Please complete SECTIONS;

SECTION 1 - Your details

SECTION 2 & 3 - partner and dependants

SECTION 5 - Choice of plan.

SECTION 6 - (IF KEYCARE PLUS - ***PLEASE ENSURE YOU:***
INSERT INCOME FOR YOU AND YOUR PARTNER (IF THEY ARE JOINING)
NOMINATE A KEYCARE DOCTOR FOR EACH PERSON

SECTION 7 – ONLY if your Employer pays your contribution.

SECTION 8 – YOUR DEBIT ORDER DETAILS - SIGN
8.2 – YOUR ACCOUNT for refunds - SIGN

SECTION 9 - Previous medical aid details.

SECTION 10 – If you are joining from another medical aid.
check if you need to answer Section 10.2

SECTION 11 - Complete ALL QUESTION

SECTION 12 - SIGN

SECTION 13 – SIGN and DATE

Vitality or Keyfit - additional premium required.

PLEASE FAX A CERTIFICATE OF MEMBERSHIP - get from the old scheme.
This may avoid a late joiner penalty.
I ALSO NEED ID COPIES!

Then FAX the completed application 0866 688 122 OR SCAN AND EMAIL

I CAN OFFER YOU THE SERVICES OF A DEDICATED TEAM WITHIN THE MEDICAL AID.
ALWAYS THERE TO ASSIST YOU. NO CALL CENTRES HERE.
AND AT NO ADDED COST! ABSOLUTELY FREE.

Kind regards,
PETER

PS. Please visit my Web page as below.

Peter J Pyburn
Approved Financial Services Provider Licence # 2995.

Financial Life Planner
Member: Masthead, FIA, Council for Medical Schemes.
☎ Mobile : 083 3778893
Fax : 0866 688 122
www.peterpyburn.co.za

Applying to become a member of Discovery Health Medical Scheme in 2017

Discovery Health Medical Scheme

Who we are

The Discovery Health Medical Scheme (referred to as 'the Scheme'), registration number 1125, is the medical scheme that you are applying to become a member of. This is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company and an authorised financial services provider. We take care of the administration of your membership for the Scheme.

Thank you for deciding to apply to join the Discovery Health Medical Scheme. This document is an application form for membership. It also contains some rules for membership. Please make sure you read and understand these rules.

What you must do

☐ Fill in the form in black ink, please print clearly.

☐ Read and understand the rules for membership (section 13).

☐ Sign section 6 (if applying to become a KeyCare member) 8, 12 and 13.

☐ Please make sure the main applicant signs and dates any changes.

☐ Email your completed and signed form to **application@discovery.co.za** or fax it to **0860 100 345**

☐ Please attach a copy of each applicant's identity document. We also accept valid passports and birth certificates for children.

Once you send us your application form, here is what will happen:

- If any details are missing or if we need more information for underwriting purposes, we will contact you.
- We will activate your membership and send you or your financial adviser an acceptance letter (if no waiting periods and/or late-joiner penalties are applied). Where you have waiting periods and/or late joiner penalties, we will issue a counter-offer letter which will indicate any conditions applicable to your membership. You may accept the offer by signing and returning this letter for us to activate your membership.
- We will send you or your financial adviser a welcome letter, SMS or an email to let you know when your application is considered to have been fully and completely made. This date may differ from the date on which you sign the application form.
- You will then get a pack in the post.

If you do not hear from us seven days after sending us your application form, please contact us on **0860 100 345** or your financial adviser.

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

1. About yourself (main applicant)

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

Title _____ Initials _____ Surname _____

First name(s) (as per identity document) _____

Preferred name _____ Sex ☐ M ☐ F Date of birth Y Y Y Y M M D D

Previous or maiden name _____

Occupation _____ Tax number _____

Total monthly earnings R _____

ID or passport number _____ Country of issue _____

Telephone (H) _____ _____ Telephone (W) _____ _____

Cellphone _____ _____ Fax _____

Email _____

Postal address (Post collected from post box, suite or private bag)

☐ PO Box ☐ Private Bag Box number _____

☐ Suite ☐ Postnet Suite Number _____

Suburb _____ Postal code _____

If your post is delivered to your street address, please complete these details under physical address.

