Agility
Gap & CoPay

54 Maxwell Drive, Woodmead
P O Box 1555 Fontainebleau, 2032
Tel: 011 801 2168
Email: gapco@agilityinsurance.co.za

AGILITY GAP & COPAY APPLICATION

Requested start date: D D M M Y Y Y Y

Please attach copies of the following:

- Copy of principal insured's ID/Passport
- Copy of dependant's birth certificate
- Copy of spouse's ID

Cover will commence after the 1st successful debit order. Should this form be received after the 21st of the month, we reserve the right to change the inception date to the 1st of the following month. The activation of application forms are subject to the underwriting process of the insurer and may result in the activation of membership after the indicated/requested activation date. This application form must be received at the insurer within 1 month following the date on which it was signed. Failure to do so will result in this application being null and void. Incomplete application forms will not be accepted.

A. PRINCIPAL MEMBER PARTICULARS

The information supplied in this section is applicable to all product classes applied for hereunder. On acceptance of the application for any accepted products, the information provided in this section will form part of the contract.

Surname
Title
First name(s) (in full)
Initials
ID / Passport no.
Date of birth D D M M Y Y Y Y
Gender M F
Name of medical scheme
Medical scheme no.
Employer name
Medical scheme option

B. DETAILS OF DEPENDANTS

The information supplied in this section is applicable to all product classes applied for hereunder. On acceptance of the application for any accepted products, the information provided in this section will form part of the contract. Dependants are defined as children or other members of immediate family in respect of whom the member is liable for care and support.

	Spouse / Partner / Dependant 1	Dependant 2
Dependant type		
Surname		
First name(s) (in full)		
Initials	Title Gender M F	Title Gender M F
ID / Passport no.		
Date of birth	D D M M Y Y Y Y Age	D D M M Y Y Y Y Age
Relationship to member		
	Disabled* Full-time student*	Disabled* Full-time student*

	Dependant 3	Dependant 4
Dependant type		
Surname		
First name(s) (in full)		
Initials	Title Gender M F	Title Gender M F
ID / Passport no.		
Date of birth	D D M M Y Y Y Y Age	D D M M Y Y Y Y Age
Relationship to member		
	Disabled* Full-time student*	Disabled* Full-time student*

*** Where relevant, please attach:**

- Proof of full-time student status from a registered institution for the applicable academic year.
- Handicapped children: Physician report to confirm disability.
- Documentary proof for immediate family who are financially dependent on the principal member.
- This policy will cover a child dependent up to the age of 21, however cover can be extended to the age of 25 for full time students (Documented proof is required).
  In the case of a dependent parent this cover is limited to biological father or mother.

C. CONTACT DETAILS OF PRINCIPAL MEMBER

The information supplied in this section is applicable to all product classes applied for hereunder. On acceptance of the application for any accepted products, the information provided in this section will form part of the contract.

Physical address

Code

Postal address

Code

E-mail address

Tel (H)

Tel (W)

Mobile

Please select your preferred method of communication to receive important information and related product content: SMS E-mail

D. PRODUCT SELECTION

The information supplied in this section is applicable to all product classes applied for hereunder. On acceptance of the application for any selected products, the information provided in this section will form part of the contract.

Gap 200 Gap 500

Combined 200 Combined 400 Combined 500 Ultra

Corporate 200 Corporate 500 Elective Advisory Fee

This advisory fee is discretionary and is payable to the financial advisor, in addition to the legislative short-term insurance commission

Requested date of commencement of membership D D M M Y Y Y Y NOTE: SUBJECT TO UNDERWRITING

E. MEDICAL QUESTIONS

The medical information contained in this section will be used to assess risk and will form part of any and all insurance contracts resulting from this application and is hereby specifically incorporated into any and all such contracts.

- All questions must be answered with a NO or YES and FULL details to be provided in addendum provided. Incomplete, inaccurate or withheld information may result in the termination of your membership and claims being repudiated.

Has ANY person indicated on the application form:

1. Taken, or expect to take, chronic medication on an ongoing basis? NO YES
2. Ever had, or expects (in the next 12 months) to have, any procedure or be admitted to hospital? NO YES
3. Ever suffered from any physical or mental impairment or other disability? NO YES
4. Ever abused illegal substances or alcohol? NO YES
5. Ever suffered from any other specific or related condition not mentioned above for which advice, diagnosis, care or treatment was recommended or received, or presented any symptoms which could potentially or reasonably be expected to result in a claim in the next 12 months? NO YES

Please note that any misrepresentation or non-disclosure of medical material or factual information will render all benefits granted by the Insurer null and void. In addition, any payment made due to such actions will be recovered from the member by the Insurer.

