

Application to add dependants (with underwriting) 2024



Contact details

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

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 medical scheme that you are applying to become a member of. This is a not-for-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 the form

1. Please use one letter per block, complete in black ink and print clearly.
2. When filling in this form, read and understand the rules for membership (Section 11).
3. Email the completed and signed form to application@discovery.co.za or fax it to 011 539 2331
4. Please attach a copy of the identity documents of your dependant/s. We also accept SA driver's licences, passports and SA birth certificates for children.
5. To avoid administration delays, please make sure this application is completed in full by you and your employer.
6. Provision is made in this form for you and your dependants to provide information relating to your race. This information is required by the Council for Medical Scheme for statistical purposes only. You are not compelled to provide this information.

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.
- We will send you or your employer, the counter offer letter and any outstanding underwriting requirements where we cannot offer standard terms of acceptance for both you and your dependant/s (adult and child dependant/s).
- 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 terms and conditions (Section 11 of this form) for membership and agree to them.

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

Contact name	<input type="text"/>	Job title	<input type="text"/>
Address	<input type="text"/>		
	<input type="text"/>	Code	<input type="text"/>
Telephone	<input type="text"/>	Fax	<input type="text"/>
Cellphone	<input type="text"/>		
Email	<input type="text"/>		
Preferred means of communication (please tick one)	Email <input type="checkbox"/>	Post <input type="checkbox"/>	Fax <input type="checkbox"/>

2. About yourself (main member)

Surname	<input type="text"/>	Membership number	<input type="text"/>
First names	<input type="text"/>	Date of birth	<input type="text"/>
Address details	<input type="text"/>		

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Telephone (H)	<input type="text"/>	Code	<input type="text"/>
Cellphone	<input type="text"/>	Telephone (W)	<input type="text"/>
Employer name	<input type="text"/>	Fax	<input type="text"/>
		Employer number	<input type="text"/>

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

When do you want your cover to start

Title Initials Surname

First name(s)
(as per identity document)

Previous or maiden name

Gender M F Date of birth

Race African Coloured Indian/Asian White Other Do not want to disclose

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

Marital status Married Single Divorced Widowed

ID or passport number

Telephone (H) Telephone (W)

Cellphone Fax

Email

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

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. 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

Signature of main applicant

Please do not sign an incomplete application form

Signature of partner

Please do not sign an incomplete application form

Date

Date

4. About your dependant/s (only complete if applying for cover)

When do you want cover to start

Dependant 1

Title Initials Surname

First name(s) (as per identity document)

Gender M F Date of birth

Race African Coloured Indian/Asian White Other Do not want to disclose

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

ID or passport number

Relationship to main member (For example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

Is your dependant 21 years or older, are they married? Yes No Financially dependant on you? Yes No

Does your dependant earn an income? Yes No

How much does your dependant earn each month? (Gross income) R

Is your dependant a student? Yes No Is your dependant disabled? Yes No

Dependant 2

Title Initials Surname

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

Gender M F Date of birth

Race African Coloured Indian/Asian White Other Do not want to disclose

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

ID or passport number

Relationship to main member (For example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

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

Does your dependant earn an income? Yes No

How much does your dependant earn each month? (Gross income) R

Is your dependant a student Yes No Is your dependant disabled? Yes No

Dependant 3

Title Initials Surname

First name(s)(as per identity document)

Gender M F Date of birth

Race African Coloured Indian / Asian White Other Do not want to disclose

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

ID or passport number

Relationship to main member (For example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

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

Does your dependant earn an income? Yes No

How much does your dependant earn each month? (Gross income) R

Is your dependent a student? Yes No Is your dependant disabled? Yes No

Dependant 4
 Title Initials Surname

 First name(s) (as per identity document)

 Gender M F Date of birth

 Race African Coloured Indian / Asian White Other Do not want to disclose

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

 ID or passport number

Relationship to main member (For example, mother, child etc. Where your child is not your biological child, please state relationship, ie adopted child, foster child. Please provide legal proof)

 If your dependant is 21 years or older, are they: Married? Yes No Financially dependant on you? Yes No

 Is your dependant a student? Yes No

 How much does your dependant earn each month? (Gross income) R .

 Is your dependant a student? Yes No Is your dependant disabled? Yes No
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 signatory

 Names

 Designation

 Department name

STAMP

6. Please select a GP

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

	Name	GP name	Practice number	Second GP name*	Practice number
Spouse or partner	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dependent One	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dependent Two	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dependent Three	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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 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.

Spouse or partner

Scheme name	Membership number	Start date	Are you still a member	End date if you have already registered	Reason for leaving
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		

Dependant one

Scheme name	Membership number	Start date	Are you still a member	End date if you have already registered	Reason for leaving
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		

Dependant two

Scheme name	Membership number	Start date	Are you still a member	End date if you have already registered	Reason for leaving
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		

Dependant three

Scheme name	Membership number	Start date	Are you still a member	End date if you have already registered	Reason for leaving
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		

Dependant four

Scheme name	Membership number	Start date	Are you still a member	End date if you have already registered	Reason for leaving
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		

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 answer “no” to any question in 8.1, you must complete all the medical questions in section 9.

