Universal
Cover | Gap

Universal Gap/Gap Plus Combination Co-Payment Cover Plan
Application Form - 2014

Health And Accident Group | FSP376 | Administered by Health & Accident Underwriting Managers (Pty) Ltd
22 Stiglingh Rd, Rivonia | PO Box 324, Rivonia 2128 | Tel. (011) 234 7333 | Fax (011) 234 7351 | Email: policyadmin@healthacc.co.za | www.healthacc.co.za

Broker name :		Inception date required:	
Medical aid scheme & option:		Medical aid number:	

PLEASE SELECT THE APPLICABLE OPTION:

Universal Gap Cover Plan			**Universal Gap Plus Cover Plan**		
Universal Gap Cover Plan Premium	**R95.00**		**Universal Gap Plus Cover Plan Premium**	**R127.00**	
Crisis Assistance Facility	R12.00		Crisis Assistance Facility	R12.00	
Universal Marketing Fee	R10.00		Universal Marketing Fee	R10.00	
Total Monthly Contribution	**R117.00**		**Total Monthly Contribution**	**R149.00**	
Additional Overage Child Dependant premium - R60 per dependant over 23 - 30 years	**R**		**Additional Overage Child Dependant premium - R60 per dependant over 23 - 30 years**	**R**	

PERSONAL DETAILS

Surname:		Title:	Male ☐ Female ☐
First Names:			
Postal Address:			
			Postal Code:
Residential Address:			
			Postal Code:
Telephone Number (home):		Telephone Number (work):	
Cellular Number:		Fax Number:	
Employer Name:		Email Address:	
Occupation:		Married ☐ Divorced ☐ Single ☐ Widowed ☐	
ID Number:		Passport Number:	
Date of Birth:		Citizenship I Nationality:	
		Signature:	

FAMILY MEMBERS TO BE COVERED

First Names	ID No. or Passport No. & Date of Birth	Gender M/F	Spouse or Child	State if living with you	
			Spouse	Yes	No
			Child	Yes	No
			Child	Yes	No
			Child	Yes	No
			Child	Yes	No
			Child	Yes	No

PLEASE GIVE THE NAME & ADDRESS OF YOUR GENERAL PRACTITIONER AS WELL AS ANY SPECIALIST YOU MAY HAVE RECENTLY CONSULTED

Doctor's Name:	Specialist's Name:
Address:	Address:
How long has your G.P. been in attendance?	When did you last consult your Specialist?
Telephone Number:	Telephone Number:

h&a health and accident group

Administered by Health & Accident Underwriting Managers (PTY) Ltd 1994/002308/07
An Authorised Financial Services Provider - FSP 376
Underwritten by Short Term Insurer Compass Insurance Co Ltd FSP 12148

COMPASS

Universal Healthcare

SPECIFIC HEALTH QUESTIONS

State whether you or your dependants have ever been treated or are currently receiving treatment for any of the following , but not limited to, illnesses:

1.	Blood disorders, e.g. anaemia, bleeding disorders, haemophilia, leukaemia	Yes	No
2.	Cancer growths or tumours whether benign or malignant	Yes	No
3.	Cardiovascular disorders, e.g. heart conditions, chest pain, coronary artery disease, high blood pressure, varicose veins, poor circulation	Yes	No
4.	Endocrine disorders, e.g. high cholesterol, diabetes, thyroid abnormalities	Yes	No
5.	Eye related disorders, e.g. glaucoma, blindness, eye surgery, retinitis pigmentosa, cataracts	Yes	No
6.	Gastro-intestinal disorders, e.g. recurrent indigestion, ulcers, bowel disorders, gallbladder disorders, liver disorders	Yes	No
7.	Gynaecological and obstetrical disorders, e.g. ectopic pregnancy, caesarean section, fibroids, endometriosis, menstrual irregularities, abnormal pap smear	Yes	No
8.	Musculo-skeletal disorders, e.g. arthritis, back problems, gout, osteoporosis, joints, e.g. knee, shoulder, etc.	Yes	No
9.	Neurological disorders, e.g. epilepsy, muscular weakness, stroke, brain or spinal cord disorders, chronic fatigue	Yes	No
10.	Psychological disorders, e.g. anxiety, depression, stress, panic attacks, alcohol or drug dependency, attention deficit	Yes	No
11.	Renal (kidney) disorders, e.g. blood in the urine, kidney stones, recurrent infections, kidney failure	Yes	No
12.	Respiratory disorders, e.g. asthma, allergic rhinitis, chronic bronchitis, emphysema, tuberculosis	Yes	No
13.	Skin disorders, e.g. eczema, psoriasis, melanoma, skin cancer	Yes	No
14.	State whether you or any of your dependants have received medical advice or treatment for any infectious diseases e.g. gonorrhoea, genital herpes, syphilis, Tuberculosis, hepatitis or tested positive for HIV(AIDS)	Yes	No
15.	Are you or any of your dependants currently pregnant? If so, please specify the expected date of delivery	Yes	No
16.	Do you or any of your dependants expect to receive any treatment, or surgery in the next 12 months and do you or your dependants expect to be, or are currently hospitalised?	Yes	No
17.	Do you or any of your dependants currently receive or expect to receive treatment with any type of medication for longer than 3 months?	Yes	No

IF 'YES' ANSWERED TO ANY OF THE QUESTIONS ABOVE, PLEASE SUPPLY FULL DETAILS BELOW.

Question Number	Applicant	Full details (including details of disorder, date diagnosed, nature and duration of treatment and the consulting doctor's contact details)

If the space provided is insufficient, please attach additional information to this application.

N.B. Any misinterpretation or non-disclosure of material medical or factual information will render all benefits granted by Health & Accident Underwriting Managers (Pty) Ltd null and void. In addition, any payment made due to such actions will be required to be repaid by the insured Person to Health & Accident Underwriting Managers (Pty) Ltd

PAYMENT METHOD

Please debit my bank account: Cheque ☐ Savings ☐ Transmission ☐

Name of Account Holder:				Name Of Bank:	
Branch:		Branch code:		Account no:	

I authorise Health & Accident Underwriting Managers (Pty) Ltd (or its appointed agents) to debit our account the monthly payment and administration fees required in terms of the cover chosen. We understand this will apply for each month or until cancelled by us in writing.

This insurance may be cancelled by the Insured Person giving one calendar month's notice to Health & Accident Underwriting Managers (Pty) Ltd., who is acting on behalf of the Underwriters. Please note cancellation of your Medical Aid is not linked to cancellation of your GAP Cover.

Account holder's signature _____ Date _____

If you have a cheque account please enclose a copy of a cancelled cheque.

DECLARATION

Please read carefully. Failure to disclose material information can result in immediate cancellation of your policy

1. Failure to disclose material information or the provision of incorrect information can result in immediate cancellation of my Policy.
2. I declare that any false statement in the above application or the non-disclosure of any material information will render the Policy and the cover afforded thereby null and void.
3. I hereby authorise any Hospital, Physician or any other person who has attended or examined me or any other Insured's covered by the Policy to furnish to Health & Accident Underwriting Managers (Pty) Ltd or their authorised representative all information with respect to any illness, injury or medical history, consultation, prescription or treatment and or medical copies of all hospital or medical history, consultation, prescription, or treatment and copies of all hospital or medical records.
4. I hereby acknowledge that any benefits paid out on my / Insured's Behalf, not covered by the terms and conditions of the policy cover, will be refunded to the Health & Accident Underwriting Managers (Pty) Ltd.
5. I hereby apply for the insurance cover and agree that any benefits due will be payable provided all relevant premiums are paid to date.
6. I accept benefits will be payable directly into my authorised bank account.
7. I authorise Health & Accident Underwriting Managers (Pty) Ltd to pay the benefits according to my authorised beneficiaries.
8. **Note:** This policy includes consent to the disclosure of private underwriting and claims information per the applicable policy terms and conditions.

Signature of Applicant	Date

Return to your Broker signed and completed application together with a copy of your current Medical Aid Membership Certificate.