Application to add dependants in 2025 (with underwriting)

Contact details
Tel: 0860 116 116 • PO Box 652509, Benmore 2010 • www.yourremedi.co.za

Who we are

Remedi is the medical scheme you are applying to become a member of, registration number 1430. This is not for profit organisation registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to “the administrator”) is a separate company and an authorised financial services provider (registration number 1997/013480/07), which takes care of the administration of your membership of Remedi.

Complete this form if you want to add dependant/s to your Remedi membership.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Read and understand the terms and conditions for membership (section 9).
3. Sign the application form.
4. Please make sure the main member signs and dates any changes.
5. Please attach a copy of each dependant’s identity document to this application form. We also accept valid passports and birth certificates for children.
6. Please email this completed and signed form with any supporting documentation to **application@yourremedi.co.za**.

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, a notification or an email to let you know when your dependant/s’ application is considered to have been fully and completely made. This date may differ from the date on which you sign the application form.
- 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.
- After accepting your dependant/s’ application to join Remedi, we will send you a notification and an email letter confirming acceptance. The Notification and email will advise you of when your dependant/s membership will start. Depending on your circumstances, it may also indicate any conditions applicable to their membership such, as waiting periods or late-joiner penalties.
- We will send you or your employer, the counter offer letter and any outstanding underwriting requirements where we cannot offer standard terms of acceptance for both you and your dependant/s (adult and child dependant/s).
- You have to sign this letter in the appropriate place and return it to Discovery Health (Pty) Ltd. When you do so, you confirm their start date and acceptance of any conditions applicable to your dependant/s’ membership of Remedi.
- You will then get a pack in the post.

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

When you sign this application, you confirm that you have read and understood the terms and conditions (section 9 of this form) for membership and agree to them.

1. About the main member

Membership number

ID or passport number

Member's surname

Member's first names

2. Adding a spouse or partner (if applying for cover)

Only complete this section if you are adding a spouse or partner.

Title

Initials

Surname

First name(s) (as per identity document)

Previous or maiden name

ID or passport number

Gender M F Date of birth D D M M Y Y Y Y

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

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

Marital status Married Single Divorced Widowed

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

Telephone (H) Telephone (W)

Cellphone

Email

Addition of spouse to an existing membership

If addition of spouse to an existing membership is:

- Due to legal and registered marriage within the last month, an official marriage certificate must accompany this application form;
- For a spouse married for more than a month, 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.

Please choose a date you want cover to start for all dependant/s you are applying for. This date must be the same for all your dependant/s applying for cover.

Cover start date D D M M Y Y Y Y

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 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. 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.

Signature of main member Date D D M M Y Y Y Y

Signature of partner Date D D M M Y Y Y Y

3. Adding an adult dependant or child (applying for cover)

Only complete this section if you are adding a child or adult dependant.

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

Dependant 1

Title Initials

Surname

First name(s) (as per identity document)

ID or passport number

Gender M F Date of birth D D M M Y Y Y Y

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

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

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 full-time student? Yes No

If the dependant is disabled, please confirm type of disability Permanent Temporary

Does your dependant earn an income? Yes ☐ No ☐

How much does your dependant earn each month? **R** ☐☐☐☐☐☐☐☐ . ☐☐

Dependant 2

Title ☐☐☐☐ Initials ☐☐☐☐☐

Surname

First name(s) (as per identity document)

ID or passport number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Gender M ☐ F ☐ Date of birth D D M M Y Y Y Y

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

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

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 full-time student? Yes ☐ No ☐

If the dependant is disabled, please confirm type of disability Permanent ☐ Temporary ☐

Does your dependant earn an income? Yes ☐ No ☐

How much does your dependant earn each month? **R** ☐☐☐☐☐☐☐☐ . ☐☐

Dependant 3

Title ☐☐☐☐ Initials ☐☐☐☐☐

Surname

First name(s) (as per identity document)

ID or passport number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Gender M ☐ F ☐ Date of birth D D M M Y Y Y Y

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

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

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 full-time student? Yes ☐ No ☐

If the dependant is disabled, please confirm type of disability Permanent ☐ Temporary ☐

Does your dependant earn an income? Yes ☐ No ☐

How much does your dependant earn each month? **R** ☐☐☐☐☐☐☐☐ . ☐☐

Dependant 4

Title ☐☐☐☐ Initials ☐☐☐☐☐

Surname

First name(s) (as per identity document)

ID or passport number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Gender M ☐ F ☐ Date of birth D D M M Y Y Y Y

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

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

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 full-time student? Yes ☐ No ☐

If the dependant is disabled, please confirm type of disability Permanent ☐ Temporary ☐

Does your dependant earn an income? Yes ☐ No ☐

How much does your dependant earn each month? **R** .

