

AGILITY GAP & COPAY APPLICATION

Email: gapco@agilityinsurance.co.za

Please attach copies of the following:

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

Requested start date:

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	<input type="text"/>	Title	<input type="text"/>
First name(s) (in full)	<input type="text"/>	Initials	<input type="text"/>
ID / Passport no.	<input type="text"/>	Date of birth	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Name of medical scheme	<input type="text"/>	Medical scheme no.	<input type="text"/>
Employer name	<input type="text"/>		
Medical scheme option	<input type="text"/>		

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.

Dependant type Surname First name(s) (in full) Initials ID / Passport no. Date of birth Relationship to member Disabled* <input type="checkbox"/> Full-time student* <input type="checkbox"/>	Spouse / Partner / Dependant 1 <input type="checkbox"/> <input type="text"/> <input type="text"/> <input type="text"/> Title <input type="text"/> Gender <input type="text"/> M <input type="text"/> F <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"/> Age <input type="text"/> <input type="text"/>	Dependant 2 <input type="checkbox"/> <input type="text"/> <input type="text"/> <input type="text"/> Title <input type="text"/> Gender <input type="text"/> M <input type="text"/> F <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"/> Age <input type="text"/> <input type="text"/>
	Dependant 3 <input type="checkbox"/> <input type="text"/> <input type="text"/> <input type="text"/> Title <input type="text"/> Gender <input type="text"/> M <input type="text"/> F <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"/> Age <input type="text"/> <input type="text"/>	Dependant 4 <input type="checkbox"/> <input type="text"/> <input type="text"/> <input type="text"/> Title <input type="text"/> Gender <input type="text"/> M <input type="text"/> F <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"/> Age <input type="text"/> <input type="text"/>

* 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 <input style="width:90%;" type="text"/> <input style="width:90%;" type="text"/> <input style="width:90%;" type="text"/> Code <input style="width:10%;" type="text"/>	Postal address <input style="width:90%;" type="text"/> <input style="width:90%;" type="text"/> <input style="width:90%;" type="text"/> Code <input style="width:10%;" type="text"/>	
E-mail address <input style="width:98%;" type="text"/>		
Tel (H) <input style="width:20%;" type="text"/>	Tel (W) <input style="width:20%;" type="text"/>	Mobile <input style="width:20%;" type="text"/>
Please select your preferred method of communication to receive important information and related product content: SMS <input type="checkbox"/> E-mail <input type="checkbox"/>		

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.

<input type="checkbox"/> Gap 200	<input type="checkbox"/> Gap 500			
<input type="checkbox"/> Combined 200	<input type="checkbox"/> Combined 400	<input type="checkbox"/> Combined 500	<input type="checkbox"/> Ultra	
<input type="checkbox"/> Corporate 200	<input type="checkbox"/> Corporate 500	<input type="checkbox"/> Elective Advisory Fee	<small>This advisory fee is discretionary and is payable to the financial advisor, in addition to the legislative short-term insurance commission</small>	

Requested date of commencement of membership 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

Signature date



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	<input type="text"/>	Height	<input type="text"/>	cm	Weight	<input type="text"/>	kg
Spouse/Partner/ Dependant 1	Initials	<input type="text"/>	Height	<input type="text"/>	cm	Weight	<input type="text"/>	kg
Dependant 2	Initials	<input type="text"/>	Height	<input type="text"/>	cm	Weight	<input type="text"/>	kg
Dependant 3	Initials	<input type="text"/>	Height	<input type="text"/>	cm	Weight	<input type="text"/>	kg
Dependant 4	Initials	<input type="text"/>	Height	<input type="text"/>	cm	Weight	<input type="text"/>	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	<input type="text"/>	Title	<input type="text"/>
First name(s) (in full)	<input type="text"/>	Initials	<input type="text"/>
ID / Passport no.	<input type="text"/>		
Physical Address	<input type="text"/>		
	<input type="text"/>	Code	<input type="text"/>

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	<input type="text"/>
Inception Date	<input type="text" value="D D M M Y Y Y Y"/>
Total monthly premium including VAT	<input type="text" value="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	<input type="text"/>	Name of Branch	<input type="text"/>
Account type	<input type="checkbox"/> Current <input type="checkbox"/> Transmission <input type="checkbox"/> Savings	Branch code	<input type="text"/>
Name of account holder	<input type="text"/>		
Account no.	<input type="text"/>		
Month policy to start	<input type="text"/>		
Debit order date	1 st <input type="checkbox"/> 7 th <input type="checkbox"/> 15 th <input type="checkbox"/> 25 th <input type="checkbox"/>		

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	<input type="text"/>	
First name(s) (in full)	<input type="text"/>	
Capacity	<input type="text"/>	
Contact number	<input type="text"/>	
<input type="text" value="SIGNATURE"/>	<input type="text"/>	<input type="text"/>
Signature of bank account holder	Name of bank account holder	Signature date

J. INTERMEDIARY DETAILS

Name of brokerage Date

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:

- 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.**
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- I will ensure that **full** details are provided for any medical condition questions answered YES.
- 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.
- The onus lies on me to make sure that premiums are paid on a monthly basis, in advance.
- One calendar 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 of applicant

Name of applicant

SIGNATURE

Signature of spouse if married in community of property

Name of spouse if married in community of property