8.2. For any person named on this application form:

1. Have you or any of your dependants been admitted to hospital in the 12 months before this application?

Yes No

2. Are you or any of your dependants currently taking regular, ongoing medicine and/or treatment of a medical condition or symptom?

Yes No

3. Are you or any of your dependants planning to or reasonably expecting to be hospitalised (including for pregnancy) or expecting to receive dental or medical treatment/investigations costing more than R2 000 in the next 12 months?

Yes No

If you answered “No” to all questions in 8.2, we will not apply a 12 months condition specific waiting period and you do not have to complete section 9.

The Scheme may apply a three-month general waiting period to your application.

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.

9. Your health questions

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

9.1 Tumours, growths and disorders of the skin

Yes No

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

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

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, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker, any autoimmune conditions, any congenital conditions, peripheral vascular disease, deep vein thrombosis and pulmonary embolus, varicose veins.

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

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9.3 Gynaecological and obstetrics conditionsYes No

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

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

9.4 Are you or any of your dependants pregnant or undergoing treatment/investigation for pregnancy?Yes No

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

9.5 Mental healthYes No

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

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

9.6 Metabolic or endocrine conditionsYes No

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

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

9.7. Abdominal conditions

Yes No

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

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

9.8 Brain and nerve conditions

Yes No

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

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

9.9 Breathing and respiratory conditions

Yes No

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

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

9.10 Musculoskeletal (back, bone and muscle pain)

Yes No

Example: arthritis (any form), ongoing/intermittent joint or muscular, ankylosing spondylitis, lupus, Sjögren's syndrome, scleroderma, polymyositis, dermatomyositis, polyarteritis nodosa, Wegener's granulomatosis, sarcoidosis, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, gout, injury, physical disability, prosthesis, amputation, any autoimmune conditions, any congenital conditions.

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

9.11 Kidney or urinary conditions including current or past dialysisYes No

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

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

9.12 Blood conditionsYes No

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

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

9.13 Eye conditionsYes No

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

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

9.14 Ear, nose and throat (ENT) and dentistry conditionsYes No

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

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

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9.15 Male urogenital conditions

Yes No

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

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

9.16 Are any of your dependants expecting surgery or planning hospitalisation or treatment in the next 12 months or have they been admitted to hospital in the last 12 months?

Yes No

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

9.17 Have any of your dependant/s received medical advice or treatment for symptoms not diagnosed by a medical professional, in the last 12 months before this application?

Yes No

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

9.18 Have any of your dependants 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	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

HIV and AIDS

If you, or one or more of your dependants, are HIV-positive, you or they must call us on **0860 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. LA Health Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before LA Health Medical Scheme starts paying for any general or specific medical conditions. A 12-month condition specific waiting period or a three-month general waiting period may therefore apply to this condition or any related condition. We will not indicate the 12-month condition specific waiting on a counter offer letter, if the waiting period is applied prior to activation of membership due to the sensitivity of this information. We will not indicate the 12-month condition specific waiting period on a membership certificate if the waiting period is applied due to the sensitivity of this information. 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..

10. LA Health Medical Scheme - Privacy Statement

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 all personal information the Scheme or the Administrator has on you, or data subjects which are related to you or under your authority ("other data subjects") (as relevant). It includes:

- financial information;
- information about your health, race or ethnic origin, biometrics, criminal behaviour or religion;
- your gender;
- your age;
- unique identifiers such as your identity number or 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.
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 the Scheme and Administrator require your acceptance of these terms and conditions, otherwise 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 understand that when you include your spouse and/or dependants on your application, we will process their personal information for the activation of their membership and to pursue their legitimate interest. We will furthermore process their information for the purposes set out in this Privacy Statement.
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 unauthorized 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 analyse risks, trends and profiles;Example of this include:
 - 7.1. Sharing your personal information with your chosen financial adviser during the membership application process to enable the Administrator to process your membership application;
 - 7.2. Obtaining and sharing your personal information with other relevant sources, including medical practitioners, contracted service providers, health information exchanges, 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 assess and value 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;
 - 7.3. If you have joined as a member of an employer group, getting information from and sharing information with your employer that is relevant to your application for membership, with due regard for considerations of confidentiality in respect of your state of health;
 - 7.4. Communicating with you about any changes to your benefit option, including changes to your contributions or 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, or
 - we need to share it with them for risk analytical or fraud detection, prevention or recovery purposes
9. You consent and agree that:
 - we may process your information, including personal information, to adhere to South African Legislative reporting obligations and to perform transaction monitoring activities;
 - we may communicate such personal information to local Regulatory Bodies as well as to other entities in the Discovery Group if any Legislative reportable matters are identified.
10. The Scheme and the Administrator may 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, and for fraud detection, prevention or recovery purposes.

