Application to add dependants (with underwriting)

LA Health
Powered by Discovery

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 with 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 certficates for children.
5. To avoid administration delays, please make sure this application is completed in full by you and your employer.

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

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

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

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

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

Contact name | Job title

Address

Code

Telephone | Fax

Cellphone

Email address

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

2. About yourself (main member)

Surname | Membership number

First names | Date of birth (Y Y Y Y M M D D)

Address details

Code

Telephone (H) | (W)

Cellphone | Fax

Employer name | Employer number

LAHNB03

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

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

Title | Initials | Surname

First names

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

Marital status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Previous or maiden name

ID or passport number

Country of issue

Telephone (H) | (W)

Cellphone | Fax

Email

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

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

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

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

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

I confirm the information is accurate and complete.

Signature of main applicant | Signature of partner

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

4. About your dependants (if applying for cover)

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

Dependant 1

Title | Initials | Surname

First names

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

ID or passport number | Country of issue

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

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

Disabled? Yes ☐ No ☐

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

How much does your dependant earn each month? R

LA Health Medical Scheme, registration number 1145, is administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07. Discovery Health (Pty) Ltd is an authorised financial services provider.

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

Dependant 2

Title | Initials | Surname

First names

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

ID or passport number | Country of issue

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

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

Disabled? Yes ☐ No ☐

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

How much does your dependant earn each month? R

Dependant 3

Title | Initials | Surname

First names

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

ID or passport number | Country of issue

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

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

Disabled? Yes ☐ No ☐

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

How much does your dependant earn each month? R

Dependant 4

Title | Initials | Surname

First names

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

ID or passport number | Country of issue

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

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

Disabled? Yes ☐ No ☐

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

How much does your dependant earn each month? R

5. Your employer warranty (where relevant)

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

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

Authorised signatories

Names

Designation

Department name

Employer stamp

LAHNB03

6. Please select a GP

Please complete if you have selected the LA KeyPlus Option

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

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

7. Previous medical scheme details

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

	Scheme name	**Membership number**	**Start date**	**End date or are you still a member?**		**Reasons for leaving**
Spouse or partner						
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
Dependant one						
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
Dependant two						
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
Dependant three						
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
Dependant four						
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	
			Y Y M M D D	Y Y M M D D	Yes ☐	

8. Moving from another medical scheme

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

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

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

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

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

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

1. Have any of your dependants been admitted to hospital, had investigations (pathology, x-rays, biopsies, scans) or casualty visit/s in the 12 months before this application? Yes ☐ No ☐
2. Are any of your dependants taking medicine and/or treatment of a medical condition/symptom? Yes ☐ No ☐
3. Are they planning to or reasonably expecting to be hospitalised (including for pregnancy) or expecting to receive dental or medical treatment costing more than R2 000 in the next 12 months? Yes ☐ No ☐

If you answered **"No"** to all questions in 8,2, we will not apply 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.

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

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

Spouse or partner

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

Your blood type ____ Your allergies ____

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

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

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

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

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

Dependant 1

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

Your blood type ____ Your allergies ____

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

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

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

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

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

Dependant 2

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

Your blood type ____ Your allergies ____

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

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

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

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

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

Dependant 3

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

Your blood type ____ Your allergies ____

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

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

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

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

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

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

Dependant 4

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

Your blood type ☐ Your allergies ☐

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

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

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

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

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

9.B Have **any of your dependants** in this application ever experienced, been treated for, or currently suffering from any of the following symptoms, conditions or disorders? We have listed some examples of conditions, symptoms or disorders under each question. These are only examples and not the full list of conditions, symptoms or disorders. Please include congenital abnormalities.
Please take note that if you have any symptom or condition not listed in the questions below, you should highlight and provide full details of this symptom or condition in response to question 8.17 below. Indication of existing medical conditions on this application does not automatically enroll your dependants onto the Scheme's Disease Management programme. For more information with regards to the Schemes disease management enrollment visit **www.lahealth.co.za.**

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

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

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

9.2 Heart and circulation conditions **Yes** ☐ **No** ☐

Example: chest pain, palpitations, shortness of breath, coronary heart disease, angina, heart attack, arrhythmia, high blood pressure (hypertension), cardiomyopathy, valvular heart disease or heart valve replacement, congenital heart disease, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker.