Please note that this questionnaire does not constitute an application for chronic medication or any other benefit.

QUESTION	APPLICANT/ DEPENDANT	DATE	DISORDER	TREATMENT	CONSULTING DOCTOR	CURRENT CONDITION

SIGNATURE

Signature of applicant

Name of applicant

D D M M Y Y Y Y

Signature date

GENRIC Insurance

PROCEDURES AND HOSPITAL ADMISSIONS

ADDENDUM 2

Please supply details of all procedure(s) and all hospital admissions that you, or any of your dependants, have undergone in the past, and/or details of all planned procedure(s) and all hospital admissions that you, or any of your dependants, expect to undergo in the future.

APPLICANT/DEPENDANT	PROCEDURE/HOSPITAL ADMISSION	DATE	REASON	DOCTOR	CURRENT CONDITION

CHRONIC CONDITIONS

ADDENDUM 3

1. Please supply details of any chronic medication (prescribed medicines used continuously for more than 3 months) currently prescribed for you or any of your dependants.
2. Should you or any of your dependants expect chronic medication to be prescribed in the next 12 months, please supply details below.

APPLICANT/DEPENDANT	PRESCRIBED MEDICATION	MEDICAL CONDITION	DATE STARTED/TO BE STARTED

F. HEIGHT AND WEIGHT

Principal member	Initials		Height	cm	Weight		kg
Spouse/Partner/ Dependant 1	Initials		Height	cm	Weight		kg
Dependant 2	Initials		Height	cm	Weight		kg
Dependant 3	Initials		Height	cm	Weight		kg
Dependant 4	Initials		Height	cm	Weight		kg

Please note that any misrepresentation or non-disclosure of medical material or factual information will render all benefits granted by the Insurer null and void. In addition, any payment made due to such actions will be recovered from the insured by the Insurer.

G. BANKING DETAILS AND PAYMENT AUTHORISATION

The information supplied in this section is applicable to all product classes applied for hereunder. On acceptance of the application for any selected products, the information provided in this section will form part of the contract.

Please complete forward this form to: gapco@agilityinsurance.co.za

INSURED DETAILS

Surname | Title

First name(s) (in full) | Initials

ID / Passport no.

Physical Address

Code

I hereby confirm acceptance of the below mentioned insurance policy, and authorise **Agility** Insurance Administrators (**Agility** Gap & CoPay Cover) to issue and deliver payment instructions to their Banker, to draw on my account at the stated institution in any manner agreed on between **Agility** Insurance Administrators and such institution.

This will be for the amount of the premium payable on condition that the sum of such payment instructions will never exceed my obligations as agreed to in the Agreement and commencing on ________________, and request the aforesaid institution to debit my account with all debits drawn against it by **Agility** Insurance Administrators.

All such withdrawals from my bank account by **Agility** Insurance Administrators shall be treated as though they had been signed by me personally.

I understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African Banks. I also understand the details of each withdrawal will be printed on my bank statement bearing a specific reference number which will reflect **AgilityGap** and the policy number as confirmed in the policy documents.

I may cancel this authority by giving **Agility** Insurance Administrators 30 calendar days' notice in writing; however, I understand that I shall not be entitled to any refund of amounts, which **Agility** Insurance Administrators has withdrawn while this authority was in force, if such amounts were legally owing to **Agility** Insurance Administrators.

POLICY DETAILS

Type of Policy

Inception Date D D M M Y Y Y Y

Total monthly premium including VAT R

Premiums are payable on a monthly basis by debit order. If two or more debit orders are returned, **Agility** Insurance Administrators will not be held liable should the policy be automatically terminated, or should claims incurred during this period of suspension not be paid. I acknowledge that any fees and charges levied by the bank on account of the debit order or any debit order payments which may be rejected for any reason whatsoever will be for my account.

H. ACCOUNT DETAILS

Name of bank ________ Name of Branch ________

Account type ☐ Current ☐ Transmission ☐ Savings Branch code ________

Name of account holder ________

Account no. ________

Month policy to start ________

Debit order date 1st ☐ 7th ☐ 15th ☐ 25th ☐

I certify that the above bank details are correct. If these banking details have not been provided accurately, or if the details change at any time in the future and I fail to notify such changes, or if payments are not made in accordance with the Debit Order Instruction, the responsibility of payment will rest with me.

