

Settlement agreement for an amount owing to Discovery Health Medical Scheme 2025

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

Purpose of the form

This form is your acknowledgement and agreement to pay back an amount owing to Discovery Health Medical Scheme. All amounts due will be indicated below.

What you must do

- Fill in the form in black ink and print clearly or complete the form digitally. You can view the list of approved digital signature providers on www.discovery.co.za, under Medical Aid > Find documents and certificates > Application forms.
- All relevant sections must be signed by the main member.
- To avoid administrative delays, please make sure this form is completed in full.
- Please include a letter of confirmation from the bank (not older than three months).
- Please upload the completed form through our Get Help service on www.discovery.co.za under Medical Aid > Get Help > Submit a document and follow the guided steps through our Virtual Agent.

1. Main member's details and acknowledgement of amount owing

First name(s)	<input type="text"/>																		
Surname	<input type="text"/>																		
Membership number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ID or passport number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone (H)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Telephone (W)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cellphone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email	<input type="text"/>																		

By signing this form, you acknowledge and agree to settle the full amount owing to the Scheme. You acknowledge that the amount quoted on the quotation attached is based on the information we have at the time and date of the quotation and if the amount you owe to the Scheme changes after this arrangement was made, we will contact you, either telephonically or in writing and offer you new payment terms.

Signature of main member



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

As part of Payment Association of South Africa (PASA) debit order mandate requirements you are required to supply the account holders residential address, email address and contact number. Please note that the details you supply will only be used for the PASA debit order mandate requirement and will not be used to update the contact details we have on system, if you wish to update any contact details please visit www.discovery.co.za > Medical aid > Manage your health plan.

2. Method of payment

Please choose your method of payment:

Direct debit (please complete section 3) Direct deposit

Date

Amount owing R .

If you choose to pay the outstanding amount by direct deposit, please use the following bank account:

Account holder:	Discovery Health Medical Scheme
Bank:	FNB
Branch:	JHB Corporate
Branch code:	255005
Account type:	Current
Account number:	58861132934

Please use your Discovery Health Medical Scheme membership number as the reference when making direct deposits and please attach your proof of payment via the get help service or get help on www.discovery.co.za under Medical Aid > Get Help > Submit a document and follow the guided steps through our Virtual Agent.

3. Your banking details if you are paying by direct debit

Bank name	<input type="text"/>																	
Branch name	<input type="text"/>				Branch code	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>								
Account number	<input type="text"/>				Type of account	Cheque <input type="checkbox"/>	Savings <input type="checkbox"/>											
Account holder	<input type="text"/>																	
Full amount owing	R	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	To be debited on*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

* If the form is not received in time for the debit order date you have chosen above, the debit order will be submitted in the following month on the same day you specified or the following working day.

By signing this direct debit request, the account holder authorises Discovery Health Medical Scheme to deduct the agreed amount from his/her bank account and confirms that:

- 3.1. He/she has the right to give Discovery Health Medical Scheme the authority to debit such account on a monthly basis. Furthermore, he/she will be liable for any claims, losses or damages of whatsoever nature arising out of debits made by Discovery Health Medical Scheme to the account as listed above should this account have insufficient funds, be incorrect or be held in the name of any other person.
- 3.2. He/she authorises Discovery Health Medical Scheme to verify the banking details as provided above for the purposes of setting up the required debit order.
- 3.3. He/she confirms that the account listed above is active and has not been de-activated due to non-compliance with verification procedures in terms of the Financial Intelligence Centre Act 38 of 2001, as amended ("FICA").

Signature of account holder



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

Signed at (town and city)

Date

Signature of main member



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