Transfer to individual capacity form 2024

Discovery Health Medical Scheme

Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are a member of or applying to become a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (members): **0860 99 88 77**, Tel (health partners): **0860 44 55 66**, **www.discovery.co.za**, PO Box 784262, Sandton, 2146, 1 Discovery Place, Sandton, 2196**.**

Purpose of the form

This form is to transfer a membership from an employer group to an individual capacity.

What you must do

- Fill in the form in black ink and print clearly, or complete digitally. You can access a list of the approved digital signatures providers from **www.discovery.co.za**, under Medical Aid > Find documents and certificates > Application forms.
- You must sign all relevant sections. The main applicant must sign and date any changes.
- To avoid administrative delays, please make sure you complete this form in full.
- Once it is complete, please email it to **administration@discovery.co.za**
- You need to submit the following with this form:
  - Copy of ID or passport (of the main member and the account holder if the main member is not the account holder)
  - Bank statement or a letter of confirmation from the bank (not older than three months).

When you sign this application, you confirm that the information given is true and correct.

1. Main member details

Membership number

ID or passport number

Member's name

Member's surname

2. New account details for contribution collection or refunds

Please note that we cannot accept credit card account details.

Effective date of the transfer D D M M Y Y Y Y

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)

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 debit 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** > Medical aid > Manage your health plan.

3. New account details for claims payments (if we do not have claims payment banking details on system or we need to update the claims payment banking details)

You can update your claims payment details by visiting **www.discovery.co.za** > Medical Aid > Manage your health plan.

Tick here if we must use the same details as we have for contribution collection and refunds ☐

When should we start using the new banking details? ☐☐☐☐☐☐☐☐

Please note that we cannot accept credit card details.

Bank name

Branch name | Branch Code

Account number | Type of account Cheque ☐ Savings ☐

Account holder

We can only change your banking details if:

3.1. You have filled in all the relevant fields on this request form.
3.2. The main member has signed the request.
3.3. Documents needed in the “What you must do” section accompany this form.

I, (first and last name),

as the main member, give Discovery Health Medical Scheme permission to change my banking details.

Signed at (town or city)

Signature of main member

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

4. Account holder declaration (this section must be signed by the person whose bank account we will debit)

1. I confirm that I have the right to give Discovery Health Medical Scheme the authority to debit the account monthly, and that this bank account belongs to me. Furthermore, I will be liable for any claims, losses or damages of any nature arising out of debits Discovery Health Medical Scheme made from the account listed above. This is if this account has insufficient funds, is incorrect or if it is held in the name of any other person.
2. I hereby authorise Discovery Health Medical Scheme to verify the banking details as given above to set up the debit order.
3. I confirm that the account listed above is active and has not been de-activated due to non-compliance with verification procedures according to the Financial Intelligence Centre Act 38 of 2001 (“FICA”), as amended.

Signature of bank account holder

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

5. Debit order mandate

The signed authority and mandate refers to the application on the signed date ("the Agreement")

I, the undersigned:

- Warrant that the account information I have provided above is an account in my name and that the information furnished by me/us in this Authority and Mandate is true and correct.
- Authorise Discovery Health Medical Scheme to issue and deliver payment instructions to my bank, recorded above, for the collection by Discovery Health Medical Scheme from the bank account (or any other bank or branch to which I may transfer my account) any amounts due under or in terms of this application on condition that the sum of such payment instructions will never exceed my obligations as framed in the Agreement which shall commence on the date that cover starts as requested on the application form and shall continue until this Authority and Mandate is terminated by me by giving Discovery Health Medical Scheme no less than 20 ordinary working days written notice thereof or immediately in the event that I instruct my bank to withdraw this Authority and Mandate.
- If the membership or change in account details is not activated in time for the debit order collection and there is an amount outstanding Discovery Health Medical Scheme can collect that amount in the interim. If I change the date of the debit order after activation, I confirm that the payment instructions must be issued and delivered on the day that I have nominated (“payment day”) and thereafter on the same day in each and every successive month. If the payment day falls on a Sunday or recognised South African public holiday, the payment day will automatically be the next working day;
- Acknowledge that my bank will treat each payment instruction to pay premiums or amounts due under this Agreement to Discovery Health Medical Scheme as if each payment instruction came from me personally as the account holder.
- Undertake to advise Discovery Health Medical Scheme in writing of any changes to my account details and acknowledge that Discovery Health Medical Scheme will not be held responsible or liable for any claim, loss or harm that I or any third party may suffer as a result of me providing incorrect banking details herein or if the bank account is in the name of another person or entity or as a result of my failure to notify

