Applying to become a member of LA Health Medical Scheme 2018 (with underwriting)

LA Health
Powered by Discovery

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

Thank you for deciding to apply to join LA Health Medical Scheme. This document is an application form for membership. It also contains some rules for membership. Please make sure you read and understand the rules.

Who we are

LA Health Medical Scheme (referred to as 'the Scheme'), registration number 1145, is the medical scheme that you 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 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.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Read and understand the rules for membership (section 10).
3. Main applicant to sign and date section 6, 9 and 10 and any changes.
4. Please fax this completed and signed form with any supporting documentation to 011 539 3000 or email it to **application@discovery.co.za**
5. Please attach a copy of each applicant's identity document to this application form. We also accept valid passports and birth certificates for children.

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

- If any details are missing or if we need more information for underwriting purposes, we will contact you.
- We will activate your membership and send you or your employer a letter of confirmation when we are offering standard terms of acceptance (no waiting periods or late-joiner penalties). For any non-standard terms, we will issue a counter-offer letter 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 for us to activate your membership.
- We will send you or your employer a welcome letter, SMS or 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.
- You will then get a pack in the post.

If you do not hear from us seven days after sending us 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 rules for membership and agree to them.

1. About yourself (main applicant)

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

Title | Initials | Surname

First name/s
(as per identity document)

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

Previous or maiden name

Preferred communication Email ☐ Post ☐ By choosing email, you will receive your communication quicker and there is less of an impact on the environment.

Preferred language English ☐ Afrikaans ☐

ID or passport number | Country of issue

Telephone (H) | (W)

Cellphone | Fax

Email

Please supply a personal email address and not a .gov email address, as your employer's firewall may prevent our emails from reaching you.

1. About yourself (main applicant)

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

☐ PO Box ☐ Private Bag Box number

☐ Suite ☐ Postnet Suite Number

Suburb Postal code

If your post is delivered to your street address, please complete these details under physical address.

Physical address:

Suite/Unit number Complex name

Street number Street name

Suburb Postal code

Occupation Tax number

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

Title Initials Surname

First name/s
(as per identity document)

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

Previous or maiden name

ID or passport number Country of issue

Telephone (H) (W)

Cellphone Tax number

Email

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. 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.

We declare we are in a long-term, committed relationship that is like a marriage and that we live together at the same residence. We understand that by signing this declaration, we agree to tell the Scheme about any change to the status of our relationship or any change to our living arrangements, such as separation. We further understand that if the information we give about our relationship or residency is false in any way, the Scheme reserves the right to end both our memberships.

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

Signature of main applicant Original hand signature required

Please do not sign an incomplete application form

Signature of partner Original hand signature required

Please do not sign an incomplete application form

Date Y Y Y Y M M D D

Date Y Y Y Y M M D D

3. About your dependant/s (if applying for cover)

Dependant 1

Title Initials Surname

First name/s
(as per identity document)

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

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 supply legal proof.)

ID or passport number Country of issue

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

Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐ Disabled? Yes ☐ No ☐ A student? Yes ☐ No ☐

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

If the adult dependant you are applying for is financially dependent on you, please attach a 3 month bank statement and an affidavit from the main member confirming the financial dependancy and the reason for joining.

3. About your dependant/s (if applying for cover) *(continued)*

Dependant 2

Title Initials Surname

First name/s
(as per identity document)

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

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 supply legal proof.)

ID or passport number Country of issue

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

Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐ Disabled? Yes ☐ No ☐ A student? Yes ☐ No ☐

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

If the adult dependant you are applying for is financially dependent on you, please attach a 3 month bank statement and an affidavit from the main member confirming the financial dependancy and the reason for joining.

Dependant 3

Title Initials Surname

First name/s
(as per identity document)

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

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 supply legal proof.)

ID or passport number Country of issue

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

Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐ Disabled? Yes ☐ No ☐ A student? Yes ☐ No ☐

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

If the adult dependant you are applying for is financially dependent on you, please attach a 3 month bank statement and an affidavit from the main member confirming the financial dependancy and the reason for joining.

4. Please select your benefit option

You have the right to ask for help in selecting a benefit option that suits your needs. By signing this application you confirm that you are familiar with the conditions and benefits of the Option you select.

☐ LA KeyPlus ☐ LA Focus ☐ LA Active ☐ LA Core ☐ LA Comprehensive

*All the Benefit Options, except LA KeyPlus, have Medical Savings Accounts. When your LA Health Medical Scheme membership is confirmed, any current Medical Savings Account balance in your previous scheme must be transferred to LA Health Medical Scheme (in terms of the Medical Schemes Act and its regulations).

