

Application to transfer an existing member to an employer group 2023

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.

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, PO Box 784262, Sandton, 2146, www.discovery.co.za, 1 Discovery Place, Sandton, 2196.

Purpose of the form

If you are an existing Discovery Health Medical Scheme main member transferring to another employer, you need to complete this form. This form may only be used if you have had no break in cover between your current membership and joining your new employer. Make reference to the footnote that indicates the expiry date of the form. Download the latest version of all forms from www.discovery.co.za, under Medical Aid>Find documents and your certificates.

What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally.
- The main applicant must sign and date any changes.
- Email the completed and signed form to administration@discovery.co.za.

1. Main policy holder details

Title	<input type="text"/>	Initials	<input type="text"/>
First name(s)	<input type="text"/>		
Surname	<input type="text"/>		
Membership number	<input type="text"/>	Employee number	<input type="text"/>
Current plan type	<input type="text"/>		
New Plan type (if applicable)	<input type="text"/>		
ID or passport number	<input type="text"/>	Date of birth	<input type="text"/>
Telephone (W)	<input type="text"/>	Cellphone	<input type="text"/>
Current email	<input type="text"/>		
New email (if applicable)	<input type="text"/>		

2. New employer details

Employer name	<input type="text"/>	Date of employment	<input type="text"/>
Employer number	<input type="text"/>	Effective date of transfer	<input type="text"/>
Branch name	<input type="text"/>	Branch number	<input type="text"/>

3. Employer warranty (employer contact person to complete)

I acknowledge the transfer of the policy holder to the employer group.

Employer contact name	<input type="text"/>		
Designation	<input type="text"/>		
Employer contact signature	<input type="text"/>	Date	<input type="text"/>

4. Rules for membership

When you sign this document, you confirm that you have read and understood the rules of membership and you agree that all information provided on this form is correct. The full set of Scheme Rules is available on www.discovery.co.za/medical-aid/scheme-rules. You acknowledge and appoint the financial adviser contracted by your employer from time to time for all matters related to your membership.

Should you not want to appoint the financial adviser contracted by your employer, please contact your employer. The new employer will explain the terms of employment of their company.

Signed at (town or city)

on

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Signature of main member



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