Anglo Medical Scheme, reg. no. 1012 | Administered by Discovery Health (Pty) Ltd, reg. no. 1997/013480/07, an authorised financial services provider | PO Box 746 Rivonia 2128 | Call: 0860 222 633, WhatsApp 011 292 8797 | member@angloms.co.za; www.angloms.co.za

Application to add dependants 2026

This document is an application form for membership.

It also contains some terms and conditions. Please make sure you read and understand the Terms.

How to complete this form

1. Print this form and complete it clearly in black ink, or complete it electronically by typing into the fields below.
2. You can either ask your HR department to send you a link to complete this information in the secure member area on the Scheme website, or
3. If you complete the form electronically, you will need to apply your signature with a digital certificate, through an approved digital signature provider. Learn more about the approved list of digital signature providers we accept.
4. Read and understand the Scheme Rules (available on the website **https://www.angloms.co.za/portal/ams/scheme-rules**) and the terms and conditions pertaining to your membership, as per below.
5. Please make sure the main applicant signs and dates any changes.
6. Once completed, submit the completed and signed application form to your employer representative.
7. Please attach a copy of each applicant's identity document to this application form. We also accept valid passports and birth certificates for children.
8. 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 Schemes for statistical purposes only. You are not compelled to provide this information.

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

If you have any questions, please let us or your employer know. Once we have assessed your application, we will let you know if your dependant/s has been accepted and what will happen next.

We will send you and 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).

Please choose a date you want cover to start for all dependant/s you are applying for.

Commencement date D D M M Y Y Y Y

1. Main member's details

Membership number

ID or passport number

Member's surname

Member's name

2. About your spouse or partner (only complete 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)

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.

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

3. About your dependant/s (only complete if applying for membership)

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.

Cellphone if over 18 years

Email

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 23 years and older, are they:

Married? Yes No Financially dependent on you? Yes No

Disabled? Yes No A student? 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)

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.

Cellphone if over 18 years

Email

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 23 years and older, are they:

Married Yes No Financially dependent on you Yes No

Disabled Yes No A student Yes No

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

Dependant 3

Title Initials

Surname

AMSAAD002

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.

Cellphone if over 18 years

Email

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 23 years and older, are they:

Married Yes No Financially dependent on you? Yes No

Disabled Yes No A student Yes No

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

4. About your employer (if applicable)

Please ask your employer to complete this section.

Name of employer

Employer billing number

Employee number

Date of employment D D M M Y Y Y Y

Branch name

Branch number

Date D D M M Y Y Y Y

Name

Designation

NB: Please note that the membership cannot be activated if the commencement date is not completed.

5. 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.

If any of your dependants applying for cover belonged to different medical schemes, please complete below:

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	
				Yes No	

AMSAAD002

6. Your health questions

Information on symptoms, conditions or disorders (must be completed for the main applicant, spouse/partner and all dependants and must include information on conditions even if covered or not on previous memberships). We use this information only for lawful purposes, for example, enabling us and our administrator to process your application and to optimally administer your membership, to verify whether the information you provide on this application form is true and complete, to provide you with customised information relevant to your health status, to develop disease management programs for specific conditions, to review and enhance Scheme benefits, to improve Scheme's financial modeling, to assist the Scheme to better assess and mitigate its risk (which includes whether to impose a waiting period on your membership) and any other relevant uses. Please note that the Council for Medical Schemes has oversight over any irregular use of your or your dependant's health information. Please also note that the Medical Schemes Act restricts the ability of the Scheme to impose waiting periods. A condition specific waiting period cannot be imposed on you or any of your dependants relating to any condition that you disclose in this application except if you or your dependant received or were recommended any medical advice, diagnosis, care or treatment in respect of such a condition within a 12-month period ending on the date on which this application is considered to be fully and properly made.

Information disclosed by you relating to health conditions prior to the preceding 12 months can serve as a basis for the Scheme requiring that you undergo a medical examination, at the Scheme's cost. Should that medical examination reveal a current health condition, waiting periods may apply in respect of such current condition. Below we require you to advise us about whether you or any dependant/s specified in this application at any time experienced, have been treated/investigated 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 take note that if you or any of your dependants have any disorder, 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 6.18 below. Please also note that you must tell us in writing if any of the information you gave, in this 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. Please take note further that any indication of existing medical conditions on this application does not automatically enroll you/your dependants onto the Scheme's Disease Management programme. For more information with regards to the Schemes disease management enrollment visit **www.angloms.co.za.**

Please answer ALL questions by ticking "Yes" or "No". If you answered 'Yes', please provide full details in the sections provided.

Please refer to Annexure A should you need to disclose information that could not be completed in the health questions section below. Be sure to include the relevant question number.