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

Please complete this if you selected the LA KeyPlus Option:

Main member's income R (total monthly cost to company)

Please complete this if you have selected the LA Health KeyPlus Option

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

Your GP must be a KeyPlus Network GP so you can have full cover.

*If you live far away from where you work or often need to work in different towns or provinces, you may need a second GP. Please only choose a second GP if this applies. Please make sure the dependant information you give in the table above is the same as the dependant information in section 3 of this form.

Please note: you and your dependant/s can only access day-to-day cover and chronic benefits through the KeyCare general practitioner/s you chose above.

5. Your employment details

5.1 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 ___ Employer or billing number ___

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

Branch name ___ Branch number ___

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

Employer warranty

1. We warrant that the main applicant detailed in section 1 is an employee of our organisation.
2. The Scheme may bill us for the amount due for this member in the same way as it does for our other employees with the Scheme.

Authorised signatory(ies) 1. Original hand signature required 2. Original hand signature required

Names ___ ___

Designations ___ ___

6. Your banking details

6.1 Your contributions

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

Please note: we cannot accept credit card account details

Bank name ___

Branch name ___

Branch code ___ – ___ – ___ – ___

Account number ___

Type of account Cheque ☐ Savings ☐

Accountholder ___

Please choose the date you would like us to debit your account:

1st ☐ 10th ☐ 15th ☐ 20th ☐ 25th ☐

If your application is captured after the date you chose above, your first debit order will go off on the first of the month and then on the chosen date after that.

Can we use this account to refund claims to you? Yes ☐ No ☐

If you want to use a different account for claim refunds or if the banking details completed above belong to someone else, please complete 6.2 to tell us which account to use for claim refunds.

Signature of account holder Original hand signature required

6.2 Your claim refunds

If you do not want to use the same banking details for your contribution and claim refunds, please give us the details you would like to use:

Please note: we cannot accept credit card account details

Bank name ___

Branch name ___

Branch code ___ – ___ – ___ – ___

Account number ___

Type of account Cheque ☐ Savings ☐

Accountholder ___

By signing below, 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.

You must inform us immediately if any of your banking details change.

Signature of account holder Original hand signature required

7. Previous medical scheme details

Please give us the details of all registered South African medical schemes that you 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.

Main applicant

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

If all dependant/s were on the same medical scheme/s as completed above, please tick here to confirm this. ☐

If any of your dependant/s applying for cover belonged to different medical schemes, please complete them below:

Dependant name	**Scheme name**	**Start date**	**End date if already resigned**	**Are they still a member?**	**Reason for leaving**
		Y Y Y Y M M D D	Y Y Y Y M M D D	Yes ☐ No ☐	
		Y Y Y Y M M D D	Y Y Y Y M M D D	Yes ☐ No ☐	
		Y Y Y Y M M D D	Y Y Y Y M M D D	Yes ☐ No ☐	
		Y Y Y Y M M D D	Y Y Y Y M M D D	Yes ☐ No ☐	
		Y Y Y Y M M D D	Y Y Y Y M M D D	Yes ☐ No ☐	
		Y Y Y Y M M D D	Y Y Y Y M M D D	Yes ☐ No ☐	
		Y Y Y Y M M D D	Y Y Y Y M M D D	Yes ☐ No ☐	

LAHNB01

8. Your health questions

Treating healthcare professional's name

Practice number

Telephone

Email

8.A. The main applicant, spouse or partner and any adult dependant applying for cover need to complete section 8.A.

Main applicant

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

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

Your blood type Your allergies

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?

Spouse or partner

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

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

Your blood type Your allergies

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?

Adult 1 (any dependant/s 21 years and older)

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

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

Your blood type Your allergies

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?

Adult 2 (any dependant/s 21 years and older)

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

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

Your blood type Your allergies

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?

Adult 3 (any dependant/s 21 years and older)

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

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

Your blood type Your allergies

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?

8. Your health questions *(continued)*

8.B Have you or **any dependant** 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.

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 8.18 below.

8.1 Tumours and growths **Yes** ☐ **No** ☐

Example: abnormal pap smear results, skin lesions, breast disease, non-cancerous tumours, cancerous tumours, cancer of any organ fibrocystic breast disease, fibroadenoma, 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

8.2 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

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

Example: abnormal pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility, ectopic pregnancy.

