Sanlam

INSURED BY CENTRIQ INSURANCE
A LICENSED NON-LIFE INSURER

Sanlam Gap Fedhealth NexGen Gap Cover Application Form

Important note

Please complete and sign this form and return to your Broker who will submit to our administrators Kaelo on your behalf. Kaelo will only accept applications received by a broker. Applications received after the 15th of the current month will only be activated on the 1st of the following month. Dedicated Sanlam Gap email address: sanlamapps@kaelo.co.za.

A. Applicant Details (Policyholder)

☐ I do not currently have Gap Cover

☐ I currently have Gap Cover with another provider but I wish to transfer my cover to Sanlam Gap Fedhealth NexGen Cover

If you have Gap Cover with another provider but wish to transfer to Sanlam Gap Fedhealth NexGen Cover, please submit your proof of cover. Waiting periods may apply.

Policy Type:

☐ Single Policy
If you are joining as a single Policyholder, you accept that cover will only apply to yourself and that should any changes be required, you must notify our adminstrator Kaelo, within 90 days. This includes the addition of dependants. Premiums are payable monthly.

☐ Family Policy
If you are joining as a family, you accept that Cover will apply to you, your spouse and your children until they reach the age of 27. Should any changes be required, you must notify our adminstrator Kaelo, within 90 days. This includes the addition of dependants. Premiums are payable monthly.

Plan Option:

☐ Fedhealth NexGen

Cover Start Date: _____

First Name: _____

Surname: _____

ID Number (compulsory field): _____ Cellphone: _____

Gender: _____ Date of Birth: _____

Email: _____

Address: _____

_____

B. Fedhealth Medical Scheme Cover Detail

Medical Scheme: _____ Option: _____

Start date of medical scheme membership: D D M M Y Y Y Y

Membership number: _____

Please note *that cover can only be granted if you are a member on the Fedhealth Savvy or any of the Fedhealth Elect options.*

C. Insured Party Details:

Should you have dependants, please provide us with a copy of your Medical Scheme membership certificate. Cover will apply to you, your spouse and your children until they reach the age of 27. If any of your dependants are on another Medical Scheme, please provide a copy of their membership certificate. Financially dependant parents excluded.

First Name:	Surname:	Relationship:	Date of Birth/ID Number:	Inception Date

D. Waiting Periods

A 3 month General Waiting Period and 12 month Condition Specific Waiting Period will be applied for all new applications. If you are transferring your cover from another Gap Cover provider with similar benefits, only the balance of the applicable waiting periods will apply.

E. Debit Order Details

The following reference will be reflected on your bank statement: Multid for SNGAP. If you are joining as a family, you accept that cover will apply to you, your spouse and your children. Should any changes be required, you must notify our administrator Kaelo within one calendar month. This includes the addition or removal of Dependants.

Account Name: _____ Account Number: _____

Branch Name: _____ Bank Name: _____

Account Type: _____ Bank Code: _____

Premium: _____

Name and Surname of Premium Payer: _____

Fedhealth NexGen rates for under 35 years:

☐ R64.90 per month individual ☐ R109 per month families

Fedhealth NexGen rates for over 35 years:

☐ R87 per month individual ☐ R160 per month families

Debit Order date: Please specify the date you would like for your debit order to take place each month.

☐ 1st ☐ 7th ☐ 15th ☐ 25th ☐ last working day

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.

Please submit a copy of your bank statement or a bank detail confirmation letter not older than 3 months with this form.

Premium Payer Signature: _____

Debit order deductions or Payment Terms are in Arrears or Advance
(This is dependent on the strike date chosen. 1st, 7th, 15th is collected in advance and 25th, 31st is collected in arrears).

F. Broker Details

Broker House Name: _____ Broker Code: _____

Broker Consultant Name:_____

G. Declaration by Policyholder

I, (full name) _____ with ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐
hereby declare that this application form, whether in my handwriting or not, is accurate and complete and forms the basis of the contract of insurance between the Insurer and myself. I hereby apply for the Sanlam Gap Fedhealth NexGen Cover (underwritten by Centriq) and agree to abide by its Policy rules and conditions and any amendments thereto which may be made from time to time.

Accurate information
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 for 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.

Premium payments
Premiums for Sanlam Gap Fedhealth NexGen Cover are payable monthly and deducted by Centriq. The payment reference will reflect as: Sanlam Gap. Premiums that are in arrears will result in my policy being suspended or possibly terminated.

Benefit payments
In the event that any policy benefit becomes payable subsequent to 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.

Medical history
I hereby provide irrevocable authority for Kaelo, the administrator, and Centriq, the Insurer, to obtain any of my or my dependant's 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.

Disclosure documents
I have read and understood the Sanlam Gap Cover Disclosure Notice which I received together with this Application Form.

Policy exclusions and terms and conditions
Please refer to your policy document for the full list of exclusions and terms and conditions.

Full Name: _____ Signature: _____

Date: D D M M Y Y Y Y

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 Broker.

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).
Kaelo Risk (Pty) Ltd holds preference shares in Centriq Insurance Company Limited.
Insurance Products are insured by Centriq Insurance Company Limited ("Centriq")
a licensed non-life insurer and authorised Financial Services Provider (FSP 3417).

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