4. Dependant classification and proof required

Definition of dependant	Documents required
Spouse	ID and marriage certificate
Natural child	ID, birth certificate
Natural child with different surname to main member	ID, birth certificate, affidavit
Step child	ID, birth certificate, affidavit
Adopted child or foster child	ID, birth certificate, proof of adoption, court order
Mentally or physically disabled child (over 21)	ID, birth certificate, written confirmation from treating doctor of nature of disability, proof of state grant or pension
Traditional or polygamous spouse	ID, certificate of customary union
Parents or siblings of main member	ID, proof of income and an Application to register an additional adult dependant form
Common-law partner or same-gender partner	ID
Student	ID, proof of registration at tertiary institution and three months bank statements
Unemployed child (over 21)	ID, affidavit confirming unemployment and an Application to register an additional adult dependant form

Where the dependant is a common-law wife, husband or partner, a partnership declaration (Section 2) must be completed by both the main member and common-law wife, husband or partner. Please complete this if you have selected the Standard Option.

5. Standard Option GP Selection

Please complete this if you have selected Remedi Standard as your chosen benefit option. Please select a GP on the Scheme GP Network for yourself as well as each of your dependants. You also need to allocate a Second GP as per the Footnote inserted below the table indicated. You may find the list of GPs to choose from by calling our Contact Centre on **0860 116 116**. If you experience any difficulties in making a selection, you may also reach out to your employer office for further assistance and/or guidance.

	Name	GP Name/ Group Practice Name	Practice Number (Required)	Second GP/Group Practice Name*	Practice Number (Required)
Main member					
Spouse or partner					
Dependant 1**					
Dependant 2**					
Dependant 3**					
Dependant 4**					
Dependant 5**					

*If you live far away from where you work or you often need to work in different towns or province, you may need a second GP. Please only choose a second GP if this applies to you.

** Please ensure that the dependant information you give above aligns with your membership and registered details as this form cannot be used to add dependants onto your membership. To add additional dependants or to change your dependants please reach out to your employer office or if you are a pensioner contact us on **0860 116 116**. If you have more than 5 dependants registered with the Scheme we will need you to contact us on **0860 116 116** to receive an additional form to complete.

6. Your employer warranty (needs to be signed by the HR or payroll contact)

Please make sure your employer completes this warranty if the member falls under an employer group.

1. We warrant that the member detailed in section 1 of this application form is an employee of our organisation.
2. Remedi may bill us for the amount due for this dependant in the same manner as for other employees with the Remedi.

Authorised signatories		
Names		
Designations		

Who we are

Remedi is the medical scheme, registration number 1430, which is 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), which takes care of the administration of your membership of Remedi.

The patient liability form must be used for any treatment that is not covered by the Remedi Standard Option Benefits e.g. non-formulary medication, pathology or radiology tests. The purpose of this form is to give you the opportunity to explain this to the member and to look at possible alternatives with the member. When it is decided that these medicines or tests are required, the member must sign this form to acknowledge that they understand that they will be liable for the cost of these medicines or tests.

Patient name	
Membership number	
Practice name	
Practice number	
Date of service	

Procedure or service to be performed

I, the above mentioned patient, acknowledge that the above procedure and/or service is not covered by the benefits available on the Remedi Standard Option. I understand and accept that I will be responsible for paying the costs for this procedure and/or service.

Patient's signature | Date D D M M Y Y Y Y

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

Doctor's signature | Date D D M M Y Y Y Y

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

7. Previous medical scheme details

Please give us the details of all registered South African medical schemes, the dependant/s you want to add, 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.

Dependant name	Scheme name	Start date	End date if already resigned	Are they still a member?	Reason for leaving
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	

8. Your spouse, partner or dependant/s' health questions

Treating healthcare professional's name

Practice number Telephone

Email

We may be able to use certain previous medical information for your dependants(if applicable) we have from previous policies. However, it is still your obligation to disclose any and all relevant information as required. By ticking this box you agree that we may utilize this information for the purposes noted below. ☐

Please give full medical details of all dependant/s in this application form.

8.1 Tumours, growths, cancerous, non-cancerous and disorders of the skin and breast

Yes ☐ **No** ☐

Example: skin lesions, eczema, psoriasis breast disease, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, lump in breast, abscess, abnormal mammogram result, 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

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, any congenital conditions and peripheral vascular disease, Deep Vein Thrombosis and Pulmonary embolus, varicose veins .

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

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

8.4 Are you or any of your dependants pregnant or undergoing treatment/investigation to fall pregnant or trying to conceive or difficulty falling pregnant? 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

8.5 Mental health conditions Yes ☐ No ☐

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

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

8.7. Abdominal conditions Yes ☐ No ☐

Example: hepatitis, cirrhosis, coeliac disease, obesity, overweight, unintentional weight loss, incontinence, abdominal pain, colo-rectal symptoms/conditions, portal hypertension, liver disease, liver failure, pancreatitis, cystic fibrosis, gall bladder, stones, GORD (reflux), heartburn, oesophageal disease, constipation, hernias, gastritis, ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis, 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

8.8 Brain and nerve conditions Yes ☐ No ☐

Example: stroke, epilepsy, seizures, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, cerebral palsy, parkinson's disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, brain shunt (VP shunt used to drain fluid from the brain), intellectual disability, CVA, bleeding on the brain, down'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

8.9 Breathing and respiratory conditions Yes ☐ No ☐

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

8.10 Musculoskeletal (back, bone, injury 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, physical disability, prosthesis and internal insertion of surgical implants, amputation, 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

