4						
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	

8. Moving from another medical scheme

If you answer "No" to any question in 8.1, you must complete all the medical questions in section 9.

8.1 **I confirm that all people named on this application:**

1. Are currently or have been members of a South African medical scheme for at least the past 24 months; and — Yes ☐ No ☐
2. Have not had a break in membership of more than 90 days since resigning from that South African medical scheme. — Yes ☐ No ☐

If you answered **"Yes"** to the above questions, please answer the questions in **8.2.**

If you answered **"No"** in **8.1** you must complete **section 9.**

8.2 **For any person named on this application form:**

1. Have they been admitted to hospital in the 12 months before this application? — Yes ☐ No ☐
2. Are they currently taking regular, ongoing medicine for a medical condition? — Yes ☐ No ☐
3. Are they planning to or reasonably expecting to be hospitalised (including for pregnancy) or expecting to receive dental or medical treatment costing more than R2 000 in the next 12 months? — Yes ☐ No ☐

If you answered **"No"** to **all** questions in 8.2, we will not apply any waiting periods and you **do not** have to complete section 9.

If you answered **"Yes"** to any questions in 8.2, we will apply a three-month general waiting period to your application and you do not have to complete section 9.

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, complete section 9.

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9. Your spouse, partner or dependant/s health questions

Treating healthcare professional's name

Practice number

Telephone

Email

9.A. Only the spouse or partner and any adult dependant applying for cover need to complete section 9.A.

Spouse or partner

How tall are you? . metres How much do you weigh? kilograms

Your blood type Your allergies

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week?

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day

If **"No"**, have you smoked in the last 24 months? Yes ☐ No ☐ If **"Yes"**, amount each day

If you stopped smoking, what was your reason for stopping?

Dependant 1

How tall are you? . metres How much do you weigh? kilograms

Your blood type Your allergies

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week?

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day

If **"No"**, have you smoked in the last 24 months? Yes ☐ No ☐ If **"Yes"**, amount each day

If you stopped smoking, what was your reason for stopping?

Dependant 2

How tall are you? . metres How much do you weigh? kilograms

Your blood type Your allergies

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week?

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day

If **"No"**, have you smoked in the last 24 months? Yes ☐ No ☐ If **"Yes"**, amount each day

If you stopped smoking, what was your reason for stopping?

Dependant 3

How tall are you? . metres How much do you weigh? kilograms

Your blood type Your allergies

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week?

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day

If **"No"**, have you smoked in the last 24 months? Yes ☐ No ☐ If **"Yes"**, amount each day

If you stopped smoking, what was your reason for stopping?

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9. Your spouse, partner or dependant/s health questions *(continued)*

Dependant 4

How tall are you? ☐ . ☐☐ metres How much do you weigh? ☐☐☐ kilograms

Your blood type ☐ Your allergies ☐

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week? ☐☐☐☐

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day ☐☐☐

If **"No"**, have you smoked in the last 24 months? Yes ☐ No ☐ If **"Yes"**, amount each day ☐☐☐

If you stopped smoking, what was your reason for stopping? ☐

9.B Have **any of your dependants** in this application ever experienced, been treated for, or 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.
Please take note that if you 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 8.17 below.

9.1 Tumours and growths **Yes** ☐ **No** ☐

Example: abnormal pap smear results, pre-cancerous skin lesions, breast disease, breast lumps, non-cancerous tumors, cancerous tumors, fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abnormal mammogram result, abnormal PSA (prostate specific antigen) result.

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

9.2 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, congenital heart disease, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker.

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

9.3 Gynaecological and obstetrics conditions **Yes** ☐ **No** ☐

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

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

9.4 Are any of your dependant/s pregnant? **Yes** ☐ **No** ☐

Patient name		

9.5 Mental health **Yes** ☐ **No** ☐

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

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

9. Your spouse, partner or dependant/s health questions *(continued)*

9.6 Metabolic or endocrine conditions Yes ☐ No ☐

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

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

9.7 Abdominal conditions Yes ☐ No ☐

Example: hepatitis, cirrhosis, portal hypertension, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis, gall bladder, gall stones, GORD (heartburn), oesophageal disease, hernias, atrophic gastritis, ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis.