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

8.4 Are you or any of your dependant/s pregnant? **Yes** ☐ **No** ☐

Patient name		

8.5 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 abuse or 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

8.6 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

8. Your health questions *(continued)*

8.7 Abdominal conditions **Yes** ☐ **No** ☐

Example: hepatitis, cirrhosis, portal hypertension, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis, gall bladder, gall stones, GORD (reflux), heartburn, oesophageal disease, hernias, atrophic gastritis, ulcers, stomach 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

8.8 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, vetriculo-peritoneal shunt (VP shunt), mental retardation, CVA, bleeding on the brain.

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

8.9 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

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

Example: arthritis (any form), ongoing neck and/or 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, neurogenic bladder, 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

8.11 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

8.12 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

8. Your health questions *(continued)*

8.13 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

8.14 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

8.15 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

8.16 Are you or 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

8.17 Have you or any of your dependant/s 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	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

8.18 Have you or 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 you or your dependant/s on this form if you do not feel comfortable doing so. However, if you or one or more of your dependants are HIV-positive, you or they must call us on **0860 103 933** within seven working days from the date we activate your LA 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. A 12-month condition specific waiting period may apply to this condition. If you do not let us know about your HIV status within 7 days of your membership being active, we may end your LA Health Medical Scheme membership.

9. LA Health Privacy Statement - How we will process and disclose your personal information and communicate with you

Definitions

The Scheme refers to LA Health Medical Scheme, registration number 1145, registered with the Council for Medical Schemes.

Administrator refers to Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider.

Discovery Group refers to Discovery Limited, registration number 1999/007789/06, including all subsidiaries of the Group. Subsidiaries in the Group are authorised financial services providers.

You and your refer to the member and his/her dependants who are registered as beneficiaries of the Scheme.

Your personal information refers to personal information about you, your spouse, your dependants, your beneficiaries, and your employees (as relevant). It includes information about health, financial status, gender, age, contact numbers and addresses.

Process(ing) (of) information means the automated or manual activity of collecting, recording, organising, storing, updating, distributing and removing or deleting personal information.

Competent person means anyone who is legally competent to consent to any action or decision being taken for any matter concerning a member or dependant for example a parent or legal guardian.

1. When you engage with the Scheme and Administrator, you trust us with personal information about yourself, your family, and in some cases, your employees. We are committed to protecting your right to privacy.

   The purpose of this Privacy Statement is to set out how we collect, use, share and otherwise process your personal information, in line with the Protection of Personal Information Act ("POPIA").
2. You have the right to object to the processing of your personal information and have a choice whether or not to accept these terms and conditions. However, it is important to note that the Scheme and Administrator require your acceptance to activate and service your medical scheme membership. If you do not accept these terms and conditions, we cannot activate and service your medical scheme membership.
3. The Scheme and Administrator will keep your personal information confidential. You may have given us this information yourself or we may have collected it from other sources. If you share your personal information with any third parties, we will not be responsible for any loss suffered by you or your employer (where applicable).
4. You warrant that when you give the Scheme and Administrator personal information about your dependants, you have received their permission to share their personal information with us for the purposes set out in this Privacy Statement and any other related purposes.
5. If you are an employer, you agree to indemnify the Scheme and Administrator against any loss or damage, direct or indirect, that an employee suffers because of any unauthorised use of your employees' personal information.
6. If you are giving consent for a person under 18 (a minor) you confirm that you are a competent person and that you have authority to give their consent for them.
7. You agree that the Scheme and Administrator may process your personal information for the following purposes:
   - for the administration of your benefit option;
   - for the provision of managed care services to you on your benefit option;
   - for the provision of relevant information to a contracted third party who requires this information to provide a healthcare service to you on your benefit option;
   - to profile and analyse risk;
   - to share your personal information with external health specialists for them to assess or evaluate certain clinical information, in the event that you are subject to such a clinical assessment.

   Examples of how this will happen include:
   i. Sharing your personal information with your chosen financial adviser during the application process to help the Administrator, if necessary, while we process your membership application;
   ii. Getting your personal information from other relevant sources, including medical practitioners, contracted service providers, financial advisers, credit bureaus, entities that are part of Discovery Group or industry regulatory bodies ("relevant 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 relevant sources that your personal information is true, correct and complete;
   iii. If you have joined as a member of an employer group, getting from and sharing with your employer information that is relevant to your application;
   iv. Communicating with you about any changes to your benefit option, including your contributions or changes and enhancements to the benefits you are entitled to on the benefit option you have chosen;
8. If a third party asks the Scheme and Administrator for any of your personal information, we will share it with them only if:
   - you have already given your consent for the disclosure of this information to that third party; or
   - we have a legal or contractual duty to give the information to that third party.
9. The Scheme and the Administrator 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, service 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.
10. The Scheme and Administrator may share and combine all your personal information for any one or more of the following purposes:
    - market, statistical and academic research; and
    - to customise our benefits and services to meet your needs.