Physical address

Suite/Unit number _____ Complex name _____

Street number _____ Street name _____

Suburb _____ Postal code _____

2. About your spouse or partner (only complete if applying for cover)

Title _____ Initials _____ Surname _____

First name(s) (as per identity document) _____

Preferred name _____ Sex ☐ M ☐ F Date of birth Y Y Y Y M M D D

Previous or maiden name _____

ID or passport number _____ Country of issue _____

Telephone (H) _____ _____ Telephone (W) _____ _____

Cellphone _____ _____ Fax _____

Email _____

3. About your dependants (only complete if applying for cover)

Dependant 1

Title _____ Initials _____ Surname _____

First name(s) (as per identity document) _____

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 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

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) _____

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 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

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) _____

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 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

Does your dependant earn an income? ☐ Yes ☐ No How much does your dependant earn each month? R _____

4. Your financial adviser's details

Financial adviser's name Peter Pyburn Code 1004647978

Intermediary house Peter J Pyburn Code 1020000277

Financial adviser's telephone number (W) 083 3778893 Lead number _____

Email peter@peterpyburn.co.za

Bank reference number (if applicable) _____ (Mandatory for all ABSA and FNB financial advisers)

I declare that:

4.1. I am an accredited financial adviser in terms of the Medical Schemes Act and licensed by the Financial Services Board in terms of the Financial Advisory and Intermediary Services Act at the date of signing this application form.

4.2. I am appointed by the client to provide advice about this application.

4.3. I have a valid contract with the Discovery Health Medical Scheme and I have made the client aware of the commission payable by Discovery Health Medical Scheme.

4.4. I am responsible for providing the applicant with:

- my name, physical address, postal address and telephone number.
- impartial advice that is in his or her best interest.

4.5. I am accountable for any advice given to the member about completion of this application form and joining the Discovery Health Medical Scheme.

Your financial adviser's details *(continued)*

Financial adviser's signature _____

5. Please select your health plan

Executive Plan	Comprehensive Series	Priority Series	Saver Series	Smart Series	Core Series	KeyCare Series
☐ Executive	☐ Classic	☐ Classic	☐ Classic	☐ Classic	☐ Classic	☐ KeyCare Plus
	☐ Classic Delta	☐ Essential	☐ Classic Delta	☐ Essential	☐ Classic Delta	☐ KeyCare Access
	☐ Classic Zero MSA		☐ Essential		☐ Essential	☐ KeyCare Core
	☐ Essential		☐ Essential Delta		☐ Essential Delta	
	☐ Essential Delta		☐ Coastal		☐ Coastal	

How would you like us to refund claims from the Medical Savings Account if your plan has one? ☐ Discovery Health Rate ☐ Cost

You have the right to ask for help in selecting a health plan that suits your needs. By signing this application, you confirm that you are familiar with the conditions and benefits of the plan you select.

6. If you choose a KeyCare Plan

Income verification will be conducted for the lower income bands. Income is considered as: The higher of the main member's or registered spouse or partner's earnings, commission and rewards from employment; interest from investments; income from leasing of assets or property; distributions received from a trust, pension and/or provident fund; receipt of any financial assistance in terms of any statutory social assistance programme.

IMPORTANT NOTICE:

Declaring income lower than your actual income is fraud. This may lead to the termination of your membership.

By signing this application form, you give your permission for us to verify your declared income using all relevant internal and external sources, as defined in 13.5.

	Main member	Spouse or Partner
Total earnings over the last 12 months	R	R
Total monthly earnings	R	R

I declare that this income declaration is true and accurate.

X Signature of main applicant _____ ⚠ **Please only sign if information is true, complete and correct.**

If the highest earner earned less than R137 000 for each year, then please provide the following supporting documentation as proof of income:

- Last 3 months' (90 consecutive days) bank statements; **and**
- If employed, your last 3 months' payslips and commission schedules, or most recent tax year's IRP5 certificate
- If student, proof of enrolment at academic institution
- If self-employed, most current financial statements
- If pensioner, proof of annuity and/or employer pension and/or State Older Person's Grant
- If unemployed, UIF certificate

Please complete this if you have selected the KeyCare Plus or KeyCare Access Plan.

	Name	GP name	Practice number	Second GP name*	Practice number
Main applicant					
Spouse or partner					
Dependant 1**					
Dependant 2**					
Dependant 3**					

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

** Please make sure that the dependant information you give above is the same as the dependant information in section 3 of this form.

7. Your employment details (only complete if your employer pays the contributions on your behalf)

7.1. **If your employer is paying your full contribution or a part of it and we need to debit their account, please complete 7.1:**

Name of employer _____ Employer or billing number _____

Employee number _____ Date of employment Y Y Y Y M M D D

(or PERSAL number for government employees. Please attach a clear copy of your salary slip.)

Branch name _____ Branch number _____

Please ensure your employer completes this warranty if this application form is not submitted with an employer application form:

Employer warranty

7.1.1. We warrant that the main applicant detailed in section 1 is an employee of our organisation.

7.1.2. The Discovery Health Medical Scheme may bill us for the amount due for this member in the same way as it does for our other employees with the Discovery Health Medical Scheme.

Your employment details (only complete if your employer pays the contributions on your behalf) *(continued)*

Authorised signatory _____

Name _____

Designation _____

7.2. **Only complete 7.2 if you own your own business and your business will be paying your contribution:**

Name of your business _____

Registration number _____ VAT number _____

Telephone _____ _____ Fax _____

Physical address _____

_____ Code _____

Postal address _____

_____ Code _____

8. Your banking details

8.1. **Your contributions**

If you will be paying your contributions in full, please complete this section:

Please note: we cannot accept credit card account details and only South African banking details are accepted. If we are debiting a third party account, the main member must sign next to the account holder.

Bank name _____

Branch name _____ Branch code _____

Account number _____ Type of account ☐ Cheque ☐ Savings

Account holder _____

We will debit your account on the first working day of the month. If your membership is not activated in time for the debit order collection, your first premium will be collected with the next debit order unless it has been paid in the interim. After we have received your first debit order, you may change your debit order date to a variable debit order date by contacting us on 0860 99 88 77.

8.2. **Your claims refund**

Can we use the same account we deduct contributions from to refund your claims? ☐ Yes ☐ No

If you do not want to use the same banking details for your contributions and claims refunds, please give us the details you would like to use:

Please note: we cannot accept credit card account details

Bank name _____

Branch name _____ Branch code _____

Account number _____ Type of account ☐ Cheque ☐ Savings

Account holder _____

By signing this application, you agree that once claims have been refunded into the bank account you have chosen, the Discovery Health Medical Scheme will not be responsible in any way for the amounts refunded.

Signature of account holder _____ Signature of main member _____

9. Previous medical scheme details

Please give us the details of all registered South African medical schemes that you 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.

Were all your dependants on the same medical scheme(s) ☐

If not, please complete your dependants' previous medical scheme cover details below:

Name	Scheme name	Start date	End date if already resigned	Are you/they still a member?	Reason for leaving
		Y Y Y Y M M D D	Y Y Y Y M M D D	☐ Yes ☐ No	
		Y Y Y Y M M D D	Y Y Y Y M M D D	☐ Yes ☐ No	
		Y Y Y Y M M D D	Y Y Y Y M M D D	☐ Yes ☐ No	
		Y Y Y Y M M D D	Y Y Y Y M M D D	☐ Yes ☐ No	
		Y Y Y Y M M D D	Y Y Y Y M M D D	☐ Yes ☐ No	
		Y Y Y Y M M D D	Y Y Y Y M M D D	☐ Yes ☐ No	

10. Moving from another medical scheme

Please make sure that you have completed section 9.