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

Yes ☐ **No** ☐

Example: Disorders of the skin, skin lesions, 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

6.2. 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, peripheral vascular disease, deep vein thrombosis, pulmonary embolus, varicose veins.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

6.3. Gynaecological and Obstetric 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

6.4. 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

6.5. Mental health conditions Yes ☐ No ☐

Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (i.e. narcolepsy), eating disorders, Alzheimer's disease, dementia, attention deficit-hyperactivity disorder, drug and/or alcohol abuse or rehabilitation, suicide attempt, post traumatic stress 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

6.6. 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

6.7. 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, hernias, atrophic 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

6.8. Brain and nerve conditions Yes ☐ No ☐

Example: stroke, epilepsy, seizures, multiple sclerosis, motor neuron disease, myasthenia gravis, chronic headaches, 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

6.9. Breathing and respiratory conditions Yes ☐ No ☐

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

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

6.10. 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, injury, physical disability, prosthesis, and internal insertion of surgical implants, sarcoidosis, polymyositis, amputation, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

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

Example: kidney 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

6.12. Blood conditions **Yes** ☐ **No** ☐

Example: deep vein thrombosis, anaemia, polycythaemia vera, blood clotting disorders / diseases, leukaemia, lymphoma, pulmonary embolus, haemochromatosis, 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

6.13. Eye conditions **Yes** ☐ **No** ☐

Example: cataract, keratoconus (cross linkage), corneal ulcer, intra-ocular pressure, visual disturbances, night blindness, 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

6.14. 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

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

Example: prostate disorders, urogenital defects, varicocele, abnormal PSA tests (prostate specific antigen), undescended testes, phimosis, urinary incontinence, urinary 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

6.16. 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

6.17. Have 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	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

6.18. Have you or any of your dependants 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

HIV and AIDS

If you, or one or more of your dependants, are HIV-positive, please call us on **0860 222 633** within seven working days from the date we activate your Anglo Medical Scheme membership. We treat this information in the strictest confidence. It is in your interest to register on the HIV *Care* Programme. Anglo Medical Scheme may have waiting periods that apply in certain circumstances. These will not be reflected on any documents sent to you due to the sensitivity of the information and it is therefore important for you to phone to confirm funding.

7. Addition of dependants over 23 years

This section must be completed if you are adding children over 23 years, aged parents and other special dependants.

1. Is the dependant at present under medical treatment (including surgery), or is he/she expected to receive treatment in the near future?

Yes ☐ Please provide details

No ☐

2. Is the dependant entirely dependent on you for maintenance and support?

Yes ☐ Please provide reasons

No ☐ Please provide source of income and amount earned per month

3. Does the dependant reside with you?

Yes ☐ Please provide reasons

No ☐ Please provide reasons

4. Is the dependant a resident of an institution?

Yes ☐ The name of the institution must be furnished and it must be clearly stated whether the institution is responsible for medical expenses and the extent thereof

No ☐

5. Is the dependant a student?

Yes ☐ State whether full or part time, name of academic institution and expected period of studies

No ☐

6. Have any exclusions been imposed by the medical scheme on which the dependant has been registered?

Yes ☐ Please provide details

No ☐

8. Privacy Statement for Anglo Medical Scheme administered by Discovery Health (Pty) Ltd

When you engage with Anglo Medical Scheme, 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 and dependants, where applicable. To view and read our Privacy Statement, please follow this link: **https://www.angloms.co.za/assets/medical-schemes/angloms/privacy-statement-for-anglo-medical-scheme.pdf**

Signature of main applicant

Date D D M M Y Y Y Y

9. Terms and Conditions

In this document, “we” refers to Anglo Medical Scheme and/or Discovery Health (Pty) Ltd (“the Administrator”). “You” refers to the main member of Anglo Medical Scheme.

Your membership

Your membership with Anglo Medical Scheme is for yourself or together with other people – your spouse, your partner and people who are financially dependent on you as defined in the Anglo Medical Scheme Rules. You may be called the main member in our future communications to you.

Anglo Medical Scheme and the Administrator may get information from other approved sources

You agree that we can get information about you and your dependant/s from other relevant sources for the purpose of administration, to profile and analyse risk or to investigate fraud, waste and/or abuse (including by medical practitioners, contracted service providers or financial advisors). These include any entity that is part of the Administrator where you hold an independent contract, medical practitioners, financial advisors, 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 in respect of this application and any matter pertaining to or that arises during your membership of Anglo Medical Scheme, is true, correct and complete. You give permission that we may get any information that is relevant from your employee.

Tell Anglo Medical Scheme or the Administrator about changes right away

If any of the information you provided changes, you must tell us in writing what the changes are. We need advance notice of administrative changes such as cancellation of membership due to termination, as we do not accept backdated changes.

When Anglo Medical Scheme may cancel your membership

Anglo Medical Scheme may cancel any membership immediately and keep any contributions paid, if you and/or your dependant/s give us any information that is not true, correct and complete.

About becoming a member

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

Anglo Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before Anglo Medical Scheme starts paying for any general or specific medical conditions.

Resign from your current medical scheme when accepted as a member of the Anglo Medical Scheme

It is illegal to be a member of more than one medical scheme at the same time. You and those you apply for must resign from your current medical scheme when you receive notice from Anglo 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 Scheme, you are responsible for ensuring that your contributions are paid on time every month.

The Administrator and Anglo Medical Scheme may record telephone calls

We may record telephone conversations with you and your dependant/s. The recordings and all information we get during the recordings will be processed and kept as required by law.

Repaying money owed to the Scheme

The Scheme has the right, at any time, to collect from you any amount that you owe. We will notify you if there is any amount that you owe the Scheme.

You must repay any monies owed in your Medical Savings Account (MSA) if you leave Anglo Medical Scheme (Managed Care Plan)

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 Anglo Medical Scheme before the year is up, you must repay the portion of the Medical Savings Account you have used that is more than you have paid back to the Anglo Medical Scheme over the year.

Contact us for more information

If you have any questions, please contact us on **0860 222 633** or email us at **member@angloms.co.za**.

Signature of main applicant

Date D D M M Y Y Y Y

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

AMSAAD002

Annexure A

Question number	Patient name	Date first Diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Date of last treatment	Symptoms/ Medical diagnosis	Medicine used for this condition and dosage within the last 12 months