APPLICATION FORM
OPTIVEST (Individual)

GapCover®
medical shortfall solutions

Email: newbusiness@optivest.co.za / Fax: 0865 846 340

Consultant Reference: | Intermediary Code:

Company:

☐ GapCover®: R171 per month (5 x Scheme Tariff; cover up to R157 000 per beneficiary, per annum)

☐ Combined Cover: R230 per month (GapCover®+ CoPay Cover R12 800 per event, cover up to R157 000 per beneficiary, per annum)

A PRINCIPAL MEMBER DETAILS

Effective Date: 0 1 M M 2 0 Y Y | Date of Birth: D D M M Y Y Y Y

Title: | Initials: | Surname:

Full Name: | Gender: MALE FEMALE

ID Number: | Passport No:

Telephone (W): | Fax No:

Telephone (H): | Cell No:

Email Address: | Medical Scheme:

Postal Address:

Home Address:

B DEPENDENT DETAILS

Do you have dependents that need to be registered? Yes: ☐ No: ☐

Spouse / Life Partner and all children registered as dependents (including full-time students and permanently disabled children) on your medical scheme may be covered on your GapCover policy. Please attach a copy of your medical scheme membership certificate to register dependents on your GapCover policy. *NB: Any changes must be communicated to the Administrator within 30 days of the occurrence and only dependents that are registered on the policy will be covered.*

C PRE-EXISTING CONDITION

Are you aware of any condition or symptom, for which you or your dependents received medical advice, diagnosis, care or treatment in the past 12 months. (Please select)

Yes: ☐ No: ☐ If yes, please refer to Clause G7 of the Declaration.

Please note: The administrator must be notified if an insured person's state of health changes from the date of signing the application to the date of inception. These conditions will also be excluded as pre-existing conditions.

D BANKING DETAILS (DEBIT ORDER)

Account Holder Name: | Account Holder Contact Number:

Name of Bank: | Branch Code:

Account No: | Account type: Cheque Current Savings Transmission

Debit Order Date: 1st 5th 10th 15th 25th

I, Full Name hereby authorise the deduction of my monthly contribution for GapCover®.

I acknowledge that these premiums will be deducted monthly on the selected debit order date from the account above.

Date: D D M M Y Y Y Y | Signature of Account Holder:

E DECLARATION BY APPLICANT

Standard Declaration

I warrant that the information provided to the insurer in connection with the policy, whether in my own handwriting or not, is true and correct. I, the undersigned, hereby declare that:

1 All the information that I give, whether telephonic, electronic or written, will form part of the policy.

2 To the best of my knowledge and belief the information provided in connection with this application, whether in my own handwriting or not, is true and I have not withheld any material facts known to me.

3 I understand that this is an accident and health policy with stated benefits in terms of the Short-term Insurance Act 53 of 1998. This is not a medical scheme and the cover is not the same as that of a medical scheme. This policy is not a subsitute for medical scheme membership.

4 I acknowledge that the sharing of claims information and underwriting (including credit information) by 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 of any claim 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 to privacy and consent to the disclosure of any information relevant to claims concerning me or any person I represent. I also acknowledge that information provided by me may be verified against other legitimate sources or databases.

5 That I specifically give consent to Insuremed Administrators contacting my current medical scheme and healthcare providers, as well as the current medical scheme and healthcare providers of my dependents on this policy, to confirm any health information relating to underwriting and claims for Insuremed Administrators, upon request. I understand that Insuremed Administrators will regard any health information supplied by my, or my dependents' medical scheme or healthcare providers as confidential and will only disclose it to another party upon my express consent.

6 If the insurer accepts this application, it will be on condition that there is no important change to the facts that I disclosed and upon which this application is based and accepted. If there has been such a change, I must inform the insurer within 30 days of the occurrence in order for him to reassess the risk for the insurance cover.

7 Upon receipt of my policy document, I will familiarise myself with all the terms and conditions of the policy and contact my Intermediary or the Administrator for clarification should anything be unclear.

8 This consent is to remain in force after my death.

F FEES AND COMMISSION

I acknowledge and appoint Optivest Health Services (FSP no. 13475) as intermediary to provide ongoing intermediary services to me regarding this policy. I agree that the insurer may pay commission to the intermediary in terms of the Short-term Insurance Act 53 of 1998.

G IMPORTANT TERMS AND CONDITIONS OF THIS POLICY

I understand and agree that:

1 To qualify for benefits under this policy, I must be a member, and my insured family must be dependants of a medical scheme approved in terms of the Medical Schemes Act and my dependents must be registered as dependents on the policy.

2 Cover will commence on the 1st day of the calendar month for which the insurer accepts my application for insurance and receives my first premium.

3 The Policy Premium may be changed annually, after the insurer has given me 30 days' notice. If I do not pay my premiums in full, I will not be covered.

4 In terms of the policy, the insurer will pay the difference between the surgical and consultation fees charged by health professionals for insured events and the benefits payable by my medical scheme. Terms and conditions will apply as stipulated in the policy contract.

5 A maximum benefit of R157 000 will be payable per beneficiary per policy per annum. A sub limit of R12 800 per event is applicable to all CoPay Cover claims and Non-DSP hospital co-payments are limited to one event per policy per annum.

6 Termination of cover will take place if I have given a calendar month's written notice of cancellation, if 3 consecutive premiums are unpaid, or if a dependant does not qualify for cover on my policy.

7 Benefits will not be paid:
If the medical scheme pays the entire claim or pays short due to scheme limits or exclusions.
If I do not submit my claim within 4 months of the date of payment by my medical scheme.
For the first 3 months of cover. (Please refer to full definition and details supplied on the Policy Contract)
For the first 12 months of cover in respect of any pre-existing condition. (Please refer to full definition and details supplied on the Policy Wording)

8 This policy does not cover Prescribed Minimum Benefits (PMB) as defined in the Medical Schemes Act 131 of 1998 with Regulations, which are payable by my medical scheme.

9 The full terms and conditions are provided in the Policy Wording.

Date: D D M M Y Y Y Y Signature of Principal Member: