

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	<input style="width: 95%;" type="text"/>
Policy Number	<input style="width: 95%;" type="text"/>
Commencement Date	<input style="width: 95%;" type="text"/>

1 POLICY HOLDER INFORMATION OR MAIN MEMBER

Title	<input style="width: 95%;" type="text"/>	Initials	<input style="width: 95%;" type="text"/>
Name	<input style="width: 95%;" type="text"/>	Surname	<input style="width: 95%;" type="text"/>
Email	<input style="width: 95%;" type="text"/>	Gender	<input style="width: 95%;" type="text"/>
Postal Address	<input style="width: 95%;" type="text"/>	Physical Address	<input style="width: 95%;" type="text"/>
	<input style="width: 95%;" type="text"/>		<input style="width: 95%;" type="text"/>
	<input style="width: 95%;" type="text"/>		<input style="width: 95%;" type="text"/>
Cell Phone Number	<input style="width: 95%;" type="text"/>	Landline Number	<input style="width: 95%;" type="text"/>
Marital Status	<input style="width: 95%;" type="text"/>	ID Number	<input style="width: 95%;" type="text"/>
Welcome Pack Delivery Address	<input style="width: 95%;" type="text"/>		

YES NO

Currently receiving treatment or have received treatment for any medical/dental condition?	<input type="radio"/>	<input type="radio"/>	
Concerned about/aware of any condition which may require medical/dental attention?	<input type="radio"/>	<input type="radio"/>	
Currently using any medication?	<input type="radio"/>	<input type="radio"/>	
Pregnant?	<input type="radio"/>	<input type="radio"/>	
Undergone any major operation(s) in the last 5 years?	<input type="radio"/>	<input type="radio"/>	

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.

2 EMPLOYER INFORMATION (for contributions deducted via payroll)

Name of Employer	<input type="text"/>	<p>We confirm that the applicant is employed by us and commenced employment on the above date.</p>	
Employee Number	<input type="text"/>		
Employer Code	<input type="text"/>		
Employment Date	<input type="text"/>		
Branch Code/Name	<input type="text"/>	Name of Salary Administrator	<input type="text"/>
Date	<input type="text"/>	Designation	<input type="text"/>
		Signature	<input type="text"/>

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	<input type="text"/>	Initials	<input type="text"/>
Name	<input type="text"/>	Surname	<input type="text"/>
Relationship	<input type="text"/>	Gender	<input type="text"/>
ID / Passport Number	<input type="text"/>		

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

3.2 DEPENDANT DETAILS

Title	<input type="text"/>	Initials	<input type="text"/>
Name	<input type="text"/>	Surname	<input type="text"/>
Relationship	<input type="text"/>	Gender	<input type="text"/>
ID / Passport Number	<input type="text"/>		

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

3.3 DEPENDANT DETAILS

Title	<input type="text"/>	Initials	<input type="text"/>
Name	<input type="text"/>	Surname	<input type="text"/>
Relationship	<input type="text"/>	Gender	<input type="text"/>
ID / Passport Number	<input type="text"/>		

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

3.4 DEPENDANT DETAILS

Title	<input type="text"/>	Initials	<input type="text"/>
Name	<input type="text"/>	Surname	<input type="text"/>
Relationship	<input type="text"/>	Gender	<input type="text"/>
ID / Passport Number	<input type="text"/>		

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

3.5 DEPENDANT DETAILS

Title	<input type="text"/>	Initials	<input type="text"/>
Name	<input type="text"/>	Surname	<input type="text"/>
Relationship	<input type="text"/>	Gender	<input type="text"/>
ID / Passport Number	<input type="text"/>		

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

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?

YES NO

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 <input type="radio"/>	R520 <input type="radio"/>	R1039 <input type="radio"/>	R411 <input type="radio"/>	R478 <input type="radio"/>
S + 1	R551 <input type="radio"/>	R723 <input type="radio"/>	R1406 <input type="radio"/>	R484 <input type="radio"/>	R564 <input type="radio"/>
S + 2	R727 <input type="radio"/>	R926 <input type="radio"/>	R1773 <input type="radio"/>	R557 <input type="radio"/>	R650 <input type="radio"/>
S + 3	R903 <input type="radio"/>	R1129 <input type="radio"/>	R2140 <input type="radio"/>	R630 <input type="radio"/>	R736 <input type="radio"/>
S + 4	R1079 <input type="radio"/>	R1332 <input type="radio"/>	R2507 <input type="radio"/>	R703 <input type="radio"/>	R822 <input type="radio"/>
Couple	R655 <input type="radio"/>	R894 <input type="radio"/>	R1785 <input type="radio"/>	R665 <input type="radio"/>	R776 <input type="radio"/>
Couple + 1	R831 <input type="radio"/>	R1097 <input type="radio"/>	R2152 <input type="radio"/>	R738 <input type="radio"/>	R862 <input type="radio"/>
Couple + 2	R1007 <input type="radio"/>	R1300 <input type="radio"/>	R2519 <input type="radio"/>	R811 <input type="radio"/>	R948 <input type="radio"/>
Couple + 3	R1183 <input type="radio"/>	R1503 <input type="radio"/>	R2886 <input type="radio"/>	R884 <input type="radio"/>	R1034 <input type="radio"/>
Couple + 4	R1359 <input type="radio"/>	R1706 <input type="radio"/>	R3253 <input type="radio"/>	R957 <input type="radio"/>	R1120 <input type="radio"/>

Total Policy Premium:

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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