8.11 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, neurogenic bladder, (loss of bladder control or inability to empty the 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

8.12 Blood conditions Yes ☐ No ☐

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

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

8.13 Eye conditions Yes ☐ No ☐

Example: cataract, intra-ocular pressure, visual disturbances, night blindness, 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

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

8.15 Male urogenital conditions Yes ☐ No ☐

Example: prostate disorders, urogenital defects, varicocele, abnormal PSA tests (prostate specific antigen), undescended testes, phimosis, urinary incontinence, retention, infertility, 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

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

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

8.18 Have you or any of your dependants ever been diagnosed with or received treatment for, any condition/ symptoms or any allergic reactions or side-effects, not mentioned in the questions above, in the last 12 months before this application? **Yes** ☐ **No** ☐

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

HIV and AIDS
If you, or one or more of your dependants, are HIV-positive, you or they must call us on **0860 116 116** within seven working days from the date we activate your Remedi 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. Remedi may have waiting periods that apply in certain circumstances. This means there may be a set time period before Remedi 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. If you do not let us know about you or your dependants HIV status within 7 days of your membership being active, we may end your Remedi membership.

9. Remedi Privacy Statement – how we will process and disclose your Personal Information and communicate with you

When you engage with Remedi, you are entrusting us with your personal information. We are committed to protecting your right to privacy and keeping your information safe. Our Privacy Statement tells you how we collect, use and share your personal information, including personal information about your spouse, employees, dependants and beneficiaries, where applicable. To view and read our Privacy Statement, please follow this link:
https://www.yourremedi.co.za/wcm/medical-schemes/remedi/assets/legal/privacy-statement-for-remedi-medical-aid-scheme.pdf

Signature of main applicant

Please only sign if you have read and understand this statement

10. Terms and conditions applicable to Remedi

Who "we" are

Remedi, registration no 1430, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd, registration number 1997/013480/07, the administrator and managed care organisation for Remedi, and an authorised financial services provider.

1. ***Scheme terms and conditions for membership***
   The terms and conditions of Remedi record your rights and responsibilities for your membership of the Remedi. 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 terms and conditions and you agree that you and those you apply for will be bound by these and Scheme terms and conditions. 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 Remedi and give permission we share your medical information and other relevant personal information about you and your dependant/s.
   The information will be shared so that he or she can help us if necessary while we process your membership application.

2. ***Who you are applying for***
   You may apply to join Remedi on your own or together with other people – your spouse, your partner and people who are financially dependent on you as defined in the Remedi terms and conditions. For anyone to be treated as financially dependent for this application, you must have a responsibility to provide financially for that dependant. We might ask you to give us proof of financial responsibility. You may be called the principal member or main member in our future communications to you.

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 any dependant/s over 18 to act for them in any matter relating to this application.
- You have the right to apply for membership and to act for those you apply for in any matter relating to this application.

4. ***Giving and getting information***
   You must give true, correct and complete information
   To consider your application for membership, we 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 us. It is important that you tell us 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.

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.

Remedi and Discovery Health (Pty) Ltd may record telephone calls
We 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.

Remedi and Discovery Health (Pty) Ltd may get information about you from other relevant sources
To consider your application for membership, conduct underwriting or to consider a claim for medical expenses, to profile and analyse risk or to investigate fraud, waste and/or abuse (including by medical practitioners, contracted service providers or financial advisers), you agree that we can get information about you and those you apply for from other medical practitioners, brokers, credit bureaus or industry regulatory bodies. We may (at any time and on an ongoing basis) verify with the parties mentioned in this section that the information you give on this application and in respect of any matter pertaining to or that arose during your membership of Remedi, is true, correct and complete. You give your permission that we may get any information that is relevant to your application from your employer.

Tell Remedi or Discovery Health (Pty) Ltd immediately if your information changes
You, your employer or your broker must tell us 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 we do not accept backdated changes.

When Remedi may cancel your membership/s
Remedi may cancel any memberships immediately, if you and those you apply for:

- Do not give us information that later turns out to be relevant to this application;
- Give us any information that is not true, correct and complete;
- Do not tell us 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.

5. ***About becoming a member***
Remedi 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 Remedi starts paying for any general or specific medical conditions. Please speak to your employer or us 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 schemes when you receive notice from Remedi by letter, email or SMS telling you that you and those you apply for have been accepted.

You must ensure contributions are paid on time
As the main member of Remedi, 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 pay your own contributions, you will be able to identify the debit order for your monthly contributions on your bank statement, the reference number REMEDICONT will be used.

6. ***Repaying money owed to the Scheme***
Remedi has the right at any time to collect from you any amount that you owe to the Scheme. We will notify you if there is any amount that you owe to the Scheme.

You must repay any medical savings owing if you leave Remedi.
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 Remedi 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 Remedi 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 REMEDICLAW will be used.

Signed at (town or city) _____ on D D M M Y Y Y Y

Signature of new main member _____

The main member must sign and date any changes
Please do not sign an incomplete application form
I confirm the information is accurate and complete