10.1. I confirm that all people named on this application:

10.1.1. have not had a break in membership of more than 90 days since resigning from the previous South African medical scheme, and ☐ Yes ☐ No

10.1.2. are currently or have been members of a South African medical scheme for at least the past 24 months. ☐ Yes ☐ No

If you answered **yes** to the above questions, please answer the questions in **10.2.**

If you answer no to any question in 10.1, you must complete all the medical questions in section 11.

10.2. For any person named on this application form:

10.2.1. Have you or any of your dependants been admitted to hospital in the 12 months before this application? ☐ Yes ☐ No

10.2.2. Are you or any of your dependants currently taking regular, ongoing medicine and/or treatment of a medical condition? ☐ Yes ☐ No

10.2.3. Are you or any of your dependants 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 **10.2**, we will not apply any waiting periods and you **do not** have to complete **section 11**.

If you answered **yes** to **any** questions in **10.2**, we will apply a three-month general waiting period to your application and you **do not have to complete Section 11**. If you feel that a three-month general waiting period should not be applied and you want to give us more information, please complete section 11.

During these three months, we will only cover claims relating to Prescribed Minimum Benefits according to the Scheme's rules.

11. Your health questions

Treating healthcare professional's name _____

Telephone _____ _____

The main applicant, spouse or partner and all dependants applying for cover needs to complete section 11.

Main applicant

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, 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? _____

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, 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 Name _____

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, 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 Name _____

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, 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? _____

Your health questions *(continued)*

Dependant 3 Name _____

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, 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? _____

Have you or **any dependant** in this application ever experienced, been treated for, or are you 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 or any of your dependants 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 11.18 below. Please answer ALL questions by ticking "Yes" or "No".

11.1. **Tumours and growths** ☐ **Yes** ☐ **No**

Example: abnormal pap smear results, pre-cancerous skin lesions, breast disease, non-cancerous tumours, cancerous tumours, 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 taken
		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

11.2. **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 taken
		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

11.3. **Gynaecological and obstetrics conditions** ☐ **Yes** ☐ **No**

Example: abnormal pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility.

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 taken
		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

11.4. **Are you or any of your dependants pregnant?** ☐ **Yes** ☐ **No**

Patient name _____

11.5. **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 taken
		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

11.6. **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 taken
		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

Your health questions *(continued)*

11.7. **Abdominal conditions** ☐ **Yes** ☐ **No**

Example: hepatitis, cirrhosis, portal hypertension, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis, gall bladder, gall stones, GORD (reflux), 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 taken
		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

11.8. **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, CVA.

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 taken
		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

11.9. **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 taken
		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

11.10. **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.

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 taken
		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

11.11. **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 taken
		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

11.12. **Blood conditions** ☐ **Yes** ☐ **No**

Example: 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 taken
		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

11.13. **Eye conditions** ☐ **Yes** ☐ **No**

Example: cataract, keratoconus, 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 taken
		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

Your health questions *(continued)*

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

Example: 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 taken
		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

11.15. **Male urogenital conditions** ☐ **Yes** ☐ **No**

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

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 taken
		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

11.16. **Are you or any of your dependants expecting to have medical investigations or 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 taken
		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

11.17. **Have you or any of your dependants received or not yet 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 taken
		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

11.18. **Have you or any of your dependants 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 taken
		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

If you, or one or more of your dependants, are HIV-positive, you or they must call us on **0860 99 88 77** within seven working days from the date we activate your Discovery Health Medical Scheme 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. A 12-month condition specific waiting period may apply to this condition. If you do not let us know about your HIV status within 7 days of your membership being active, we may end your Discovery Health Medical Scheme membership.