The individual payment instructions so authorised to be issued and delivered as follows:

Monthly ☐ Annually ☐

*If the facility is in the name of a Company, Close Corporation, Trust or Association the full names of such entity and the capacity of the signatory must be reflected.

In the event that the payment day falls on a Sunday, or recognised South African public holiday, the payment day will automatically be the next ordinary business day.

Payment instructions due in December may be debited against my account on _______________.

I acknowledge that all payment instructions issued shall be treated by my above-mentioned Bank as if the instructions have been issued by me personally.

I acknowledge that this Authority may be ceded or assigned to a third party if the Agreement is also ceded or assigned to that third party, but in the absence of such assignment of the Agreement, this Authority and Mandate cannot be assigned to any third party.

I. ACCEPTANCE

Surname ________

First name(s) (in full) ________

Capacity ________

Contact number ________

SIGNATURE

Signature of bank account holder

Name of bank account holder

D D M M Y Y Y Y

Signature date

J. INTERMEDIARY DETAILS

Name of brokerage ______ Date D D M M Y Y Y Y

Brokerage tel ______

Brokerage e-mail address ______

Name and surname of broker ______

Broker tel ______ Broker cell ______

Broker e-mail address ______

Name and surname of Broker Consultant ______

Broker Consultant tel ______ Broker Consultant cell ______

Broker Consultant e-mail address ______

AIA broker code ______

Sections only to be completed if principal member has selected to purchase the product:

K. AGILITY GAP / COPAY OR COMBINED DECLARATION BY PRINCIPAL MEMBER

I, the undersigned, hereby declare that:

1. To the best of my knowledge, the information provided in connection with this application, whether it be in my own handwriting or not, is true and that I have not withheld any material facts which are known to me. A material fact is defined as a fact that is likely to impact the assessment of this application by **Agility** Insurance Administrators (Pty) Ltd.
2. I understand that any relevant material fact omitted from this application form may lead to **Agility** Insurance Administrators (Pty) Ltd not meeting claims, should the omitted fact have been of such importance that the risk may not have been accepted in the first instance, in terms of the policy. This may lead to cancellation of this policy or rejection of claims without refund of premiums where applicable.
3. I understand that this is an accident and health policy with stated benefits in terms of the Short Term Insurance Act no 53 of 1998, and not a medical scheme product.
4. I acknowledge that the sharing of claims information and underwriting (including credit information) by the insurers is essential to enable the insurance industry to underwrite policies and assess risk fairly and reduce the incidence of fraudulent claims, in the public interest and with a view to limiting premiums. I hereby waive any rights to privacy in any claims information supplied by me or on my behalf in respect of any insurance claim made or lodged by me and I consent to such information being disclosed to any other insurance company or its agent. I also waive any rights of privacy and consent to the disclosure of any information relevant to the claims concerning me or any person I represent. I further acknowledge that the information provided by me may be verified against other legitimate sources or databases.
5. I specifically consent to **Agility** Insurance Administrators (Pty) Ltd contacting my current medical scheme and/or medical practitioner to verify any medical details as provided in my application form. I further consent to information being disclosed to **Agility** Insurance Administrators (Pty) Ltd for purposes of verifying the disclosure as provided on my application form.
6. A family means two adults and three children under the age of 18 years. Concessions can be made for children who are financially dependent on their parents (21), or full-time students (25). A letter from me should be sent to **Agility** Insurance Administrators (Pty) Ltd to prove that the child is financially dependent, and a letter from a registered and recognised tertiary education institution to prove full-time student status.
7. Adult dependants, such as the main member's mother or father, will need to be placed on a separate policy. If not financially dependent on Policy Holder. Note only one financially dependent, biological parent can be added.
8. I will ensure that **full** details are provided for any medical condition questions answered YES.
9. Application forms will be underwritten and conditions may be excluded for longer than 12 months, or permanently. A Terms of Acceptance letter will be sent to me to confirm this.
10. The onus lies on me to make sure that premiums are paid on a monthly basis, in advance.
11. One calender month notice period to be served for all cancellation requests.

I hereby confirm that cognisance has been taken of the contents of the abovementioned conditions, which I understand and that the information is true and correct.

Signed at ______________ on this ______________day of __________ / __________

SIGNATURE	SIGNATURE
Signature of applicant	Signature of spouse if married in community of property
Name of applicant	Name of spouse if married in community of property
______________	______________