54 Maxwell Drive,
Woodmead,
Sandton,
Johannesburg

Po Box 1555, Fontainebleau, 2032

Telephone: 011 796 6464
E-mail: gapco@agilityinsurance.co.za

EMPLOYER GROUP APPLICATION FORM

Name of Group

Region

Please ensure that the Member Application form is completed in respect of each applying member and that proof of identification is attached (ID's for majors and birth certificates for minors)

FOR OFFICE USE ONLY

Group Reference Number

Region

Date of Inception

D D M M Y Y Y Y

Applicable Option

- ☐ **Gap 200**
- ☐ **Gap 500**
- ☐ **Combined 200**
- ☐ **Combined 400**
- ☐ **Combined 500**
- ☐ **Corporate 200**
- ☐ **Corporate 500**

Underwriting Decision:

Authorisation:

Name

Signature

Date:

D D M M Y Y Y Y

A. EMPLOYER DETAILS (Note: Please complete all sections in **BLACK** ink)

Employer Name

Registration No. Employer Contact Person

Telephone No. Title Fax No.

Email Address

Alternative Email Address

Postal Address

Code

Physical Address

Code

Nature of Business

Vat No.

Trading Name

B. GROUP ELIGIBILITY DETAILS

Note: With the exception of pensioner members, members must be actively at work at the commencement date of this contract. Where this is not the case, confirmation of cover will be deferred until such time as the applicant is actively at work.

1. DETAILS OF THE GROUP (To be completed in all instances)

Will cover be available to all employees employed by your company? YES NO

State the total number of employees actively employed by your company

State the total number of pensioners

State the total number of active employees eligible to be covered

State the total number of active employees that will participate

State the total number of pensioners eligible to be covered

State the total number of pensioners that will participate

State the number of branches

Member correspondence to group HR? YES NO

C. EXISTING MEDICAL SCHEME DETAILS

Please provide details of your group's medical scheme membership over the past 2 years.

1 Name of scheme

From D D M M Y Y Y Y To D D M M Y Y Y Y

2 Name of scheme

From D D M M Y Y Y Y To D D M M Y Y Y Y

Has your company ever been declined, loaded, or had exclusions applied by a medical scheme? YES NO

(If "Yes" please provide details) _____

_____

D. BILLING METHOD (Please indicate with an "X" where applicable)

☐ Advance ☐ Arrear

Schedule ☐ 30th ☐ 1st ☐ 5th

Contact person for schedule

Name

Designation

Telephone No. Email

Prefered option for all group members YES NO of which option:

ACTIVE MEMBERS ☐ One bill for the entire group **OR** ☐ One bill per branch

PENSIONER MEMBERS ☐ Employer **OR** ☐ Member

OR ☐ Specify

E. WELCOME PACKS

☐ Emailed ☐ Delivered to Company

F. COMMUNICATION

May we communicate directly with the members? YES NO

If "Yes" please indicate communication type ☐ Email ☐ Internet ☐ Printed Media ☐ SMS

☐ Other _____

Name of Contact Person

Contact No. Email

G. PAYMENT DETAILS

Payment Method ☐ Debit Order ☐ Electronic Transfer

Name of Bank | Branch

Account Type | Branch Code

Name of Account Holder

Account No.

GENRIC Insurance Company Ltd claims will be reimbursed at Underwriter rate, unless otherwise indicated. All other claims will be reimbursed as per the policy document. GENRIC Insurance Company Ltd is hereby authorised to draw against the above bank account the amount due in terms of this contract, wherever it may be conducted. Similarly, I authorise my bank to debit my account with amounts drawn against it by the Insurer.

I understand that the withdrawals hereby authorised will be processed by computer through a debit order system and I also understand that the details of each withdrawal will be printed on my bank statement. I agree to pay any bank charges relating to this instruction.

The authority may be cancelled by myself giving GENRIC Insurance Company Ltd one calendar months' notice in writing by completing a cancellation form, but I understand that I shall not be entitled to any refund of amounts which the insurer has withdrawn while this authority was in force if such amounts were legally owing to the insurer. Receipt of this instruction by GENRIC Insurance Company Ltd shall be regarded as receipt thereof by my bank. I further agree to advise GENRIC Insurance Company Ltd in writing of any changes which may occur.

Authorised Signatory(ies)	SIGNATURE	SIGNATURE
Full Name		
Surname		
Designation		

H. INTERMEDIARY DECLARATION

1. *I, the undersigned hereby confirm:*

1.1 That the appointed intermediary is accredited at date of signing the application form;

1.2 That the appointed intermediary is licensed by the FSCA in terms of the FAIS Act;

1.3 That the appointed intermediary has made his/her name, physical, postal address and contact number available;

1.4 That I am aware of commission payable by the Underwriter on this transaction to the appointed intermediary;

1.5 That the appointed intermediary is contractually bound to the Underwriter;

1.6 That there has been no material misrepresentation of facts by the appointed intermediary and that in such an event the appointed intermediary undertakes to refund all monies paid to the Underwriter;

1.7 That I have been given all the relevant information with regards to the application information to the appointed intermediary;

1.8 That the advice given to me by the appointed intermediary was in my best interest and unprejudiced.

I. INTERMEDIARY DETAILS

Full name of Broker | Individual Broker Reference No.

Name of Brokerage | Agility Gap & CoPay Broker Code

Telephone No. | Email Address

Fax No.

SIGNATURE	SIGNATURE
Signature of Intermediary	**Signature of Consultant**

J. DECLARATION

General

1. As a participating employer we hereby apply for membership for our employees of Agility Gap & CoPay cover.
2. On our employees' behalf, we accept:

2.1 The benefits provided for in terms of the Rules of GENRIC Insurance;
2.2 The Rules of GENRIC Insurance together with any amendments from time to time.

3. We warrant the correctness of the statements and information contained in this application and acknowledge that the correctness thereof and of all other documents submitted now or in the future by any officer, members or intermediary of or on behalf of the employer shall constitute a condition precedent to the payment of the benefits provided for in terms of the Rules of Agility Insurance Administrators.
4. We consent to our employees and their listed dependants participating in the contracts to which this proposal relates being called upon to submit to such medical examinations and tests as Agility Insurance Administrators deems necessary, during the currency of the said contracts and of the Underwriter addressing such requests directly to our employees or their dependants, with the same legal consequences as if such requests had been addressed to us.
5. We acknowledge and accept that Agility Insurance Administrators reserves the right to cancel membership of Agility Insurance Administrators if any contribution is
6. We understand that Agility Insurance Administrators assumes no liability for any employee until such time as a notice of acceptance of the risk is given by Agility Insurance Administrators and payment of the first contribution has been received.
7. We undertake to give Agility Insurance Administrators immediate notice should any changes relating to the assessment of this application occur prior to the date upon which the Agility Insurance Administrators grants written acceptance. Thus enabling Agility Insurance Administrators to reconsider the terms of acceptance.

Signed at _____ on this _____ day of _____ / _____

Authorised Signatory(ies)	SIGNATURE	SIGNATURE
Designation		