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

9.8 Brain and nerve conditions Yes ☐ No ☐

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

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

9.9 Breathing and respiratory conditions Yes ☐ No ☐

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

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

9.10 Musculoskeletal (back, bone and muscle pain) Yes ☐ No ☐

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

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

9.11 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, bladder infections, other bladder or kidney problems.

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

9.12 Blood conditions Yes ☐ No ☐

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

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

9. Your spouse, partner or dependant/s health questions *(continued)*

9.13 Eye conditions **Yes** ☐ **No** ☐

Example: cataract, keratoconus, corneal ulcer, uveitis, glaucoma, squint, ptosis, any abnormality of eyelids, retinopathy, macular degeneration, cornea transplant, eye surgery, blurry vision, blindness (partial or full), retinal detachment.

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

9.14 Ear, nose and throat (ENT) and dentistry conditions **Yes** ☐ **No** ☐

Examples: chronic otitis media (middle ear infection), chronic otitis externa, hearing problems, hearing aid, cochlear implant, tonsillitis, adenoiditis, vertigo, deafness, sinus problem, nasal surgery, dental treatment or dental surgery.

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

9.15 Male urogenital conditions **Yes** ☐ **No** ☐

Example: prostate disorders, urogenital defects, varicocele, tumours, undescended testes, phimosis, urinary incontinence.

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

9.16 Are any of your dependant/s expecting surgery or planning hospitalisation or treatment in the next 12 months or have you been admitted to hospital in the last 12 months? **Yes** ☐ **No** ☐

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

9.17 Have you or any of your dependant/s 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	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

9.18 Have any of your dependant/s been diagnosed with or received treatment for, any condition not mentioned in the questions above, in the last 12 months before this application? **Yes** ☐ **No** ☐

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

HIV and AIDS

You do not need to disclose the HIV status of your dependant/s on this form if you do not feel comfortable doing so. However, if one or more of your dependants is HIV-positive they must call us on **0860 103 933**, within seven working days from the date we activate their LA Health Medical Scheme membership. We treat this information in the strictest confidence. If one or more of your dependants, is HIV-positive, it is in their best interest to register on the HIV*Care* Programme. A 12-month condition–specific waiting period may apply to this condition.