Discovery Health Medical Scheme of a change in banking details or if the bank account has insufficient funds to meet my obligations under or in terms of the Agreement.

- Know and understand that the withdrawals hereby authorized will be processed through a computerized system provided by South African banks. The details of each withdrawal from my bank account will be printed on my bank statement and must show the reference number of the membership inserted in the Agreement so as to enable me to identify this membership.
- Acknowledge that although this Authority and Mandate may be terminated by me, such termination does not necessarily terminate this Agreement. In the event of such termination, I am not entitled to any refund of any premiums or amounts due that was withdrawn by Discovery Health Medical Scheme whilst this Authority and Mandate was in force if such premiums or amounts were legally owing to Discovery Health Medical Scheme in terms of the Agreement.
- Acknowledge that by signing this Authority and Mandate I am bound by the payment terms applicable to this Agreement.
- Acknowledge that this Authority may be assigned to a third party if this agreement is also assigned to a third party.

Reference number:

This Agreement reference number: Your membership number

Abbreviated name:

Abbreviated name as registered with the bank: DISCPREM

Deduction amount: as per your activation of membership letter

Deduction date: as per section 1 of your membership application form

Payment start date: as per section 1 of your membership application form

Account holder signature

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

This form is only a complete application when it contains all the information we need to fully process your application. We take the date on which we receive the complete application as the application date, and not the date on which you sign the form.

6. Financial adviser details

Please note that the below section is compulsory. We will not be able to complete the transfer if the below section is not completed.

Note: The selection will not impact the monthly contributions

Please choose from one of the three below options:

1. I choose to continue using the financial adviser of the employer I'm moving from.
2. I would like to choose a new financial adviser

If you would like an adviser, a Discovery Connect Distribution Services adviser will be in contact with you via email to confirm the appointment of an adviser.

Please complete the section below with the new Financial adviser details, if option 2 above is selected.

Financial adviser name

Financial adviser code

Financial adviser contact details

Financial adviser email address

3. I choose to continue without the financial adviser

By choosing to continue my membership without advise from a financial adviser, I understand that this decision will not affect my monthly contribution.

Discovery Ltd. registration number: 1999/007789/06. Companies in the Group are authorised Financial Services Providers.

7. Authorisation (only applicable if selecting a new Financial Adviser)

I, _____ am duly authorised to appoint the financial adviser and intermediary house mentioned above, I also give the Discovery companies consent to share with my appointed financial adviser all policy information, including personal and underwriting information necessary to ensure the efficient administration, assessing of claims and to ensure that Discovery complies with all relevant legislation on an ongoing basis. I understand and accept that this consent can be revoked at any time failing which Discovery shall be entitled to continue sharing such information with the appointed individuals until termination of such policy.

Financial adviser's signature _____ Date _____

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

8. Financial adviser's details (if applicable)

I, _____, have been appointed as the principal financial adviser on record for (client's name) _____ Policy Number(s) _____ from this day, the _____ of _____ 20 _____

In terms of the provisions made in Section 7 (4) of the Financial Sector Conduct Authority General Code of Conduct for Authorised Financial Services . Providers and Representatives, I confirm that I will complete a review of the above client's portfolio at policy annual review date as set out in this agreement.

NB: Principal financial adviser must sign the form and declaration.

Financial adviser's signature _____ Date _____

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