12. Fair Collection Notice – how we will process and disclose your Personal Information and communicate with you

1. This Fair Collection Notice ("Notice") explains how we obtain, use, disclose and otherwise process personal information, which may include health and financial information ("Personal Information"), as required by the Protection of Personal Information Act ("POPI").
2. Acceptance of these terms and conditions is voluntary, but is a requirement for activation and servicing of your medical scheme membership. If you do not accept these terms and conditions, we cannot activate and service your membership.
3. Please note:
   a. We may amend this Notice from time to time. Please check our website periodically to inform yourself of any changes;
   b. You have the right to object to the processing of your Personal Information;
   c. If you believe that we have used your personal information contrary to applicable law, you must first attempt to resolve any concerns with us in terms of our complaints or disputes process. If you are not satisfied with such process, you have the right to lodge a complaint with the Information Regulator, under POPI.
4. Discovery Health Medical Scheme and the administrator (we/us) will keep any information, including Personal Information relating to yourself and your dependants and/or beneficiaries, supplied to us in this application or collected from other sources ("Your Personal Information") confidential.
   You confirm that when you provide us with your Personal Information, your dependants and/or beneficiaries have provided you with the appropriate permission to disclose their Personal Information to us for the purposes set out below and any other related purposes. In the event of you providing information and signing consent on behalf of a minor (person younger than 18 years old) you confirm that you are a competent person and authorised to do so on their behalf.
5. You agree to us processing and disclosing your Personal Information in the following manner:
   We may collect, collate, process, store and disclose your Personal Information:
   a. For the administration of your health plan;
   b. For providing managed care services to you or any dependant/s on your health plan;
   c. For providing relevant information to a contracted third party who requires this information to provide a healthcare service to you or any dependant/s on your health plan;
   d. To profile and analyse risk;
   e. For academic research conducted by any company within the Discovery Group and/or contracted research and survey providers in South Africa as well as outside the borders of the Republic.

   Examples of how this will happen includes:
   a. Sharing your Personal Information with your chosen financial adviser during the application process to help the administrator, if necessary, while we process your membership application;
   b. Getting your Personal Information from other relevant sources, including medical practitioners, contracted service providers, financial advisers, credit bureaus, entities that are part of Discovery Limited or industry regulatory bodies ("Sources"), and further processing of such information to consider your membership application, to conduct underwriting or risk assessments, or to consider a claim for medical expenses. We may (at any time and on an ongoing basis) verify with the Sources that your Personal Information is true, correct and complete;
   c. Getting and sharing any information that is relevant to your application from or with your employer, if you have joined as a member of an employer group;
   d. Communicating with you about any changes in your health plan, including your contributions or changes and enhancements to the benefits you are entitled to on the health plan you have chosen;
   e. Transferring your Personal Information outside the borders of the Republic of South Africa where appropriate, for example to administer the ISOS and Africa Benefit, if you provide an email address which is hosted outside the borders of South Africa, or for processing, storage or academic research. We will ensure that anyone to whom we pass your Personal Information agrees to treat your information with the same level of protection as we are obliged to;
   f. Making use of external health specialists to assess or evaluate certain clinical information. Your Personal Information will be shared with such specialist/s in the event that you or your dependants are subject to such a clinical assessment.
6. If asked to do so, we will share your Personal Information with a third party if you have already given your consent for the disclosure of this information to such third party or if a contractual relationship exists in terms of which we are obliged to provide the information to such third party.
7. We will 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 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.
8. We may provide any credit bureau or credit providers industry association with any information about your consumer credit record, including personal information about any judgement or default history.
9. We and any entity within the Discovery Group will keep you updated on information about any offers or new products Discovery may make available at any time. Please contact us if you do not wish to receive any telephonic direct marketing information from us.
10. If we want to share your information for any other reason, we will do so only with your permission.
11. You have the right to request a copy of the Personal Information we hold about you. To do this, simply complete the 'Data Subject Request Form' on www.discovery.co.za/legal and specify what information you would like. We will take all reasonable steps to confirm your identity before providing details of your Personal Information.

Please note that any such Data Subject Request may be subject to a payment of a legally allowable fee.

