

APPLICATION FORM 2019

Please complete this form in black ink and CAPITAL letters

Medical Scheme membership no.:		Name of Medical Scheme:	
Medical Scheme Option:			
Is this application part of a group? yes ☐ no ☐ If YES, group name:			
Previous Gap Cover:		Date Joined:	
Date Terminated:		Required Inception Date:	

Please attach membership certificate

PRINCIPAL INSURED DETAILS

Name and Surname:						
ID number \ Passport:		Mr ☐	Mrs ☐	Miss ☐	Dr ☐	Other
Date of birth:		Email Address:				
Contact details:	Home no.:	Work no.:				
	Fax no.:	Cell no.:				
Postal address:						
						Code:
Residential address:						
						Code:

SPOUSE DETAILS

Name and Surname:						
ID number \ Passport:		Mr ☐	Mrs ☐	Miss ☐	Dr ☐	Other
Date of birth :		Email Address:				
Contact details:	Home no.:	Work no.:				
	Fax no.:	Cell no.:				
Medical Scheme membership no.:		Name of Medical Scheme:				
Medical Scheme Option:						

DEPENDANTS

Dependants are:

- Spouse and/or dependant children up to the age of 21 years
- Adopted/foster child (please attach documentary proof)
- Students up to the age of 27 (please prove full time enrolment)
- Provide studency proof or medical certificate if you are on the same medical aid

Name and Surname:				
ID number \ Passport:		Male ☐	Female ☐	
Date of birth :		Relationship to applicant:		

Name and Surname:				
ID number \ Passport:		Male ☐	Female ☐	
Date of birth :		Relationship to applicant:		

Name and Surname:				
ID number \ Passport:		Male ☐	Female ☐	
Date of birth :		Relationship to applicant:		

Name and Surname:				
ID number \ Passport:		Male ☐	Female ☐	
Date of birth :		Relationship to applicant:		

SPECIFIC HEALTH QUESTIONS

The following questions are related to the policyholder and or any beneficiaries or dependents on the policy.

YES NO

1	Have you been admitted to hospital in the last 4 months?		
2	Are you expecting a hospital admission or aware of any conditions or illness that would require treatment in the next 12 months?		
3	Are you or any of your dependents currently pregnant?		
4	Have you taken or are currently taking chronic medication in the past 24 months?		
5	Have you been on gap cover before and / or have had a gap claim? If yes, who was the provider?		

If you answered "Yes" to any of the questions, please provide details below.

Question no.	Applicant/dependents	Disorder	Medication	Date Diagnosed

DEBIT ORDER DETAILS

Name of account holder:

Account no.:

Bank: ☐ Standard Bank ☐ ABSA ☐ FNB ☐ Nedbank ☐ Capitec Other

Account type: ☐ Cheque ☐ Savings ☐ Transmission Other

Debit order day: ☐ 1st ☐ 7th ☐ 15th ☐ 25th ☐ 31st ☐ Other

I hereby instruct and authorise you to draw against my bank account the amount necessary for payment of my monthly premium due in respect of the above mentioned insurance, without prejudice to the rights of Sirago Underwriting Managers (Pty) Ltd. I further authorise you to increase the amount in the terms of the policy from time to time and authorise my bank to effect payment.

Signature of account holder Date:

IMPORTANT INFORMATION

- Please make sure FULL details are given for questions answered YES.
- Application forms could be underwritten and conditions may be excluded for longer than 10 months.
- The onus lies on the insured to make sure that premiums are paid on a monthly basis. Reference on bank statements read: MD SIRAGO_MED
- Effective from 1 January 2019.
- In the event of a bereavement related claim the Insurer will pay the benefit into the principal or nominated beneficiaries account. The beneficiary must be noted on the policy prior to any loss. We will require the full name, surname and ID to note the beneficiary. At the time of a claim we will require the beneficiary's ID and proof of bank. Should there be no beneficiary noted on the policy prior to the loss or should we be unable to confirm the identity of the beneficiary, payment will always be made into the principal policyholders account.

DECLARATION BY APPLICANT

I, the undersigned, hereby declare:

- That to the best of my knowledge and belief the information provided in connection with this application whether in my own handwriting or not, is true and I have not withheld any material facts which are known to me. (A material fact is likely to influence the assessment of this application by Sirago Underwriting Managers (Pty) Ltd. If you are in any doubt as to whether a fact is material or not, you should disclose it.)
- That I understand that any relevant material fact omitted in this proposal form may lead to Sirago Underwriting Managers (Pty) Ltd not meeting claims, should the omitted fact have been of such importance that the risk may not have been accepted in the first instance, in terms of the policy. This may lead to the cancellation of this policy or rejection of claims without refund of premiums.
- That I understand that this is an Accident and Health policy with stated benefits in terms of the Short-term Insurance Act 53 of 1998 and not a Medical Scheme product.
- The sharing of claims information and underwriting information by Insurers is essential to enable the insurance industry to underwrite policies, assess risks fairly, reduce the incidence of fraudulent claims and protect the public interest in terms of limiting excessive premium increases. You hereby waive any right to privacy of any insurance information provided by you or on your behalf, in respect of any insurance policy or claims you lodge. You also consent to this information being disclosed to any other insurance company and/or verified against other legitimate source or a database.
- I specifically consent to Sirago Underwriting Managers (Pty) Ltd contacting my current Medical Scheme and/or medical practitioner to verify any medical details as provided in my application form. I further consent to such information being disclosed to Sirago Underwriting Managers (Pty) Ltd for purpose of verifying the disclosure as provided on my application form.
- That I will advise Sirago Underwriting Managers (Pty) Ltd of any changes to my health state between the point of application and actual inception of my policy.
- As part of our claims validation process we used the services of a contracted third party in order to authenticate medical scheme membership, plan option type, relevant beneficiaries and agreed medical scheme option tariffs amongst other relevant information to validate the claim.
- We reserve the right to call for additional information of a clinical nature. In the event that Sirago requests a PMA (Post Medical Assessment) from your doctor as part of the claims assessing and authentication process
- I authorise Sirago Underwriting Managers to negotiate with service providers on my behalf for my medical claims and or bill and pay the provider direct.
- By agreeing to the terms of this consent form, I expressly consent to the processing of my information for marketing purposes and know & understand that by agreeing to same that I may on occasion, receive marketing materials in the form of sms and / or emails and the like from Sirago Underwriting Managers (Pty) Ltd.

Signature of policy holder Date:

Spouse (If married in community of property) Date:

INTERMEDIARY DETAILS

Intermediary Group:		Intermediary Code:	
Sales Person:		Sales Code:	
Tel no.:		Cell no.:	

OPTION SELECTION

☐ ULTIMATE GAP COVER	☐ INDIVIDUAL	☐ 64 UNDER	☐ 65+	☐ FAMILY
☐ PLUS GAP COVER	☐ INDIVIDUAL	☐ 64 UNDER	☐ 65+	☐ FAMILY
☐ GAP COVER	☐ INDIVIDUAL	☐ 64 UNDER	☐ 65+	☐ FAMILY
☐ GAP-LITE COVER	☐ INDIVIDUAL	☐ 64 UNDER	☐ 65+	☐ FAMILY
☐ GOV-GAP COVER	☐ INDIVIDUAL	☐ FAMILY		
☐ EXACT COVER	☐ INDIVIDUAL	☐ 64 UNDER	☐ 65+	☐ FAMILY
☐ EXACT WITH CO-PAY COVER	☐ INDIVIDUAL	☐ 64 UNDER	☐ 65+	☐ FAMILY
☐ EXACT COVER WITH GAP	☐ INDIVIDUAL	☐ 64 UNDER	☐ 65+	☐ FAMILY
☐ EXACT WITH GAP AND CO-PAY COVER	☐ INDIVIDUAL	☐ 64 UNDER	☐ 65+	☐ FAMILY

OPTION BY APPLICANT:

Premium per month	R
TOTAL PREMIUM PAYABLE	R
*Intermediary Fee (Optional)	R

* The Intermediary fee will only be collected subject to us receiving a signed contract between the Intermediary and Policyholder

* This Intermediary fee is optional and is paid to the intermediary on top of the statutory commission on your approval

Please return the completed form to applications@sirago.co.za or by fax to 086 508 2292. | In what Language would you like your policy documents in? English ☐ Afrikaans ☐

NOMINATED BENEFICIARY (related to death benefits and/or premium waivers)

Name and Surname:						
ID number / Passport:		Mr ☐	Mrs ☐	Miss ☐	Dr ☐	Other
Date of birth :		Email Address:				
Contact details:	Home no.:		Work no.:			
	Fax no.:		Cell no.:			
Relationship to Main member:						

BANKING DETAILS FOR REFUNDS

SHOULD YOU NOT COMPLETE THIS SECTION IT WILL RESULT IN US USING YOUR DEBIT ORDER DETAILS

Name of account holder:					
Account no.:					
Bank:	☐ Standard Bank	☐ ABSA	☐ FNB	☐ Nedbank	
Other:					
Account type:	Cheque ☐	Savings ☐	Transmission ☐	Other	
Signature of account holder				Date:	

STATISTICS

Race:	☐ Indian/Asian	☐ Black	☐ Coloured	☐ White	☐ Other	
Gender:	☐ Male	☐ Female				
Income Bracket:	☐ 0 - 2 500	☐ 2 501 - 5 000	☐ 5 001 - 7 500	☐ 10 001 - 12 500	☐ 12 501 - 15 000	☐ 15 001 +

We believe in protecting your privacy and will not share, rent or sell any personal information or any statistical data received to third parties outside of Sirago Underwriting Managers, except as described in this policy.