11. 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.
12. Information about you may be shared with third parties such as academics and researchers, including those outside South Africa. We ensure that all data about you that is shared with such third parties will be made anonymous to the extent possible and where appropriate. Note also that personal information will be made available to such third party only if that third party has agreed to abide by strict confidentiality protocols that we require. If we publish the results of any academic 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.
13. We have a duty to take all reasonably practicable steps to ensure your personal information is complete, accurate, not misleading and updated on a regular basis. To enable this, we will always try to obtain personal information from you directly. Where we are unable to do so, we will make use of verifiable independent third party data sources.
14. By accepting this privacy statement, 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, and default history. It also includes sharing of information for purposes of risk analysis, tracing and any related purposes.
15. The Scheme and Administrator have the right to communicate with you electronically about any changes to your benefit option, including changes to your contributions or changes to the benefits you are entitled to on the benefit option you have chosen.
16. We may process your information using automated means (without human intervention in the decision making process) to make a decision about you or your application for any product or service. You may query the decision made about you.
17. 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.

Please let the Administrator know if you do not wish to receive any direct telephonic marketing.
18. You also confirm that we may share, both within the Discovery Group and with our service providers, and combine all your personal information, including your unique identifiers, for any one or more of the following purposes directly or through a third party:
 - 18.1. Market, statistical and academic research, including cross-company analytics;
 - 18.2. To customise and enhance our benefits and services to meet your needs; and
 - 18.3. To market our services to you.
19. You may opt out of Electronic Marketing by:
 - 19.1. Logging into your profile on www.lahealth.co.za or the Discovery App;
 - 19.2. Following the unsubscribe prompts on the electronic marketing communication received;
 - 19.3. By informing your appointed financial adviser.
20. We will store your personal information for the purpose of processing this request and action it as soon as reasonably possible.
21. You have the right to know what personal information the Scheme and Administrator holds about you. If you wish to receive this information please complete an 'Access Request Form', attached to the PAIA manual, on www.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.
22. 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.
23. Where the Scheme and Administrator are required by law to collect and keep personal information, we shall do so. We are required to collect and keep personal information in terms of the following laws:
 - 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, 2002Legislation specific to Discovery Health (Pty) Ltd only:
 - Financial Advisory and Intermediary Services Act, 2002
 - Companies Act, 2008
24. 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
 - for processing, storage or academic research, or
 - to administer certain services, for example, cloud services.When we share your information with a person (or company) outside South Africa, we will require of, such person (or company) to treat your information in a manner that complies with the requirements of that country and at least with the same level of protection as we are obliged to do in South Africa. Unless you specifically give us consent to share your personal information with such person (or company).
25. If the Scheme or Administrator becomes involved in a proposed or actual amalgamation or merger, acquisition or any form of sale of any assets, 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. The terms of this Privacy Statement will continue to apply.
26. The Scheme or Administrator may change this Privacy Statement at any time. The current version is available on www.lahealth.co.za.
27. If you believe that the Scheme or Administrator have used your personal information contrary to this Privacy Statement, we encourage you to first follow the Scheme or Administrator's internal complaints process to resolve the complaint. We explain the complaints and disputes process on the website at www.lahealth.co.za. If you are not satisfied after this process, you have the right to lodge a complaint with the Information Regulator, under POPIA.

Contact details for the Information Regulator:
The Information Regulator (South Africa)

LHAADW001

11. LA Health Medical Scheme terms and conditions for membership

11.1. **Terms and conditions for membership**

The terms and conditions of the 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.

11.2. **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 received permission from your spouse and/or 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 to become the main member on your membership of the Scheme, we must learn more about you. Information about you must be true, correct and complete. This includes the details you give in this application form and in future dealings with The Scheme and the Administrator

Your legal address

We will email, SMS or post your documents to you. If it is necessary to send you any legal notices or summonses, our legal team will serve these at the physical address you have given, or at any other address you have given us. It is your responsibility to make sure we have the correct address for you.

The Administrator and the Scheme may record telephone calls

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

Tell the Scheme or The Administrator immediately if your information changes

You, your employer or your broker must tell the Scheme or the Administrator in writing if any of the information you gave changes between the day you sign this document and the day your membership status is changed. We need advance notice of any administrative changes such as cancellation of membership, as backdated changes may not be accepted.

When the Scheme may cancel your membership/s

The Scheme may cancel any memberships immediately:

If you do not give the Scheme and the Administrator information that later turns out to be relevant to this application;
If you give the Scheme and the Administrator any information that is not true, correct and complete;

11.5. **You must ensure contributions are paid on time**

As the main member of the Scheme, you are responsible for ensuring that your and those persons registered as your dependants' contributions 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. If you are paying your contributions, the reference number **LAH CONT** will be used on your bank statement to identify the debit order.

11.6. **Repaying money owed to the Scheme**

The 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.

If the benefit option you chose offers a medical savings account, the Scheme makes money available in advance for you to use for medical expenses during the year. If you leave the Scheme before the year is up, you must repay the portion of medical savings you have used that is more than you have paid back to the Scheme during the specific year.

You will be able to identify the debit order for the money owing to the Scheme on your bank statement, the reference number **LAH CLAW** will be used. When you agree that we may recover outstanding money due to the Scheme by debit order,

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

D	D	M	M	Y	Y	Y	Y
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