12. You have the right to contact and ask us to update, correct or delete your Personal Information.
13. You agree that we may retain your Personal Information until such time as you request us to destroy them (unless we are obliged by law to retain it, regardless of such request).
14. If the Scheme, the administrator or Discovery (Ltd), as the holding company of the administrator, becomes involved in a proposed or actual merger, acquisition or any form of sale of some or all its assets, we may use and disclose your Personal Information to third parties in connection with the evaluation of the transaction. The surviving company, or the acquiring company in the case of a sale of assets, would have access to your Personal Information which would continue to be subject to this Notice.
15. Discovery Health Medical Scheme and the administrator are required to collect and retain information in terms of the following legislation (amongst others):

15.1 The Medical Schemes Act, 1998
15.2 The Consumer Protection Act, 2008
15.3 The Protection of Personal Information Act, 2013
15.4 Electronic Communications and Transactions Act, 2002
15.5 Promotion of Access to Information Act, 2000

Legislation specific to the administrator only:

15.6 Financial Advisory and Intermediary Services Act, 2002

Signature of main applicant _____ ⚠ **Please only sign if information is true, complete and correct.**

13. Discovery Health Medical Scheme rules for membership

13.1. ***Who "we" are***

Discovery Health Medical Scheme, registration no 1125, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, the administrator and managed care organisation for Discovery Health Medical Scheme, an authorised financial services provider.

13.2. ***Rules for membership***

The rules of the Discovery Health Medical Scheme record your rights and responsibilities for your membership of the Discovery Health Medical 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 financial adviser you or your employer appointed, may communicate with us on this application and your membership of the Discovery Health Medical Scheme.

You give permission that we can share your medical information and other relevant Personal Information about you and your dependant/s with your chosen financial adviser. The information will be shared so that he or she can help us if necessary while we process your membership application.

Please speak to your financial adviser or Discovery Health (Pty) Ltd if there is anything you do not understand.

13.3. ***Who you are applying for***

You may apply to join the Discovery 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 Discovery Health Medical Scheme rules. 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 or legal responsibility.

You may be called the principal member or main member in our future communications to you.

13.4. ***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.

13.5. ***Giving and getting information***

You must give true, correct and complete information.

To consider your application for membership, the Discovery 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 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 more information about themselves.

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 Medical Scheme and the administrator 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.

Discovery Health Medical Scheme and the administrator may get information about you from other relevant sources

To consider your application for membership, conduct underwriting or risk assessments or to consider a claim for medical expenses, you agree that we can get information about you and those you apply for from other relevant sources. These include any entity that is part of Discovery Limited, medical practitioners, financial advisers, credit bureaus or industry regulatory bodies. The administrator and the Discovery Health Medical Scheme 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 the Discovery Health Medical Scheme, 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 Discovery Health Medical Scheme or the administrator immediately if your information changes

You, your employer or your financial adviser 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 the Discovery Health Medical Scheme may cancel your membership/s

The Discovery Health Medical Scheme may cancel any membership 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.

13.6. ***About becoming a member***

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

Discovery Health Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before the Discovery Health Medical Scheme starts paying for any general or specific medical conditions. Please speak to your financial adviser or to 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 the Discovery Health Medical Scheme 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 the Discovery 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.

Discovery Health Medical Scheme rules for membership *(continued)*

13.7. ***Repaying money owed to the Scheme***

Discovery 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 if there is any amount that you owe to the Scheme.

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

When you become a member, depending on the plan 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 the Discovery 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 the Discovery Health Medical Scheme over the 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.

Signature of main applicant _____ Date **2 0** Y Y M M D D

The main applicant must sign and date any changes.

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

Application to join Vitality or KeyFIT or both

Please complete this form and submit it to us by email at **vitalitysales@discovery.co.za** or by fax to **(011) 539 2509**.

Please make sure that you sign this application

Main applicant's name and surname _____

Main applicant's ID number _____

Please choose one of the following options:

☐ Vitality ☐ KeyFIT ☐ Vitality and KeyFIT

Only members with a KeyCare Health Plan can join KeyFIT without joining Vitality.

1. Banking details and payment date

If you are paying your own Vitality contribution, please complete this section.

Bank name _____

Branch name _____ Branch number _____

Account number _____ Type of account ☐ Cheque ☐ Savings

Account holder _____

Accountholder's signature _____ Signature of main applicant _____

Please note: If you are using someone else's bank account, the accountholder must sign above to confirm and consent to this.

