

Sanlam Gap Cover Employee Application form

Applications received after the 15th of the current month will only activate the 1st of the following month

Important information

- Do not sign unless you understand the benefits, terms and conditions of the insurance product.
- Your signature confirms that you accept the terms and conditions as set out in the insurance policy.
- This form must be signed and returned to your servicing Financial planner who will submit it to Kaelo on your behalf. Should you have any questions regarding this insurance product, we invite you to contact your servicing Financial planner to explain the product features, benefits and associated risks.
- Insurance products are underwritten by Centriq Insurance Company Limited ("Centriq") a licensed non-life insurer and authorised Financial Services Provider (FSP No 3417). Claims are administered and settled by Kaelo Risk (Pty) Ltd who has been mandated as the binder holder and who is an authorised Financial services provider (FSP No 36931).

A. Details of Member & Dependants

(Note: You have to be a member of a medical aid. Cover for dependants* as per your medical aid. Cover for children until they reach the age of 27.) * Financially dependant parents excluded.

First Name/s	Surname	Birthdate
Member: _____	_____	_____
ID Number (compulsory for main member):	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Spouse: _____	_____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Child 1: _____	_____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Child 2: _____	_____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Child 3: _____	_____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

(If the space is insufficient please attach a signed addendum to this application form)

Address (Physical): _____

Contact number: _____ E-mail address: _____

B. Employer

Name: **Public Servants Association** Branch: _____

Employment Date: _____

C. Cover Detail

Medical Scheme: _____ Option: _____

Start date of medical scheme membership:

Membership number: _____

Please indicate your desired month to join Sanlam Gap Cover (month/year):

D. Details of Intermediary

Name of Company: **Optinvest Health Services** Intermediary Code: **S486283**

Name of Advising Intermediary: _____

Telephone (w): _____ Cell: _____

E-mail: **Corpnbsupport@optinvest.co.za**



E. Health Questionnaire

Please answer each question below (tick the relevant box):

- Do you or any of your eligible dependants have any medical conditions, or are you or they receiving any form of ongoing treatment or medication?
(e.g. heart or vascular disease / back, neck or joint problems / digestive system problems / sinusitis / cancer (incl. in remission) / kidney disorders / gynaecological problems / ear, nose or throat problems, etc) Yes No
- Have you or any of your eligible dependants been hospitalised within the last 24 months? Yes No
- Have you or any of your eligible dependants consulted with any doctors within the last 12 months? Yes No
- Do you or any of your eligible dependants have any existing medical conditions? Yes No
- Are you or any of your eligible dependants currently pregnant or planning to become pregnant? Yes No

If you have answered yes to any of the questions above, please provide full details in the space provided below:

(if the space is insufficient please attach a signed addendum to this application form):

Dependant Name _____ **Question Number** _____

Details of Condition / Treatment / Medication: _____

Provide details of Future Treatment incl. date/s: _____ Last Date of Treatment:

Dependant Name _____ **Question Number** _____

Details of Condition/Treatment /Medication: _____

Provide details of Future Treatment incl. date/s: _____ Last Date of Treatment:

Dependant Name _____ **Question Number** _____

Details of Condition/Treatment/Medication: _____

Provide details of Future Treatment incl. date/s: _____ Last Date of Treatment:

Dependant Name _____ **Question Number** _____

Details of Condition/Treatment/Medication: _____

Provide details of Future Treatment incl. date/s: _____ Last Date of Treatment:

F. Application Status

Please indicate the status of your application by ticking one of the relevant boxes below:

- I do not currently have gap cover but wish to join via my employer who has arranged this cover Yes No
- I do not currently have gap cover but wish to join in my private capacity Yes No
- I am currently a Sanlam Gap Cover member but I am leaving my employer and wish to continue cover in my private capacity Yes No
- I currently have gap cover with another provider but I wish to transfer my cover to Sanlam Gap Cover Yes No

Notes:

- Waiting periods may apply to your cover.
- If you answered Yes to Question 4 of this section(F.), please provide proof of cover with the other provider i.e. current Gap Cover Membership Certificate.
- All applications remain subject to our standard underwriting terms and conditions which is available in the Sanlam Gap Cover insurance policy agreement.



G. Debit Order Details

(If your employer is deducting premiums from payroll, please complete section H below)

Use this account for all contribution collections

Bank Name: _____

Branch Code: _____ Account Number: _____

Use this account for refunds only

Bank Name: _____ Branch Name: _____

Branch Code: _____ Account Type: _____

Account Number: _____ Account Name: _____

If only one bank account is provided, it will be used for both contribution collections and refunds.

Debit Order date: Please specify the date you would like for your debit order to take place each month.

1st 7th 15th 25th last working day

H. Employer deduction from payroll

Premium to be collected monthly in arrears via a company payroll deduction:

R N/A **Not applicable - R200 via debit order**

