GENESIS EMPLOYEE BENEFITS

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

GENESIS-GAP COVER SERIES
INDIVIDUAL DEBIT ORDER 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)	

PERSONAL PARTICULARS

APPLICANT

TITLE		SURNAME	
ID OR PASSPORT NUMBER		FIRST NAMES	
DATE OF BIRTH	D D M M Y Y Y Y		

EMPLOYER

NAME OF EMPLOYER		DATE EMPLOYED	D D M M Y Y Y Y

MEDICAL SCHEME

NAME OF MEDICAL SCHEME		PLAN OPTION	
DATE JOINED	D D M M Y Y Y Y	MEDICAL SCHEME NUMBER	

DEPENDANTS To see who qualifies as a dependant see DECLARATION c)

FIRST NAME (AND SURNAME IF DIFFERENT)	RELATIONSHIP	ID OR PASSPORT NUMBER	DATE OF BIRTH
			D D M M Y Y Y Y
			D D M M Y Y Y Y
			D D M M Y Y Y Y
			D D M M Y Y Y Y
			D D M M Y Y Y Y
			D D M M Y Y Y Y

CONTACT DETAILS

POSTAL ADDRESS		PHYSICAL ADDRESS (IF DIFFERENT TO POSTAL)	
POSTAL CODE		POSTAL CODE	
HOME NUMBER	AREA CODE	WORK NUMBER	AREA CODE
CELL NUMBER	AREA CODE	E-MAIL	

MEDICAL QUESTIONNAIRE

1. DO YOU OR ANY OF YOUR DEPENDANTS SUFFER FROM ANY CHRONIC OR RECURRING ILLNESS OR ANY OTHER SERIOUS AILMENT? NO ☐ YES ☐

IF "YES" PLEASE SPECIFY

2. HAVE YOU OR ANY OF YOUR DEPENDANTS RECEIVED TREATMENT OR ADVICE BY A MEDICAL PRACTITIONER IN THE LAST 12 MONTHS? NO ☐ YES ☐

IF "YES" PLEASE SPECIFY

NAME OF FAMILY'S GENERAL MEDICAL PRACTITIONER

CONTACT NUMBER AREA CODE

3. HAVE YOU OR ANY OF YOUR DEPENDANTS BEEN HOSPITALISED DURING THE LAST 12 MONTHS? NO ☐ YES ☐

IF "YES" TO THE ABOVE PLEASE SPECIFY THE CONDITION FOR WHICH HOSPITALISATION WAS NECESSARY

NAME	DATE HOSPITALISED	REASON FOR HOSPITALISATION
	D D M M Y Y Y Y	
	D D M M Y Y Y Y	

4. DO YOU OR ANY OF YOUR DEPENDANTS EXPECT TO BE HOSPITALISED DURING THE NEXT 12 MONTHS? NO ☐ YES ☐

IF "YES" TO THE ABOVE PLEASE SPECIFY THE CONDITION FOR WHICH HOSPITALISATION IS NECESSARY

NAME	EXPECTED DATE OF HOSPITALISATION	REASON FOR HOSPITALISATION
	D D M M Y Y Y Y	
	D D M M Y Y Y Y	

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**	☐
	- 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**	☐
	- 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**	☐
	- TRAVEL-CARE	**R5,000,000 PER INSURED**		

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

PREMIUM PAYMENT

DEBIT ORDER DETAILS

ACCOUNT HOLDERS NAME		BANK / BUILDING SOCIETY		
ACCOUNT NUMBER		BRANCH		
BRANCH CODE		ACCOUNT TYPE		CURRENT
				TRANSMISSION
				SAVINGS

PLEASE SELECT PREFERRED DEBIT ORDER COLLECTION DATE

1st		7th		15th		20th		25th		28th		LAST DAY OF THE MONTH	

I, the undersigned, hereby request and authorise the Insurer or it's representative to deduct the premium payable under the above plan against my bank account or institution (or any other bank or institution or branch where my account is kept or transferred to) on the preferred debit order collection date.
Should the collection date selected fall on a weekend or public holiday, I understand that a debit will be processed against my account on the first working day following the weekend or public holiday.
I further declare that:

- I authorise my bank or institution (as stated) to debit my account with all debits which may be presented by the company as if I personally signed for each one.
- I also understand that the details of each debit order will be printed on my bank statement as a separate line as proof thereof.
- I declare that all bank costs related to this debit order system and approval, will be for my own account.
- I understand and accept that I or the company can change this arrangement at any time in writing (by giving the other party 30 days' notice) or cancel this arrangement, given that it won't have any effect on the deductions of the company which was already agreed and authorised herein.
- I understand and accept that all payments in terms of this agreement will be made without any prejudice.
- I understand and accept that if any payment in terms of this agreement is not received, the relevant policy/ies will be cancelled effective from the last day of the uninterrupted period for which payment(s) were received.
- I accept that this request and authorisation will be applicable for all amounts payable from inception and monthly thereafter.
- I acknowledge that I need to ensure that premiums are collected for cover to remain in force.

SIGNATURE OF ACCOUNT HOLDER

DATE D D M M Y Y Y Y

DECLARATION

I declare that I have not withheld any information and I accept that this application and declaration shall be the basis of the contract of insurance between me and 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.
I further confirm that the following notable conditions have been explained to me:

a) No benefits will be payable during a general 3 month waiting period for all treatment received unless the treatment was required as a result of an accident (external violent physical means).
b) No benefits will be payable for treatment during the first 12 months of the policy if treatment or advice was received 12 months prior to inception of the policy that related to the subsequent treatment.
c) Not all your dependants on your medical scheme are automatically covered under this policy, only your eligible spouse and your eligible children are covered as per the policy definitions.
   i. Only one spouse is allowed.
   ii. The maximum age for a child dependant is under 21. This age may be extended to 25 (under 26) in respect of an unmarried child who is a dependant on the Principal Insured Person's Medical Scheme.
   iii. No cover is provided for extended family members.

I confirm that although I have completed this application form, it does not constitute an insurance contract until a membership number is assigned, policy issued and premium is successfully paid.

SIGNATURE OF APPLICANT

PRINTED NAME OF APPLICANT

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: admin@ambledown.co.za