Applying to become a member of LA Health Medical Scheme (with underwriting) 2024

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 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 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. Email the completed and signed form to **application@discovery.co.za** or fax it to 011 539 2331
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.
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 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, 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).
- 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 terms and conditions (Section 10 of this form) for membership and agree to them.

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

1. About yourself (main applicant)

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

Are you in active employment? ☐ Are you retired from employment? ☐

Title ☐☐☐☐ Initials ☐☐☐☐☐ Surname ☐

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

Preferred name ☐ Gender M ☐ F ☐

Race African ☐ Coloured ☐ Indian / Asian ☐ White ☐ Other ☐

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

Do not want to disclose ☐

Date of birth D D M M Y Y Y Y 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

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.

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

☐ PO Box ☐ Private Bag Box number

☐ Suite ☐ Postnet Suite Number

Suburb Post Code

Physical address:

Suite/unit number Complex name

Street number Street name

Suburb Postal code

Occupation Tax number

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

Title Initials Surname

First name(s)
(as per identity document)

Preferred name Gender M ☐ F ☐

Race African ☐ Coloured ☐ Indian / Asian ☐ White ☐ Other ☐

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

Do not want to disclose ☐

Date of birth D D M M Y Y Y Y

Previous or maiden name

ID or passport number 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 signature required
Please do not sign an incomplete application form

Date D D M M Y Y Y Y

Signature of partner

Original signature required
Please do not sign an incomplete application form

Date D D M M Y Y Y Y

LHABML001

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

Dependant 1

Title | Initials | Surname

First name(s) (as per identity document)

Preferred name | Gender M F

Race African Coloured Indian/Asian White Other

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

Do not want to disclose

Date of birth D D M M Y Y Y Y | 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

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 dependency and the reason for joining.

Dependant 2

Title | Initials | Surname

First name(s) (as per identity document)

Preferred name | Gender M F

Race African Coloured Indian/Asian White Other

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

Do not want to disclose

Date of birth D D M M Y Y Y Y | ID Number or passport

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

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 | Gender M F

Race African Coloured Indian/Asian White Other

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

Do not want to disclose ☐

Date of birth D D M M Y Y Y Y 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 ☐

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 Comprehensive ☐ LA Core ☐ LA Active ☐

* 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 if you have 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 One					
Dependant Two					
Dependant Three					

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 of billing number

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

Branch name Branch code

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)

Original signature required

Original 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

Account holder

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.

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

Account holder contact number

Account holder email address

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

We will debit your account on the first working day of the month. If the membership is not activated in time for the debit order collection and there is an amount outstanding LA Health will collect that amount in the interim, upon activation. Once your account is paid up to date, you may change your debit order date to a variable debit order date by contacting us on 0860 103 933.

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 section 6.2 to tell us which account to use for claim refunds.

Signature of account holder

Original signature required

6.2 Your claims refund

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

Account holder

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

If third party bank details, please insert the third party ID number.

ID Number

If the third party bank account is joint account company account trust account

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

Account holder contact number

Account holder email address

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

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 signature required

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

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

Main applicant

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

If all dependant/s were on the same medical schemes 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
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	

8. Your health questions

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

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

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. Indication of existing medical conditions on this application does not automatically enroll you/your dependants onto the Scheme's Disease Management programme. If you want to access cover from the Chronic Illness Benefit, you must apply for it. You must complete a Chronic Illness Benefit application form with your doctor and submit it for review. If your doctor uses HealthID, your doctor can apply for cover online, provided you give your consent.

You need to meet the benefit entry criteria for your condition to be registered on the Chronic Illness Benefit. You or your doctor may need to provide certain test results or extra information to finalise your application. Please ensure that these documents are submitted with your application to avoid any delays in the process.

You can find the application form on the website **www.lahealth.co.za**

8.1 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 taken
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

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, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker, any autoimmune conditions, peripheral vascular disease, any congenital conditions, deep vein thrombosis, pulmonary embolus, vericose 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 taken
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

8.3 Gynaecological and obstetrics conditions

Yes ☐ **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 taken
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

8.4 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 taken
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

8.5 Mental health Yes ☐ No ☐

Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (i.e. 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 taken
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

8.6 Metabolic or endocrine conditions Yes ☐ No ☐

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

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

8.7. Abdominal conditions Yes ☐ No ☐

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

8.8 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 (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 taken
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

8.9 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 taken
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

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

Example: arthritis (any form), ongoing/intermittent joint or muscular pain, ankylosing spondylitis, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, 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 taken
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

8.11 Kidney or urinary conditions including current or past dialysis Yes ☐ No ☐

Example: kidney 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 taken
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

8.12 Blood conditions Yes ☐ No ☐

Example: deep vein thrombosis, anaemia, any autoimmune conditions, any congenital conditions, polycythaemia vera, blood clotting diseases, leukaemia, lymphoma, pulmonary embolus, haemophilia, haemochromatosis and other bleeding disorders, 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 taken
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

8.13 Eye conditions Yes ☐ No ☐

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

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

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

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

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

8.15 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 taken
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

8.16 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 taken
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

8.17 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 taken
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

8.18 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 taken
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

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.

9. 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, 2002
      Legislation 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)
JD House |27 Stiemens Street | Braamfontein |Johannesburg
PO Box 31533 |Braamfontein |Johannesburg |2001
PAIAComplaints@inforegulator.org.za and POPIAComplaints@inforegulator.org.za

10. LA Health Medical Scheme terms and conditions for membership

10.1. ***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.

10.2. **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 received permission from your spouse and/or 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 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;

10.5. **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.

10.6. **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

11. Your broker details

Do you have a financial advisor? Yes ☐ No ☐

If yes, your financial adviser must complete the details below

Broker | Code | Principal

Broker house | Code

Broker's contact details:

Tel (W) | Cellphone

Signature of intermediary(ies)

Broker stamp

I

hereby confirm that I appoint the broker indicated above to act on my behalf.

Signature of main applicant

Date D D M M Y Y Y Y

Original signature required

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

12. Third Party Bank details

Please attach the relevant proof of bank account if you providing a third party bank account for claims refund.

THIRD PARTY ACCOUNT (e.g. spouse, aunt, uncle, friend, father, son)

- Proof of the account (bank statement or bank letter not older than three months)
- A copy of the third party's (account holder) ID, Passport or Driver's Licence
- A copy of the main members ID, Passport or Driver's Licence

JOINT ACCOUNT

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, Passport or Driver's Licence of each of the joint

COMPANY ACCOUNT

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, Passport or Driver's Licence of the signatories who have authority to sign on behalf of the company
- A letter of authority stating that the account can be used including the details of the signatory and stating the membership details for which the bank account will be used. The letter must be dated, signed by an authorized person on behalf of the company and it must contain the membership or policy number(s)
- A copy of the company's certificate of registration
- A copy of the main members ID, Passport or Driver's Licence

TRUST ACCOUNT

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, Passport or Driver's Licence of each of the trustees of the account
- A copy of the Trust's certificate of registration
- A copy of the Trust resolution, showing the The resolution must be dated, signed by an authorized person on behalf of the Trust and it must contain the membership or policy number(s)
- A copy of the main members ID, Passport or Driver's Licence

If you are completing the request on behalf of the main member, please include proof that you have obtained the necessary authority (example, Letter of Authority or Letter of Executorship).