Please note that if your activation request reaches Vitality between the 1st and 15th of the month, the policy will be effective from the first of the current month. If you activate Vitality between the 16th and last day of the month, the policy will be effective from the first of the following month.

Please choose the date you would like us to debit your account (if you are not a government employee):

☐ 1st ☐ 10th ☐ 15th ☐ 20th ☐ 25th

If your membership is not activated in time for the debit order date you chose above, you will have two separate debit orders in the first month you pay your contribution, because you pay your contribution in advance. The first debit order will be collected on the first day of the month and the second debit order will be collected on the actual date you have chosen in the same month. From then on we will collect your monthly contribution on the date you have chosen.

If you are a government employee on the PERSAL payroll system, please tick the box below to tell us which day of the month you want us to debit your account.

☐ 1st ☐ 5th ☐ 8th ☐ 21st ☐ 26th

2. The Discovery Card

Discovery Card is a Visa credit card which boosts Vitality rewards. Vitality members get better savings and bigger rewards. Get the Card and Get Rewarded.

Would you like to apply for a Discovery Card? ☐ Yes ☐ No

Please note: When assessing your Discovery Card application, a credit check will be done. An accredited consultant will phone you to complete the application. A Discovery Card will only be issued if you meet the credit approval criteria.

You give consent to Discovery Vitality to share information with Discovery Card to facilitate this application process ☐ Yes ☐ No

3. Vitality contributions for 2017

	Vitality	KeyFIT	Vitality and KeyFIT
Member	R219	R47	R239
Member + spouse or dependant	R265	R57	R289
Member + 2 or more dependants	R296	R71	R329

4. Permission to process and disclose information and to communicate with you

This Fair Collection Notice ("Notice") explains how Discovery Vitality (Pty) Ltd, a company of the holding company Discovery Ltd, (we/us) obtain, use, disclose and otherwise process Personal Information, which may include health and financial information ("Personal Information"), as required by the Protection of Personal Information Act ("POPI"). Acceptance of these terms and conditions is voluntary, but is a requirement for activation and servicing of your policy. If you do not accept these terms and conditions, we cannot activate and service your policy. Discovery Vitality (Pty) Ltd (we/us) will keep any information, including Personal Information relating to you and your dependant/s and/or beneficiaries, supplied to us in this application or collected from other sources ("Your Personal Information") confidential. You confirm that when you provide us with your Personal Information, your dependant/s and/or beneficiaries have provided you with the appropriate permission to disclose their Personal Information to us for the purposes set out below and any other related purposes. In the event that you are signing a Vitality consent form on behalf of a minor (person younger than 18 years old) you confirm that you are a competent person and authorised to provide such consent on their behalf.

Permission to process and disclose information and to communicate with you *(continued)*

We may collect, collate, process, store and disclose your Personal Information for the following purposes:

- The administration of the Vitality programme;
- The provision of any services that you or any dependant on your Vitality policy may require;
- The provision of relevant information to a contracted third party who require such information to render a service to you or any dependant on your Vitality policy and only if such contracted third party agrees to keep the information confidential; and
- Academic research by any company within the Discovery Group and/or by contracted research and survey providers in South Africa as well as outside the borders of the Republic.

Please note:

