

Continuation Form

Important note

Continuations received after the 15th of the current month will only come into effect on the first of the following month. Please complete, sign this form and return to your Broker. Dedicated Sanlam Gap email address: sanlamapps@kaelo.co.za.

Policy Number: _____ Effective Date: _____

A. Policyholder Details

First Name: _____

Surname: _____

ID Number (compulsory field): _____ Cellphone: _____

Gender: _____ Date of Birth: _____

Email: _____

Address: _____

B. Policy Type and Continuation Premium

Single Policy **R233.00**

If you are continuing as a single Policyholder, you accept that cover will only apply to yourself and that should any changes be required, you will notify Kaelo, our administrator within 90 days. This includes the addition of dependants.

Premiums are payable monthly.

Family Policy **R409.00**

If you are continuing as a family, you accept that Cover will apply to you, your spouse and your children up to the maximum age of 26. Children will only be covered only until they reach the age of 27. Should any changes be required, you will notify Kaelo, our administrator within 90 days. This includes the addition or removal of dependants. Financially dependant parents are excluded.

Premiums are payable monthly.



C. Debit Order Details

Account Name: _____ Account Number: _____

Branch Name: _____ Bank Name: _____

Account Type: _____ Bank Code: _____

Debit Order Date: Last working day of the month Premium: _____

Name and Surname of Premium Payer: _____

Please note Premiums are due in arrears.

I, the Premium payer, hereby authorise Centriq to draw against the above bank account all amounts due to Centriq in terms of this insurance cover. Should the relevant Premiums be adjusted, I hereby confirm that the adjusted amount may be drawn from the above account subject to the notice period outlined in the Policy. This request is to remain in force unless cancelled by one month's written notice.

Premium Payer Signature: _____

D. Broker Details

Broker House Name: _____ Broker Code: _____

Broker Consultant Name: _____

E. Mandatory Documents

Please ensure that the following documents are submitted with your your amendment/s:

- A clear copy of either the ID or Birth Certificate of all Insured Parties being registered.
- A clear copy of the Medical Scheme Membership Certificate is required.



F. Declaration

I, _____ (full name) hereby declare that this continuation form, whether in my handwriting or not, is accurate and complete and forms the basis of the contract of insurance between the Underwriter and myself. I hereby apply for the insurance product/s and agree to abide by its Policy rules and/or those of its Underwriter and any amendments thereto which may be made from time to time. I confirm that all the information provided herein is complete and true and that I have not concealed any relevant or pertinent information that may affect the evaluation of risk considered under this Policy of cover. I understand that the provision of any false, misleading or missing information could result in my application being rejected or my Policy being cancelled or claims being rejected. Should this occur, I agree to refund all Benefit payments that I have received in relation to this Policy of insurance.

I hereby provide irrevocable authority for Kaelo, our administrator and its Underwriter to obtain any of my or my beneficiaries' medical history from any Medical Service Provider, Medical Scheme, insurance company or healthcare broker for the purposes of assessing this application for insurance as well as the underwriting of any future risk or the assessment of any claim that relates to this insurance cover. Premiums due to Centriq are payable monthly. Premiums that are in arrears will result in my Policy being suspended or possibly terminated. In the event that any Policy Benefit becomes payable subsequent to or as a result of my death, I hereby provide an irrevocable authority for such Benefits to be paid directly to my surviving Spouse or failing such circumstance to the nominated guardians or trustees responsible for the future care of my minor Children or failing either of the preceding events to my estate. Where applicable, I hereby authorise Centriq to draw against the above bank account all amounts due to Centriq in terms of this insurance cover. Should the relevant Premiums be adjusted by the Underwriters, I hereby confirm that the adjusted amount may be drawn from the above account subject to the notice period outlined in the Policy. This request is to remain in force unless cancelled by one month's written notice. Where my employer deducts the Premium from my salary. I hereby provide authority for my employer to deduct such Premium and pay this across to Centriq. I accept that any notice given to my employer is deemed to have been given to me.

Full Name:

Signature:

Date:

POPIA Consent

I consent to Centriq Insurance, and its operators, processing, and further processing, my personal information in accordance with the Protection of Personal Information Act, for the purposes of concluding, and performing in terms of, this insurance contract.

For further information please read our Privacy Notice, which can be found on www.centriq.co.za

Once signed, this application form should be returned to your servicing Financial planner.

This is not a Medical Scheme and the cover is not the same as that of a Medical Scheme.
This Policy is not a substitute for Medical Scheme membership.

Kaelo Risk(Pty)Ltd is an authorised financial services provider (FSP 36931)
Insurance Products are underwritten by Centriq Insurance Company Limited ("Centriq")
a licensed non-life insurer and authorized Financial Services Provider (FSP 3417)

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