GENESIS EMPLOYEE BENEFITS
Proudly Genesis Capital

GENMEDPRIMARYCARE
YOUR ACCESS TO QUALITY PRIMARY HEALTH CARE

AfroCentric ESSENTIALMED

APPLYING TO JOIN GENMEDPRIMARYCARE AS PART OF AN EMPLOYER GROUP

Afrocentric Essential Med is not a medical scheme but a Primary Health Care product licensed under the Long Term Insurance Act.

Portfolio Manager	
Policy Number	
Commencement Date	

1 POLICY HOLDER INFORMATION OR MAIN MEMBER

Title		Initials	
Name		Surname	
Email		Gender	
Postal Address		Physical Address	
Cell Phone Number		Landline Number	
Marital Status		ID Number	
Welcome Pack Delivery Address			

	YES	NO
Currently receiving treatment or have received treatment for any medical/dental condition?	○	○
Concerned about/aware of any condition which may require medical/dental attention?	○	○
Currently using any medication?	○	○
Pregnant?	○	○
Undergone any major operation(s) in the last 5 years?	○	○

Please provide details about the condition, treatment, procedures or medication if you answered Yes to any of the above questions.

Any pre-existing conditions not disclosed on application, may result in the policy being cancelled with immediate effect, with no refunds. This pertains to main member as well as to dependants.

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2 EMPLOYER INFORMATION (for contributions deducted via payroll)

Name of Employer

Employee Number

Employer Code

Employment Date

Branch Code/Name

Date

We confirm that the applicant is employed by us and commenced employment on the above date.

Name of Salary Administrator

Designation

Signature

3 DEPENDANTS

"**Dependant**" means a spouse, partner and children, described as follows:
"**Dependant Child(ren)**" means:

- a child of a Principal Member under the age of 21 (twenty one) years, including a stepchild, an illegitimate child or legally adopted child, including a child adopted in terms of a customary adoption under a tradition practiced by the people of Southern Africa provided that the child's natural parents are both deceased, or an adoption under the tenets of any religion practiced by the people of Southern Africa provided that the child's natural parents are both deceased;
- a child of a Principal Member being permanently mentally or physically disabled and totally dependent upon the Principal Member;
- a child of a Principal Member under the age of 26 (twenty-six) years who is a full- time student at any learning institution registered in terms of legislation in the Republic of South Africa, and who is unmarried.

3.1 DEPENDANT DETAILS

Title

Initials

Name

Surname

Relationship

Gender

ID / Passport Number

	YES	NO
Currently receiving treatment or have received treatment for any medical/dental condition?	☐	☐
Concerned about/aware of any condition which may require medical/dental attention?	☐	☐
Currently using any medication?	☐	☐
Pregnant?	☐	☐
Undergone any major operation(s) in the last 5 years?	☐	☐

Please provide details about the condition, treatment, procedures or medication if you answered Yes to any of the above questions.

3.2 DEPENDANT DETAILS

Title		Initials	
Name		Surname	
Relationship		Gender	
ID / Passport Number			

	YES	NO
Currently receiving treatment or have received treatment for any medical/dental condition?	○	○
Concerned about/aware of any condition which may require medical/dental attention?	○	○
Currently using any medication?	○	○
Pregnant?	○	○
Undergone any major operation(s) in the last 5 years?	○	○

Please provide details about the condition, treatment, procedures or medication if you answered Yes to any of the above questions.

3.3 DEPENDANT DETAILS

Title		Initials	
Name		Surname	
Relationship		Gender	
ID / Passport Number			

	YES	NO
Currently receiving treatment or have received treatment for any medical/dental condition?	○	○
Concerned about/aware of any condition which may require medical/dental attention?	○	○
Currently using any medication?	○	○
Pregnant?	○	○
Undergone any major operation(s) in the last 5 years?	○	○

Please provide details about the condition, treatment, procedures or medication if you answered Yes to any of the above questions.

3.4 DEPENDANT DETAILS

Title		Initials	
Name		Surname	
Relationship		Gender	
ID / Passport Number			

	YES	NO
Currently receiving treatment or have received treatment for any medical/dental condition?	○	○
Concerned about/aware of any condition which may require medical/dental attention?	○	○
Currently using any medication?	○	○
Pregnant?	○	○
Undergone any major operation(s) in the last 5 years?	○	○

Please provide details about the condition, treatment, procedures or medication if you answered Yes to any of the above questions.

3.5 DEPENDANT DETAILS

Title		Initials	
Name		Surname	
Relationship		Gender	
ID / Passport Number			

	YES	NO
Currently receiving treatment or have received treatment for any medical/dental condition?	○	○
Concerned about/aware of any condition which may require medical/dental attention?	○	○
Currently using any medication?	○	○
Pregnant?	○	○
Undergone any major operation(s) in the last 5 years?	○	○

Please provide details about the condition, treatment, procedures or medication if you answered Yes to any of the above questions.

4 EXISTING MEDICAL SCHEME / HOSPITAL PLAN

	YES	NO
If you do have an existing medical aid or insurance, will you be cancelling it and replacing it with this policy?	◯	◯

Please provide the details of the medical aid or medical insurance if you are retaining it:

5 POLICY, OPTIONS & FEES

	OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5
Single Member	R375 ◯	R520 ◯	R1063 ◯	R411 ◯	R478 ◯
S + 1	R551 ◯	R723 ◯	R1430 ◯	R484 ◯	R564 ◯
S + 2	R731 ◯	R930 ◯	R1801 ◯	R557 ◯	R650 ◯
S + 3	R911 ◯	R1137 ◯	R2172 ◯	R630 ◯	R736 ◯
S + 4	R1091 ◯	R1344 ◯	R2543 ◯	R703 ◯	R822 ◯
Couple	R655 ◯	R894 ◯	R1809 ◯	R665 ◯	R776 ◯
Couple + 1	R831 ◯	R1097 ◯	R2176 ◯	R738 ◯	R862 ◯
Couple + 2	R1007 ◯	R1300 ◯	R2543 ◯	R811 ◯	R948 ◯
Couple + 3	R1183 ◯	R1503 ◯	R2910 ◯	R884 ◯	R1034 ◯
Couple + 4	R1359 ◯	R1706 ◯	R3277 ◯	R957 ◯	R1120 ◯

Total Policy Premium: R

ACKNOWLEDGEMENT

- I warrant that I have been provided with all the intermediary, insurance and benefit details.
- I warrant that all details and facts herein are accurate and properly disclosed, even if completed by the intermediary or representative on my behalf.
- I understand that the benefits offered are risk benefits only and that there are no surrender values. Failure to pay premiums will result in benefits lapsing.
- I acknowledge that this is a Health Insurance Policy and that the benefits are not similar or a replacement to that of a Medical Aid.
- I am satisfied that the plan chosen by me, best suits my needs.
- I understand that applications are subject to approval and that Essential Med reserves the right to decline an application.

Initial & Surname

Voice Recording Reference

Date **Signature**