

|                     |  |
|---------------------|--|
| Policy Number       |  |
| Group Policy Number |  |
| Policy Start Date   |  |
| Processor           |  |
| Brokerage Code      |  |
| Consultant Code     |  |



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**Policy Amendment Form**

Essmed Medical Cover (Pty) Ltd - Reg No: K2011/116999/07 - trading as Essential Med - FSB Liscense No. 42980

www.essentialmed.co.za

**1: Personal Information - Principal Applicant**

|           |                      |          |                      |       |                      |               |                               |                                 |
|-----------|----------------------|----------|----------------------|-------|----------------------|---------------|-------------------------------|---------------------------------|
| Title     | <input type="text"/> | Initials | <input type="text"/> | Names | <input type="text"/> | Gender        | Male <input type="checkbox"/> | Female <input type="checkbox"/> |
| Surname   | <input type="text"/> |          |                      |       |                      | Policy Number | <input type="text"/>          |                                 |
| ID Number | <input type="text"/> |          |                      |       |                      |               |                               |                                 |

**2: Change in Contact Details**

|                  |                      |             |                      |                               |                      |  |  |
|------------------|----------------------|-------------|----------------------|-------------------------------|----------------------|--|--|
| Physical Address | <input type="text"/> |             |                      | Postal Address                | <input type="text"/> |  |  |
|                  | <input type="text"/> | Suburb      | <input type="text"/> | City                          | <input type="text"/> |  |  |
| City             | <input type="text"/> | Postal Code | <input type="text"/> | Postal Code                   | <input type="text"/> |  |  |
| E-mail           | <input type="text"/> |             |                      | H: ( <input type="text"/> )   | <input type="text"/> |  |  |
|                  |                      |             |                      | W: ( <input type="text"/> )   | <input type="text"/> |  |  |
|                  |                      |             |                      | C: <input type="text"/>       |                      |  |  |
|                  |                      |             |                      | Fax: ( <input type="text"/> ) | <input type="text"/> |  |  |

**3: Change in Marital Status**

Marital Status    Married     Single     Divorced     Widow/er     Co-habiting

**4: Adding Dependants**

Spouse/Partner: A person to whom the principal applicant is either married or has a committed and serious relationship with, similar to that of a marriage in which there is mutual financial and emotional support and a shared household, irrespective of the gender of either party.  
Dependants: Children or other immediate family members in respect of whom, the principal member is liable for care and support. Maximum age of child dependant is 21, unless the dependent child is studying full time or is mentally or physically handicapped and fully dependent on the principal applicant.

Please note: If you do not have your dependant(s) ID number(s), please provide their date of birth in the ID Number field as follows: DDMMYYYY

|            |                      |     |              |                      |
|------------|----------------------|-----|--------------|----------------------|
| 4.1: Names | <input type="text"/> | M/F | Surname      | <input type="text"/> |
| ID Number  | <input type="text"/> |     | Relationship | <input type="text"/> |

|            |                      |     |              |                      |
|------------|----------------------|-----|--------------|----------------------|
| 4.2: Names | <input type="text"/> | M/F | Surname      | <input type="text"/> |
| ID Number  | <input type="text"/> |     | Relationship | <input type="text"/> |

|            |                      |     |              |                      |
|------------|----------------------|-----|--------------|----------------------|
| 4.3: Names | <input type="text"/> | M/F | Surname      | <input type="text"/> |
| ID Number  | <input type="text"/> |     | Relationship | <input type="text"/> |

**5: Removing Dependants**

|            |                      |     |              |                      |
|------------|----------------------|-----|--------------|----------------------|
| 5.1: Names | <input type="text"/> | M/F | Surname      | <input type="text"/> |
| ID Number  | <input type="text"/> |     | Relationship | <input type="text"/> |

|            |                      |     |              |                      |
|------------|----------------------|-----|--------------|----------------------|
| 5.2: Names | <input type="text"/> | M/F | Surname      | <input type="text"/> |
| ID Number  | <input type="text"/> |     | Relationship | <input type="text"/> |

|            |                      |     |              |                      |
|------------|----------------------|-----|--------------|----------------------|
| 5.3: Names | <input type="text"/> | M/F | Surname      | <input type="text"/> |
| ID Number  | <input type="text"/> |     | Relationship | <input type="text"/> |

**6: Additional Information / Pre-Existing Conditions / Underwriting Questions - (New dependants)**

Note that Hospital Benefits and all claims arising from a known pre-existing condition are excluded for a minimum period of 24 months.

- 6.1: Currently receiving treatment on any medical / dental condition?
- 6.2: Concerned about / aware of any condition which may require medical / dental attention?
- 6.3: Currently use any medication?
- 6.4: Pregnant?
- 6.5: Undergone any major operations in the last 5 years?
- 6.6: Are you or your spouse a member of a medical scheme or a hospital plan?

|     |    |
|-----|----|
| YES | NO |
| YES | NO |
| YES | NO |
| YES | NO |
| YES | NO |
| YES | NO |

If the answer to any of these questions is YES, please complete section 5 below with relevant information.

