Application form for gap cover for MBMed members

Important information

- Do not sign this form unless you understand the benefits, terms and conditions of the insurance policy.
- Your signature confirms that you accept the terms and conditions as will be set out in the insurance policy.
- Should you have any questions regarding this insurance policy, we invite you to contact the AON Resolution Centre at arc@aon.co.za or 0860 835 272
- This insurance policy is underwritten by Centriq Insurance Company Limited, a member of the Sanlam Group. Claims are administered and settled by Xelus (Pty) Ltd who has been mandated by Centriq as the binder holder and who is an authorised financial services provider (FSP No 36931).
- The intermediary is Aon South Africa (Pty) Ltd, an authorised financial services provider FSP No. 20555

A. Details of Member & Dependants

(Note: You have to be a member of a medical scheme . Cover for dependants as per your medical scheme . Cover for children up to age 27.)

	First Name/s	Surname	Birth Date
Member:			
ID Number (complusory for main member):			
Spouse:			D D M M Y Y Y Y
Child 1:			D D M M Y Y Y Y
Child 2:			D D M M Y Y Y Y
Child 3:			D D M M Y Y Y Y

(if the space is insufficient please attach a signed addendum to this application form)

Telephone (h): _____ Cell: _____

E-mail: _____

B. Employer

Employment Date: _____ Employee Salary Number: _____

Tick boxes:

- ☐ Salaries
- ☐ Wages

Payrolls:

- ☐ DFM
- ☐ MBFS
- ☐ MBSA Pretoria
- ☐ MBSA East London

C. Cover Detail

Start Date: D D M M Y Y Y Y Membership Number: _____

Please indicate your desired date of commencement of cover (month/year): M M Y Y Y Y

D. Product Choice

Premium to be collected monthly in arrears via a company payroll deduction

☐ Comprehensive at *R125 per month

Commission of 20% of premiums is payable to the intermediary as and when premiums are paid.

** Premiums are valid for 2017*

E. Health Questionnaire

Please answer each question below (tick the relevant box).

Have you or any of your eligible dependants:

E.1 Any existing medical conditions, or do you or they receive any form of on-going treatment or medication? Yes No
(e.g. heart or vascular disease / back, neck or joint problems / digestive system problems / sinusitis / cancer (incl in remission) kidney disorders / gynaecological problems / ear, nose or throat problems, etc)

E.2 Been hospitalised within the last 24 months? Yes No

If you have answered yes to any of the questions above, please provide full details in the space provided below
(if the space is insufficient please attach a signed addendum to this application form):

Applicant Name _____ Question Number _____

Details of Condition / Treatment / Disorder: _____

Last Date of Treatment: D D M M Y Y Y Y

Provide details of Future Treatment incl. date/s: _____

Dependant Name _____ Question Number _____

Details of Condition / Treatment / Disorder: _____

Last Date of Treatment: D D M M Y Y Y Y

Provide details of Future Treatment incl. date/s: _____

Dependant Name _____ Question Number _____

Details of Condition / Treatment / Disorder: _____

Last Date of Treatment: D D M M Y Y Y Y

Provide details of Future Treatment incl. date/s: _____

Dependant Name _____ Question Number _____

Details of Condition / Treatment / Disorder: _____

Last Date of Treatment: D D M M Y Y Y Y

Provide details of Future Treatment incl. date/s: _____

F. Do you currently have gap cover?

Please answer the following questions:

F.1 I do not currently have gap cover but wish to join this gap cover and agree that my premiums will be deducted from my salary. Yes No

F.2 I currently have gap cover with another provider but I wish to transfer my cover to this gap cover Yes No

Notes:

- Waiting periods may apply to your cover.
- If answered Yes to Question F.2 , please provide proof of cover with the other provider i.e. Current Gap Cover Membership Certificate
- All applications remain subject to our standard underwriting terms and conditions which is available in the Sanlam Gap Cover insurance policy agreement.

G. Debit Order Details

(Only complete this section if your employer is not deducting premiums from payroll)

Bank Name: _____ Branch Name: _____

Branch Code: _____ Account Type: _____

Account Number: _____ Account Name: _____

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

15th ☐ Last working day

H. Declaration by Principal Member

I hereby give consent to my employer to deduct monthly the premium from payroll. Yes

I, (full name) _____ with ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐
hereby apply for the gap cover product underwritten by Centriq and agree to abide by its policy rules 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 of pertinent information that may affect the evaluation of risk considered under this policy of insurance.

I understand that the provision of any false, misleading or missing information could result in my application being rejected or my membership 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.

In the event that my employer is selecting the cover under this policy, I hereby provide authority for my employer to make such cover nomination on my behalf and furthermore indemnify Centriq against liability for any loss that may result from an incorrect nomination of such cover by the employer.

Premium payments

Premiums due to Centriq are payable monthly. Premiums that are in arrears will result in my membership being suspended or possibly terminated.

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.

Benefit payments

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.

Policy Exclusions

I have read and understood the policy exclusions listed in the Sanlam Gap Cover insurance policy agreement, Section D POLICY CHOICE.

Full Name: _____ Signature: _____

Date: D D M M Y Y Y Y

I. Details of Intermediary

Name of Company: Aon Broker house code: 69

Cell number: 0860 835 272 E-mail: arc@aon.co.za

Please return the completed application form to:

Email: Apps@aon.co.za