GENESIS EMPLOYEE BENEFITS

CONSTANTIA
Insurance made personal
Constantia Insurance Company Limited, an authorised FSP 31111

GENESIS-GAP COVER SERIES EMPLOYER GROUP APPLICATION FORM

Underwritten by Constantia Insurance Company Limited (CICL), Reg. No. 1952/001514/06, FSP No: 31111 (The Insurer)

- **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.**
- **THE MASTER POLICY ISSUED IS THE SOURCE OF ALL BENEFITS, RIGHTS, AND OBLIGATIONS AND EXCLUSIONS. TO DETERMINE YOUR INDIVIDUAL NEEDS, WE SUGGEST THAT YOU CONTACT YOUR BROKER AND REQUEST ADVICE FROM HIM / HER.**

BROKER DETAILS

BROKER / CONSULTANT NAME			
NAME OF BROKERAGE			
FSP NUMBER		BROKER CODE	
BROKER CONTACT NUMBER	AREA CODE	VAT NUMBER	
BROKER E-MAIL ADDRESS		UNIQUE IDENTIFIER (IF NECESSARY)	

EMPLOYER GROUP DETAILS

COMPANY NAME			
REGISTRATION NUMBER		VAT NUMBER	
POLICY NUMBER			
PAYMENT METHOD	ELECTRONIC FUNDS TRANSFER (EFT)		
	INDIVIDUAL DEBIT ORDERS		

CONTACT DETAILS

POSTAL ADDRESS	PHYSICAL ADDRESS (IF DIFFERENT TO POSTAL)
POSTAL CODE	POSTAL CODE

CONTACT NAME		DESIGNATION	
HOME NUMBER	AREA CODE	WORK NUMBER	AREA CODE
CELL NUMBER	AREA CODE	E-MAIL	
INCEPTION DATE	D D M M Y Y Y Y		
NUMBER OF EMPLOYEES TO BE COVERED			
BASIS OF PARTICIPATION	VOLUNTARY		
	COMPULSORY		
CATEGORY OF EMPLOYEES COVERED ON A COMPULSORY PARTICIPATION BASIS:			

BENEFITS SUMMARY

BENEFIT	DESCRIPTION
GAP COVER	COVERS UP TO 500% OF MEDICAL SCHEME RATE FOR IN-HOSPITAL TREATMENT
TRAVEL-CARE	TRAVEL-CARE OF R5 000 000 PER INSURED
SUB-LIMITATION	R10 000 SUB-LIMITATION COVER BENEFIT PER ADMISSION
CO-PAYMENT	R20 000 CO-PAYMENT BENEFIT PER ADMISSION (INCLUDES MRI, CT & PET SCANS)
CASUALTY BENEFIT	R7 500 CASUALTY BENEFIT PER ADMISSION
CANCER COVER	R200 000 EXCESS. TRADITIONAL CANCER COVER RELATED TO CANCER TREATMENT.
BIOLOGICAL CANCER COVER	R200 000 EXCESS. BIOLOGICAL CANCER DRUG COVER WHEN THE MEDICAL AID IMPOSES A SUB-LIMIT.

PRODUCT SUMMARY & SELECTION

PRODUCT	LISTED BENEFITS	SPECIFIC LIMITATION PER INSURED / PER ADMISSION / EXCESS	OVERALL LIMITATION PER INSURED PERSON PER ANNUM	PREMIUM PER FAMILY PER MONTH (incl. VAT) 18-65 YEARS OLD
PRIMARY PLAN	- GAP COVER		R157,000	☐ R158.00
	- TRAVEL-CARE	R5,000,000 PER INSURED		
VITAL PLAN	- GAP COVER - SUB-LIMIT COVER - CO-PAYMENT COVER	R10,000 PER ADMISSION R20,000 PER ADMISSION	R157,000	☐ R215.00
	- TRAVEL-CARE	R5,000,000 PER INSURED		
ULTIMATE PLAN	- GAP COVER - SUB-LIMIT COVER - CO-PAYMENT COVER - CASUALTY BENEFIT - TRADITIONAL CANCER COVER - BIOLOGICAL CANCER COVER	R10,000 PER ADMISSION R20,000 PER ADMISSION R7,500 PER ADMISSION R200,000 EXCESS R200,000 EXCESS	R157,000	☐ R315.00
	- TRAVEL-CARE	R5,000,000 PER INSURED		

INCEPTION DATE (DATE COVER IS TO COMMENCE) D D M M Y Y Y Y

PREMIUM PAYMENT

THE EMPLOYER MUST PROVIDE AMBLEDOWN WITH A MONTHLY MEMBERSHIP LISTING UPON PAYMENT OF PREMIUM WHEN PAYMENT IS MADE BY WAY OF EFT OR DEBIT ORDER.

DAY IN EACH MONTH ON WHICH PREMIUM EFT WILL BE PAID OVER TO THE INSURER. EG. 1ST	
WILL PREMIUM BE PAID IN ARREARS?	☐ YES ☐ NO
PREMIUMS ARE TO BE TRANSFERRED TO THE FOLLOWING ACCOUNT	IOM (PTY) LTD FNB CORPORATE BANKING ACCOUNT NUMBER: 62206927850 BRANCH CODE: 255005 REFERENCE: PREFIX AMBLE, FOLLOWED BY A 10-CHARACTER DESCRIPTION

DEBIT ORDER DETAILS

ACCOUNT HOLDERS NAME		BANK / BUILDING SOCIETY	
ACCOUNT NUMBER		BRANCH	
BRANCH CODE		ACCOUNT TYPE	☐ CURRENT ☐ TRANSMISSION ☐ SAVINGS
EMPLOYER'S PERSON RESPONSIBLE FOR PREMIUM COLLECTION & PAYMENT			

IF CONTACT DETAILS ARE DIFFERENT TO THE ABOVE PLEASE PROVIDE THE FOLLOWING

CONTACT NUMBER	AREA CODE	EMAIL	

SIGNATURE OF AUTHORISED ACCOUNT SIGNATORY

DATE D D M M Y Y Y Y

DECLARATION

I declare that I am an authorised signatory on behalf of the above mentioned Employer Group and that I have not withheld any material information and I accept that this application and declaration shall be the basis of the contract of insurance with The Insurer, which will become effective on the first day of the month for which premiums are received. I also acknowledge that should this application not be considered as part of a full financial needs analysis and I have instructed the broker not to proceed with a full financial needs analysis, this could have the effect that all my financial needs may not be properly addressed.

SIGNED

NAME OF AUTHORISED SIGNATORY

DATE D D M M Y Y Y Y

Please return to your broker or alternatively:

Ambledown Financial Services (Pty) Ltd
PO Box 1862, Cramerview, 2060
Tel Number 0861 262533, Fax Number 011 463 1600
E-mail Address: premium@ambledown.co.za