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

1. This Fair Collection Notice ("Notice") explains how we obtain, use, disclose and otherwise process personal information, which may include health and financial information ("Personal Information"), as required by the Protection of Personal Information Act ("POPIA").
2. Acceptance of these terms and conditions is voluntary, but is a requirement for activation and servicing of your LA Health Medical Scheme membership. If you do not accept these terms and conditions, we cannot activate and service your membership.
3. Please note:
   a. We may amend this Notice from time to time. Please check our website periodically to inform yourself of any changes;
   b. You have the right to object to the processing of your Personal Information;
   c. Should you believe that we have utilised your Personal Information contrary to applicable law, you will first resolve any concerns with us. If you are not satisfied with such process, you have the right to lodge a complaint with the Information Regulator, under POPIA.
4. LA Health Medical Scheme and Discovery Health (Pty) Ltd (we/us) will keep any information, including Personal Information relating to yourself and your dependant/s and/or beneficiaries, supplied to us in this application or collected from other sources ("Your Personal Information") confidential.
   You confirm that when you provide us with your Personal Information, your dependant/s and/or beneficiaries have provided you with the appropriate permission to disclose their Personal Information to us for the purposes set out below and any other related purposes.
   You agree to us processing and disclosing Your Personal Information in the following manner:
   We may collect, collate, process, store and disclose your Personal Information:
   a. For the administration of your benefit option;
   b. For providing managed care services to you or any dependant/s on your benefit option;
   c. For providing relevant information to a contracted third party who requires this information to provide a healthcare service to you or any dependant/s on your benefit option;
   d. To profile and analyse risk;
   e. For academic research conducted by any company within the Discovery Group and/or contracted research and survey providers in South Africa as well as outside the borders of the Republic.
   Examples of how this will happen include:
   a. Sharing your Personal Information with your chosen broker during the application process to help Discovery Health (Pty) Ltd, if necessary, while we process your membership application;
   b. Getting Your Personal Information from other relevant sources, including any entity that is part of Discovery Limited, medical practitioners, contracted service providers, brokers, credit bureaus or industry regulatory bodies ("Sources"), and further processing of such information to consider your membership application, to conduct underwriting or risk assessments, or to consider a claim for medical expenses. We may (at any time and on an ongoing basis) verify with the Sources that your Personal information is true, correct and complete;
   c. Getting and sharing any information that is relevant to your application from or with your employer, if you have joined as a member of an employer group;
   d. Communicating with you about any changes in your benefit option, including your contributions or changes and enhancements to the benefits you are entitled to on the benefit option you have chosen;
   e. Transferring your Personal Information outside the borders of the Republic of South Africa, where appropriate, if you provide an email address which is hosted outside the borders of South Africa, or for processing, storage or academic research. We will ensure that anyone to whom we pass your personal information agrees to treat your information with the same level of protection as we are obliged to;
   f. Making use of external health specialists to assess or evaluate certain clinical information. Your Personal Information will be shared with such specialist/s in the event that you or your dependant/s are subject to such a clinical assessment.
5. If asked to do so, we will share your Personal Information with a third party if you have already given your consent for the disclosure of this information to such third party or if a contractual relationship exists in terms of which we are obliged to provide the information to such third party.
6. We will provide your Personal Information to any other entity within the Discovery Group with whom you or your dependant/s already have a relationship or where you or your dependant/s have applied for a product or benefit from such entity. This information will be provided for the administration of your or your dependant's products or benefits with other entities within the Discovery Group.
7. We may provide any credit bureau or credit providers industry association with any information about your consumer credit record, including personal information about any judgement or default history.
8. We and any entity within the Discovery Group will keep you updated on information about any offers or new products Discovery may make available at any time. Please contact us if you do not wish to receive any telephonic direct marketing information from us.
9. If we want to share your information for any other reason, we will do so only with your permission.
10. You have the right to request a copy of the Personal Information we hold about you. To do this, simply complete the 'Data Subject Request Form' on www.discovery.co.za/legal and specify what information you would like. We will take all reasonable steps to confirm your identity before providing details of your personal information. Please note that any such Data Subject Request may be subject to a payment of a legally allowable fee.
11. You have the right to contact and ask us to update, correct or delete your personal information.
12. You agree that we may retain Your Personal Information until such time as you request us to destroy them (unless we are obliged by law to retain it, regardless of such request).
13. If LA Health Medical Scheme, Discovery Health (Pty) Ltd or Discovery (Ltd) becomes involved in a proposed or actual merger, acquisition or any form of sale of some or all its assets, we may use and disclose your Personal Information to third parties in connection with the evaluation of the transaction. The surviving company, or the acquiring company in the case of a sale of assets, would have access to your Personal Information which would continue to be subject to this Notice.
14. LA Health Medical Scheme and Discovery Health (Pty) Ltd are required to collect and retain information in terms of the following legislation (amongst others):
    14.1. The Medical Schemes Act, 1998
    14.2. The Consumer Protection Act, 2008
    14.3. The Protection of Personal Information Act, 2013
    14.4. Electronic Communications and Transactions Act, 2002
    14.5. Promotion of Access to Information Act, 2000
    Legislation specific to Discovery Health (Pty) Ltd only:
    14.6. Financial Advisory and Intermediary Services Act, 2002

Signature of main applicant

Please do not sign an incomplete application form.