- We may amend this Notice from time to time. Please check our website periodically to inform yourself of any changes;
- You have the right to object to the processing of Your Personal Information;
- Should you believe that we have utilised Your Personal Information contrary to applicable law, you will first resolve any concerns with us. If you are not satisfied with such process, you have the right to lodge a complaint with the Information Regulator, once established.
- We will only share your Personal Information if it is requested by a third party to whom you have already given your consent for the disclosure of this information and the party that we share the information with agrees to keep the information confidential. If we want to share your information for any other reason, we will do so only with your permission.
- We will provide Your Personal Information to any other entity within the Discovery Group where you or your dependant/s already have a relationship, or have applied for a product or benefit from, such entity. This information will be provided for the administration of your or your dependant/s products or benefits.
- We may obtain relevant health information from Discovery Health (Pty) Ltd and the Scheme to administer the Vitality Programme.
- We may provide to any credit bureau or credit providers industry association any information relating to your creditworthiness or any consumer credit information including but not limited to credit history, financial history, and judgement or default history in accordance with the requirements of the National Credit Act and Regulations.
- We may communicate any changes in your Vitality policy to you, including any changes in your contributions or any changes/enhancements to the benefits you are entitled to.
- Discovery Vitality (Pty) Ltd and any entity within the Discovery Group as well as contracted third party service providers will keep you updated on information about any offers for new products Discovery may make available at any time. Please contact us if you do not wish to receive any telephonic direct marketing from us.
- You have the right to request a copy of the Personal Information we hold about you. To do this, simply complete the 'Data Subject Request Form' on www.discovery.co.za and specify what information you would like. We will take all reasonable steps to confirm your identity before providing details of your Personal Information. Please note that any such Data Subject Request may be subject to a payment of a legally allowable fee.
- You have the right to contact and ask us to update, correct or delete your Personal Information.
- You agree that Discovery Ltd may transfer your Personal Information outside the borders of the Republic of South Africa if you provide an email address which is hosted outside the borders of South Africa. We may also need to transfer your Personal Information to another country for processing, storage or academic research. We will ensure that anyone to whom we pass your personal information agrees to treat your information with the same level of protection as we are obliged to.
- You agree that Discovery Ltd may retain your Personal Information until such time as you request us to destroy them (unless we are obliged by law to retain it, regardless of such request) If Discovery Ltd becomes involved in a proposed or actual merger, acquisition or any form of sale of some or all its assets, we may use and disclose your Personal Information to third parties in connection with the evaluation of the transaction. The surviving company, or the acquiring company in the case of a sale of assets, would have access to Your Personal Information which would continue to be subject to this Notice.
- Discovery Vitality is also required to collect and retain information in terms of the following legislation:
  - The Electronic Communications and Transactions Act (ECT)
  - The Financial Intelligence Centre Act (FICA)
  - The Financial Advisory and Intermediary Services Act (FAIS)
  - The National Credit Act (NCA)
  - The Consumer Protection Act (CPA); amongst others.

If you believe that we have used your personal information contrary to applicable law, you will first resolve any concerns with us. If you are not satisfied with such process, you have the right to lodge a complaint with the Information Regulator, under POPIA.

5. Vitality rules for membership

Discovery Vitality and KeyFIT are separate from the Scheme and administrator

Discovery Vitality is a separate company from Discovery Health (Pty) Ltd ('the administrator') and the Discovery Health Medical Scheme (referred to as 'the Scheme'). It is formally registered under the name Discovery Vitality (Pty) Ltd, (registration number 1999/007736/07) and takes care of the administration of the Vitality and KeyFIT programmes ('Discovery Vitality'), Discovery Card and the Discovery Card loyalty programme.

Rules of the Vitality programme

A full set of rules is available on www.discovery.co.za or you can call Discovery Vitality on 0860 99 88 77. In the event of a conflict between what is set out here, on our website and the rules of Vitality, the rules will always apply.

Your contributions to Discovery Vitality are separate

The contributions you pay are for Discovery Vitality and are not part of the contributions you pay to the Scheme.

Cancellation of Vitality membership

Please give notice on the first day of the month if you wish to cancel your Vitality membership in that month. Otherwise, your membership will only end on the last day of the next month. You must be a member of Vitality at the time of the *billing cycle (not the time of the transaction) in order to be eligible for your reward.

*Billing Cycle refers to the date decided by Discovery Vitality, on which your Vitality benefits are calculated on a monthly basis.

When you sign this application to join Vitality, you confirm that you accepted the rules for membership and you agree that you and those you apply for will be bound by them.

Signed at (town or city) _____ on **2 0** Y Y M M D D

Signature of main applicant _____ **The main applicant must sign and date any changes.**