

Declaration of medical scheme membership 2026

Contact details

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

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.

Contact us

Tel (members): **0860 103 933**, www.lahealth.co.za, PO Box 652509, Benmore 2010

What you must do

Complete this form if you (or your dependants) are or have been a member of any other medical schemes. These details are part of your application to join LA Health Medical Scheme. Information about you and those you apply for must be true, correct and complete. Make reference to the footnote that indicates the expiry date of the form. Download the latest version of all forms from www.lahealth.co.za.

I, (first name and surname),

ID or passport number

declare that I am now or have been a member of the following medical schemes: (As the main member, I also declare these details for any dependants I am applying for.)

Main member

1. Name of previous medical scheme	Membership number	Date joined	Date ended
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Main member

2. Name of previous medical scheme	Membership number	Date joined	Date ended
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Main member

3. Name of previous medical scheme	Membership number	Date joined	Date ended
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Spouse/partner

1. Name of previous medical scheme	Membership number	Date joined	Date ended
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Spouse/partner

2. Name of previous medical scheme	Membership number	Date joined	Date ended
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Spouse/partner

3. Name of previous medical scheme	Membership number	Date joined	Date ended
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Adult/child dependant

1. Name of previous medical scheme	Membership number	Date joined	Date ended																
<input type="text"/>	<input type="text"/>	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y												
D	D	M	M	Y	Y	Y	Y												

Adult dependant/child

2. Name of previous medical scheme	Membership number	Date joined	Date ended																
<input type="text"/>	<input type="text"/>	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y												
D	D	M	M	Y	Y	Y	Y												

Adult/child dependant

3. Name of previous medical scheme	Membership number	Date joined	Date ended																
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D	D	M	M	Y	Y	Y	Y												
D	D	M	M	Y	Y	Y	Y												

If you have belonged to more than three medical schemes, please attach the details to this declaration.

Please answer the following questions:

1. Are you changing your medical scheme due to a change in employment? Yes No

2. Do you or any of your dependants have a waiting period? Yes No

(A waiting period is the time before you can claim for a medical condition.)

If yes, please provide the details:

Name of member or dependant	Condition	Effective date								
<input type="text"/>	<input type="text"/>	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y			
<input type="text"/>	<input type="text"/>	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y			
<input type="text"/>	<input type="text"/>	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y			

3. Do you currently have a late-joiner penalty? Yes No

If yes, please mark the late-joiner penalty: 5% 25% 50% 75%

4. Do you or any of your dependants currently have a late-joiner penalty? Yes No

If yes, please provide the name of the dependant and indicate the late-joiner penalty applied:


Name of dependant	Late-joiner penalty			
<input type="text"/>	5% <input type="checkbox"/>	25% <input type="checkbox"/>	50% <input type="checkbox"/>	75% <input type="checkbox"/>
<input type="text"/>	5% <input type="checkbox"/>	25% <input type="checkbox"/>	50% <input type="checkbox"/>	75% <input type="checkbox"/>

I understand and agree that these details form part of my application for membership of LA Health Medical Scheme and that all the information is true, correct and complete.

Signed at (town or city) on

D	D	M	M	Y	Y	Y	Y
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Signature of main applicant

 Please only sign if information is true, complete and correct.