    Your personal information may be shared with third parties such as academics and researchers, including those outside South Africa. We ensure that the academics and researchers will keep your personal information confidential and all data will be made anonymous to the extent possible and where appropriate. No personal information will be made available to a third party unless that third party has agreed to abide by strict confidentiality protocols that we require. If we publish the results of this research, you will not be identified by name.

    If we want to share your personal information for any other reason, we will do so only with your permission.
11. By signing this application form, you authorise the Scheme and Administrator to obtain and share information about your creditworthiness with any credit bureau or credit providers' industry association or industry body. This includes information about credit history, financial history, judgments, default history and sharing of information for purposes of risk analysis, tracing and any related purposes.
12. The Scheme and Administrator have the right to communicate with you electronically about any changes to your benefit option, including your contributions or changes and improvements to the benefits you are entitled to on the benefit option you have chosen.
13. The Scheme and Administrator have a duty to keep you updated about any offers and new products that are made available from time to time. The Scheme, Administrator, any entity within the Discovery Group and contracted third-party service providers may communicate with you about these.
14. Please let the Administrator know if you do not wish to receive any direct telephonic marketing.
15. You have the right to know what personal information the Scheme holds about you. If you wish to receive this information please complete a 'PAIA Form to Request Access to Records' onwww.lahealth.co.za. and specify the information you would like. We will take all reasonable steps to confirm your identity before providing details of your personal information.

    We are entitled to charge a fee for this service and will let you know what it is at the time of your request.
16. You agree that the Scheme and Administrator may keep your personal information until you ask us to delete or destroy it. You have the right to ask us to update, correct or delete your personal information, unless the law requires us to keep it. Where we cannot delete your personal information, we will take all practical steps to de-personalise it.

9. LA Health Privacy Statement - How we will process and disclose your personal information and communicate with you *(continued)*

17. Where the Scheme and Administrator are required by law to collect and keep personal information, we shall do so. At a minimum, this includes the following:
    - Medical Schemes Act, 1998
    - The Consumer Protection Act, 2008
    - The Protection of Personal Information Act, 2013
    - Electronic Communications and Transactions Act, 2002
    - Promotion of Access to Information Act, 2002

    Legislation specific to Discovery Health (Pty) Ltd only:
    - Financial Advisory and Intermediary Services Act, 2002
18. You agree that the Scheme and Administrator may transfer your personal information outside South Africa:
    - if you give us an email address that is hosted outside South Africa; or
    - to administer certain services, for example, cloud services.

    When we share your information to administer certain services, we will ensure that any country, company or person that we pass your personal information to agrees to treat your information with the same level of protection as we are obliged to.
19. If the Scheme or Administrator becomes involved in a proposed or actual amalgamation, transfer or merger, acquisition or any form of sale of any assets, as appropriate, we have the right to share your personal information with third parties in connection with the transaction. In the case of such an event, the new entity will have access to your personal information.
20. The Scheme may change this Privacy Statement at any time. The current version is available on www.lahealth.co.za
21. If you believe that the Scheme or Administrator have used your personal information contrary to this Privacy Statement, you have the right to lodge a complaint with the Information Regulator, under POPIA, but we encourage you to first follow our internal complains process to resolve the complaint. We explain the complaints and disputes process on www.lahealth.co.za . Contact details for the Information Regulator: The Information Regulator (South Africa) |SALU Building | 316 Thabo Sehume Street | PRETORIA | | Tel: 012 406 4818 | Fax: 086 500 3351 | inforeg@justice.gov.za

Signature of main applicant

Original hand signature required

The main applicant must sign and date any changes

10. LA Health Medical Scheme rules for membership

10.1 Rules for membership

The Rules of LA Health Medical Scheme record your rights and responsibilities for your membership of the 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.

10.2 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 those dependant/s. 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.

10.3 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.

10.4 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.

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.

10.5 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

10. LA Health Medical Scheme rules for membership *(continued)*

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 scheme(s) 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 as members.

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.

10.6 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 of any amount that you must pay 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 applicant Original hand signature required

Date 2 0 Y Y M M D D

The main applicant must sign and date any changes.
Please do not sign incomplete forms.

11. Your broker details

Broker

Code

Principal

Broker house

Code

Broker's contact details:

Tel (W)

Cellphone

Signature of intermediary(ies) Original hand signature required

Commissioner of oath stamp