Sanlam UASA UNDERWRITTEN BY CENTRIQ INSURANCE

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):			
Spouse:			DD MM YYYY
Child 1:			DD MM YYYY
Child 2:			DD MM YYYY
Child 3:			DD MM YYYY

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

Address (Physical): _____

Contact number: _____ E-mail address: _____

B. Employer

Name: UASA Branch: _____

Employment Date: _____

C. Cover Detail

Medical Scheme: _____ Option: _____

Start date of medical scheme membership: DD MM YYYY

Membership number: _____

Please indicate your desired month to join Sanlam Gap Cover (month/year): 01 MM YYYY

D. Details of Intermediary

Name of Company: Optivest Health Services Intermediary Code: S486283

Name of Advising Intermediary: _____

Telephone (w): _____ Cell: _____

E-mail: corpnbsupport@optivest.co.za

E. Health Questionnaire

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

1. 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

2. Have you or any of your eligible dependants been hospitalised within the last 24 months? Yes No

3. Have you or any of your eligible dependants consulted with any doctors within the last 12 months? Yes No

4. Do you or any of your eligible dependants have any existing medical conditions? Yes No

5. 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: D D M M Y Y Y Y

_____

Dependant Name _____ Question Number _____

Details of Condition/Treatment /Medication: _____

Provide details of Future Treatment incl. date/s: Last Date of Treatment: D D M M Y Y Y Y

_____

Dependant Name _____ Question Number _____

Details of Condition/Treatment/Medication: _____

Provide details of Future Treatment incl. date/s: Last Date of Treatment: D D M M Y Y Y Y

_____

Dependant Name _____ Question Number _____

Details of Condition/Treatment/Medication: _____

Provide details of Future Treatment incl. date/s: Last Date of Treatment: D D M M Y Y Y Y

_____

F. Application Status

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

1. I do not currently have gap cover but wish to join via my employer who has arranged this cover Yes No
2. I do not currently have gap cover but wish to join in my private capacity Yes No
3. 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
4. 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 - R198 via debit order**

I. Declaration by Principal Member

I, (full name) _____ with ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐
hereby declare that this application form, whether in my handwriting or not, is accurate and complete and forms the basis of the contract of insurance between the underwriter and myself. I hereby apply for Sanlam Gap Cover (underwritten by Centriq) and agree to abide by its policy rules and/or those of its underwriter and any amendments thereto which may be made from time to time. I hereby authorise Centriq to draw against the above bank account all amounts due to Centriq in terms of this insurance cover. I hereby authorise that this application form can be provided by my servicing Financial planner to the following email addresses: sanlamapps@kaelo.co.za

Accurate information
I confirm that all the information provided herein is complete and true and that I have not concealed any relevant of pertinent information that may affect the evaluation of risk considered under this policy of cover.

I understand that the provision of any false, misleading or missing information could result in my application being rejected or my membership being cancelled or claims being rejected. Should this occur, I agree to refund all benefit payments that I have received in relation to this policy of insurance.

In the event that my employer is selecting the cover under this policy, I hereby provide authority for my employer to make such cover nomination on my behalf and furthermore indemnify Sanlam and the Underwriter against liability for any loss that may result from an incorrect nomination of such cover by the employer.

Premium payments
Premiums for Sanlam Gap Cover are payable monthly and deducted by Centriq. The payment reference will reflect as: Multid for SNGAP. Premiums that are in arrears will result in my membership being suspended or possibly terminated.

Where my employer deducts the premium from my salary I hereby provide authority for my employer to deduct such premium and pay this across to Centriq. I accept that any notice given to my employer is deemed to have been given to me.

Benefit payments
In the event that any policy benefit becomes payable subsequent to or as a result of my death, I hereby provide an irrevocable authority for such benefits to be paid directly to my surviving spouse or failing such circumstance to the nominated guardians or trustees responsible for the future care of my minor children or failing either of the preceding events to my estate.

Disclosure documents
I have read and understood the Sanlam Gap Cover Disclosure Notice which I received together with this Application Form.

In the case of transferring my cover to Sanlam Gap Cover (as chosen in F.4 of this form), I understand the difference between my current gap cover and Sanlam Gap Cover as explained to me by my intermediary.

Policy Exclusions and Terms and Conditions
Please refer to your final policy document for the full list of exclusions and terms and conditions.

Full Name: _____ Signature: _____

Date: D D M M Y Y Y Y

POPIA Consent

☐ I consent to Centriq, and its operators, processing, and further processing, my personal information in accordance with the Protection of Personal Information Act, for the purposes of concluding, and performing in terms of, this insurance contract.

For further information please read our Privacy Notice, which can be found on www.centriq.co.za

Once signed, this application form should be returned to your servicing Financial planner.

T 0861 111 167
E sanlaminfo@kaelo.co.za