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11. LA Health Medical Scheme rules for membership

11.1 Rules for membership

The rules of LA Health Medical Scheme record your rights and responsibilities for your membership of LA Health Medical Scheme. They may change from time to time. You may ask us for a copy at any time.

When you sign this application, you confirm that you have read and understood the rules and you agree that you and those you apply for will be bound by them. Where applicable you also acknowledge and confirm that the broker you or your employer appointed, may communicate with us on this application and your membership of LA Health Medical Scheme.

You give permission that LA Health Medical Scheme and Discovery Health (Pty) Ltd can share your medical information and other relevant personal information about you and your dependant/s with your chosen broker. The information will be shared so that he or she can help Discovery Health (Pty) Ltd if necessary while we process your membership application. Please speak to your broker or Discovery Health (Pty) Ltd if there is anything you do not understand.

11.2 Who you are applying for

You may apply to join LA Health Medical Scheme on your own or together with other people – your spouse, your partner and people who are financially dependent on you as defined in the LA Health Medical Scheme rules. For anyone to be treated as financially dependent for this application, you must have a legal responsibility to provide financially for that dependant. We 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.

11.3 Acting for others

You confirm you have the right to act for others

By signing this document, you confirm that:

- you have the right to apply for membership and to act for those you apply for in any matter relating to this application;
- you have received permission from your spouse and any dependant/s over 18 to act for them in any matter relating to this application.

11.4 Giving and getting information

You must give true, correct and complete information

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

Information about you and those you apply for must be true, correct and complete. This includes the details you give in this application form and in future dealings with LA Health Medical Scheme and Discovery Health (Pty) Ltd. It is important that you tell LA Health Medical Scheme and Discovery Health (Pty) Ltd about any medical condition, symptom or illness relating to you or those you apply for, even if you do not consider it relevant to your application.

We may ask those you apply for who are 18 and older for information and this will be treated as if LA Health Medical Scheme had asked you in your role as main member.

Your legal address

We will send documents to you at the address you indicated as the communication channel you prefer to be contacted on. 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.

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

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

LA Health Medical Scheme and Discovery Health (Pty) Ltd may get information about you from other relevant sources

To consider your application for membership, conduct underwriting or risk assessments or to consider a claim for medical expenses, you agree that Discovery Health (Pty) Ltd and LA Health Medical Scheme can get information about you and those you apply for from other relevant sources. These include any entity that is part of Discovery Limited, medical practitioners, brokers, credit bureaus or industry regulatory bodies. Discovery Health (Pty) Ltd and LA Health Medical Scheme may (at any time and on an ongoing basis) verify with the parties mentioned in this section that the information you give on this application and in respect of any matter pertaining to or that arose during your membership of LA Health Medical Scheme, is true, correct and complete. You give your permission that LA Health Medical Scheme and Discovery Health (Pty) Ltd may get any information that is relevant to your application from your employer.

Tell LA Health Medical Scheme or Discovery Health(Pty) Ltd immediately if your information changes

You, your employer or your broker must tell LA Health Medical Scheme or Discovery Health (Pty) Ltd 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 backdated changes may not be accepted.

When LA Health Medical Scheme may cancel your membership/s

LA Health Medical Scheme may cancel any memberships immediately, if you and those you apply for:

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

11.5 About becoming a member

LA Health Medical Scheme might not pay for certain expenses immediately after you become a member

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

Resign from current medical schemes when accepted

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

You must ensure contributions are paid on time

As the main member of LA Health Medical Scheme, you are responsible for ensuring that your contributions and the contributions of those you apply for are paid on time every month to avoid suspension of benefits. The Scheme has the right to amend monthly contributions and benefits from time to time.

11.6 Repaying money owed to the Scheme

LA Health Medical Scheme has the right at any time to collect from you any amount that you owe to the Scheme. We will notify you if there is any amount that you owe to the Scheme.

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

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

Signature of main member

Date Y Y Y Y M M D D

The main member must sign and date any changes.
Please do not sign an incomplete application form.

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