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

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

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

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

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

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

9.5 Mental health **Yes** ☐ **No** ☐

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

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

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

9.6 Metabolic or endocrine conditions **Yes** ☐ **No** ☐

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

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

9.7 Abdominal conditions **Yes** ☐ **No** ☐

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

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

9.8 Brain and nerve conditions **Yes** ☐ **No** ☐

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

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

9.9 Breathing and respiratory conditions **Yes** ☐ **No** ☐

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

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

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

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

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

9.11 Kidney or urinary conditions including current or past dialysis **Yes** ☐ **No** ☐

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

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

9.12 Blood conditions **Yes** ☐ **No** ☐

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.17 Have you or any of your dependant/s received medical advice or treatment for symptoms, not yet diagnosed by a medical professional, in the last 12 months before this application? **Yes** ☐ **No** ☐

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

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

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

HIV and AIDS

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

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

Definitions

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

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

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

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

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

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

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

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

   The purpose of this Privacy Statement is to set out how we collect, use, share and otherwise process your personal information.
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 warrant that when you give the Scheme and Administrator personal information about your dependants, you have received their permission to share their personal information with us for the purposes set out in this Privacy Statement and any other related purposes. You understand that when you include your spouse and/or dependents 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 ;
   - to share your personal information with external healthcare providers for the purposes of evaluating certain clinical information, in the event that you require medical treatment.

   Examples of this include:

   i. Sharing your personal information with your chosen financial adviser during the membership application process to enable the Administrator to process your membership application;
   ii. 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;
   iii. 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;
   iv. 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

   You consent and agree that:
   - we may process your information, including personal and special 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.
9. 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.
10. The Scheme and Administrator may share and combine all your personal information for any one or more of the following purposes:
    - market, statistical and academic research; and
    - to customise our benefits and services to meet your needs.

    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.
11. 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.
12. 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.
13. 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.
14. 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.

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

15. Please let the Administrator know if you do not wish to receive any direct telephonic marketing.
16. 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.
17. 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.
18. 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
19. 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).
20. 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.
21. The Scheme or Administrator may change this Privacy Statement at any time. The current version is available on www.lahealth.co.za.
22. If you believe that the Scheme or Administrator have used your personal information contrary to this Privacy Statement, we encourage you to first follow our 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 are:
    The Information Regulator (South Africa),
    SALU Building,
    316 Thabo Sehume Street, Pretoria.
    Tel: 012 406 4818
    Fax: 086 500 3351
    inforeg@justice.gov.za

Signature of main applicant

Original hand signature required

The main applicant must sign and date any changes

11. LA Health Medical Scheme rules for membership

10.1 Rules for membership

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

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

10.2 Who you are applying for

You may apply to join LA Health Medical Scheme on your own or together with other people – your spouse, your partner and people who are financially dependent on you as defined in the LA Health Medical Scheme Rules. For anyone to be treated as financially dependent for this application, you must have a legal responsibility to provide financially for those dependant/s. We might ask you to give us proof of financial or legal responsibility. You may be called the principal member or main member in our future communications to you.

10.3 Acting for others

You confirm you have the right to act for others

By signing this document, you confirm that:

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

10.4 Giving and getting information

You must give true, correct and complete information

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

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

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

Your legal address

We will send documents to you at the address you indicated as the communication channel you prefer to be contacted on. If it is necessary to send you any legal notices or summonses, our legal team will serve these at the physical address you have given, or at any other address you have given us. It is your responsibility to make sure we have the correct address for you.

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

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

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

You, your employer or your broker must tell LA Health Medical Scheme or Discovery Health (Pty) Ltd in writing if any of the information you gave in your application for membership changes between the day you sign this document and the day your membership starts. This includes information about your health and the health of those you apply for. We need advance notice of any administrative changes such as cancellation of membership, as backdated changes may not be accepted.

LAHNB03

11 LA Health Medical Scheme rules for membership *(continued)*

When LA Health Medical Scheme may cancel your membership/s

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

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

10.5 About becoming a member

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

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

Resign from current medical schemes when accepted

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

You must ensure contributions are paid on time

As the main member of LA Health Medical Scheme, you are responsible for ensuring that your contributions and the contributions of those you apply for, are paid on time every month to avoid suspension of benefits. The Scheme has the right to amend monthly contributions and benefits from time to time. If you are paying your contributions, the reference number LAH CONT will be used on your bank statement in order to identify the debit order.

10.6 Repaying money owed to the Scheme

LA Health Medical Scheme has the right at any time to collect from you any amount that you owe to the Scheme. We will notify you of any amount that you must pay to the Scheme.

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

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

By signing this form, you agree that any money you owe to the Scheme may be deducted from any future claim payment amounts that are due to be paid to you. 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.

Signature of main member

Date Y Y Y Y M M D D

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