**7: Existing Medical Conditions / Events / Medical Scheme or Hospital Insurance Plan (New dependants)**

|      |                      |  |                      |
|------|----------------------|--|----------------------|
| Name | <input type="text"/> | Condition / Event / Medical Scheme Information | <input type="text"/> |
| Name | <input type="text"/> | Condition / Event / Medical Scheme Information | <input type="text"/> |
| Name | <input type="text"/> | Condition / Event / Medical Scheme Information | <input type="text"/> |
| Name | <input type="text"/> | Condition / Event / Medical Scheme Information | <input type="text"/> |

**8: Changing Policy Options and Fees**

Please tick new Option

| Breakdown         | BASIC                          |                                |                                | BALANCE                        |                                | BOOST                          |                                |
|-------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
|                   | Day-to-day benefit only        | Hospital cover only            | Comprehensive                  | Hospital cover only            | Comprehensive                  | Hospital cover only            | Comprehensive                  |
| Single            | R 285 <input type="checkbox"/> | R 115 <input type="checkbox"/> | R 345 <input type="checkbox"/> | R 335 <input type="checkbox"/> | R 520 <input type="checkbox"/> | R 445 <input type="checkbox"/> | R 628 <input type="checkbox"/> |
| Including 1 child | R 395 <input type="checkbox"/> | R 140 <input type="checkbox"/> | R 494 <input type="checkbox"/> | R 365 <input type="checkbox"/> | R 675 <input type="checkbox"/> | R 515 <input type="checkbox"/> | R 799 <input type="checkbox"/> |

|                      |       |       |         |       |         |         |         |
|----------------------|-------|-------|---------|-------|---------|---------|---------|
| Including 2 children | R 515 | R 165 | R 616   | R 395 | R 815   | R 588   | R 972   |
| Including 3 children | R 600 | R 190 | R 739   | R 415 | R 945   | R 639   | R 1,122 |
| Including 4 children | R 645 | R 190 | R 869   | R 445 | R 960   | R 692   | R 1,177 |
| <b>Couple</b>        | R 455 | R 165 | R 559   | R 590 | R 985   | R 705   | R 1,052 |
| Including 1 child    | R 570 | R 190 | R 681   | R 645 | R 1,135 | R 785   | R 1,234 |
| Including 2 children | R 680 | R 215 | R 804   | R 690 | R 1,265 | R 855   | R 1,405 |
| Including 3 children | R 780 | R 240 | R 926   | R 700 | R 1,395 | R 935   | R 1,586 |
| Including 4 children | R 855 | R 240 | R 1,090 | R 735 | R 1,430 | R 1,005 | R 1,656 |

**9: Changing Bank Account Details / New Debit Order for Policy Amendments**

**Nominated Bank and Account details:**

Bank Name  Cheque  Transmission  Savings   
Branch Name  Branch Code   
Account No.

I / We hereby request "instruct" and authorise you / payroll master to draw / deduct from my / our account / salary with the below mentioned bank (or any other bank or branch to which I / We may transfer my / our account) the amounts (as indicated in point 8.1) or any other variable amount pertaining to this agreement. This being the amounts necessary for the settlement in respect of my / our purchases / agreement. These withdrawals from my / our bank account by you shall be treated as though it has been signed by me / us personally.

**NB. Debit Dates - 25th or 1st day of each month!**

9.1: Policy Premium  AMOUNT IN WORDS on the  DAY of  MONTH  YEAR

I / We understand that the withdrawal hereby authorised will be processed by Insurance Outsource Managers (Pty) Ltd, and I / we also understand that the details of each withdrawal will be printed on my bank statement or on an accompanying voucher. I / We agree to pay any bank charges relating to this debit order instruction.

I / we understand that if the debit order action date falls on a non banking day that the debit order may be actioned on the banking day preceding the debit order action date.

This authority may be cancelled by me / us by giving you thirty days notice in writing, sent by prepaid registered post. I / we understand that I / we shall not be entitled to any refund of amounts which you have withdrawn while this authority was in force if such amounts were legally owing to you. Receipt of this instruction by you shall be regarded as receipt thereof by my / our bank (whichever it is or will be).

ASSIGNMENT: I / We acknowledge that the party hereby authorised to effect the drawing (s) against my / our account may not cede or assign any of its rights to any third party without my / our prior written consent. I / we may not delegate any of my / our obligations in terms of this contract authority to any third party without prior written consent of the authorised party.

Name of account holder  Signature   
Date

**9: Acknowledgement**

- 1: I warrant that I have been provided with all the intermediary, insurance and benefit details, or any other information as I may have requested.
- 2: I warrant that all details and facts herein are accurate and properly disclosed, even if completed by the intermediary or representative on my behalf.
- 3: I understand that the benefits offered are risk benefits only, and that there are no surrender values.
- 4: Failure to pay premiums will result in benefits lapsing.
- 5: In the event of any query regarding this policy or any other claim in terms of this policy, I consent to the disclosure of any relevant information to the intermediary or any Essential Med or Day 1 official for the purpose of resolving the query.
- 6: In the event of no nominated beneficiary, I agree that the benefit be payable to the first claimant with reasonable title to claim any benefit.
- 7: I acknowledge that the Health Care Plan is not a Medical Aid and that the benefits are not equivalent to that of a medical aid.
- 8: I am satisfied that the plan chosen by me best suits my needs.

**10: Amendments / Changes Date**

From

**Applicant**

Initials and Surname  Signature   
Application Date