

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



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Medical Insurance Application Form

Essmed Medical Cover CC - Reg No 2005 / 146525 / 23 Trading as Essential Med - FSB License Number - 31157

Where did you about Essential Med? Please tick

Essential Med Agent	<input type="checkbox"/>	Facebook	<input type="checkbox"/>	Magazine	<input type="checkbox"/>	TV	<input type="checkbox"/>
Promotional Email	<input type="checkbox"/>	SMS Campaign	<input type="checkbox"/>	Radio	<input type="checkbox"/>	Other	<input type="checkbox"/>
Google Search	<input type="checkbox"/>	Newspaper	<input type="checkbox"/>	Word of mouth	<input type="checkbox"/>		

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"/>					Postal Address	<input type="text"/>	
Physical Address	<input type="text"/>					City	<input type="text"/>	
City	<input type="text"/>	Suburb	<input type="text"/>	Postal Code	<input type="text"/>	Postal Code	<input type="text"/>	
E-mail	<input type="text"/>					H: ()	<input type="text"/>	
ID Number	<input type="text"/>					W: ()	<input type="text"/>	
Marital Status	Married <input type="checkbox"/>	Single <input type="checkbox"/>	Divorced <input type="checkbox"/>			C:	<input type="text"/>	
	Widow/er <input type="checkbox"/>	Co-habiting <input type="checkbox"/>			Fax: ()	<input type="text"/>		

1.2: Employment Information

Employee No	<input type="text"/>	Company Name	<input type="text"/>
Monthly Income	<input type="text"/>		

2: 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

2.1: Names	<input type="text"/>	M / F	<input type="checkbox"/>	Surname	<input type="text"/>
ID Number	<input type="text"/>			Relationship	<input type="text"/>
2.2: Names	<input type="text"/>	M / F	<input type="checkbox"/>	Surname	<input type="text"/>
ID Number	<input type="text"/>			Relationship	<input type="text"/>
2.3: Names	<input type="text"/>	M / F	<input type="checkbox"/>	Surname	<input type="text"/>
ID Number	<input type="text"/>			Relationship	<input type="text"/>
2.4: Names	<input type="text"/>	M / F	<input type="checkbox"/>	Surname	<input type="text"/>
ID Number	<input type="text"/>			Relationship	<input type="text"/>
2.5: Names	<input type="text"/>	M / F	<input type="checkbox"/>	Surname	<input type="text"/>
ID Number	<input type="text"/>			Relationship	<input type="text"/>

3: Beneficiary - Death Benefit

Name	<input type="text"/>	M / F	<input type="checkbox"/>	Surname	<input type="text"/>
ID Number	<input type="text"/>			Contact Number	() <input type="text"/>

4: Additional Information / Pre-Existing Conditions / Underwriting Questions

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

- 4.1: Currently receiving treatment on any medical / dental condition?
- 4.2: Concerned about / aware of any condition which may require medical / dental attention?
- 4.3: Currently use any medication?
- 4.4: Pregnant?
- 4.5: Undergone any major operations in the last 5 years?
- 4.6: 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.

5: Existing Medical Conditions or Events

Name		Existing Medical Scheme	
Name		Existing Conditions/Events	
Name		Existing Conditions/Events	
Name		Existing Conditions/Events	

6: Policy Options and Fees Please tick

Policy Options	Day to Day Benefits Only	Please Tick	Hospital Plan Only	Please Tick	Day to Day & Hospital Plan	Please Tick
Single	R 268	<input type="checkbox"/>	R 325	<input type="checkbox"/>	R 485	<input type="checkbox"/>
Including 1 child	R 371	<input type="checkbox"/>	R 350	<input type="checkbox"/>	R 620	<input type="checkbox"/>
Including 2 children	R 474	<input type="checkbox"/>	R 380	<input type="checkbox"/>	R 740	<input type="checkbox"/>
Including 3 children	R 577	<input type="checkbox"/>	R 410	<input type="checkbox"/>	R 860	<input type="checkbox"/>
Including 4 children	R 577	<input type="checkbox"/>	R 440	<input type="checkbox"/>	R 890	<input type="checkbox"/>
Couple	R 423	<input type="checkbox"/>	R 580	<input type="checkbox"/>	R 900	<input type="checkbox"/>
Including 1 child	R 526	<input type="checkbox"/>	R 610	<input type="checkbox"/>	R 1 030	<input type="checkbox"/>
Including 2 children	R 629	<input type="checkbox"/>	R 640	<input type="checkbox"/>	R 1 150	<input type="checkbox"/>
Including 3 children	R 732	<input type="checkbox"/>	R 670	<input type="checkbox"/>	R 1 270	<input type="checkbox"/>
Including 4 children	R 732	<input type="checkbox"/>	R 700	<input type="checkbox"/>	R 1 300	<input type="checkbox"/>

7: Additional Benefits Included

- | | |
|--|---|
| <input checked="" type="checkbox"/> Emergency Medical Evacuation | <input checked="" type="checkbox"/> Emergency Home Response |
| <input checked="" type="checkbox"/> Personal Health Advisor | <input checked="" type="checkbox"/> Roadside Assistance |
| <input checked="" type="checkbox"/> Emergency Identification and Information | <input checked="" type="checkbox"/> Map and Direction Service |
| <input checked="" type="checkbox"/> Legal Assistance / Law Call | <input checked="" type="checkbox"/> Travel Assistance |

8: Debit Order Instruction

I / We hereby request "instruct" and authorize 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!

8.1: Policy Premium on the of

I / We understand that the withdrawal hereby authorized will be processed by Anvil (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 authorized 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 authorized party.

Nominated Bank and Account details:

Bank Name		Cheque		Transmission		Savings	
Branch Name		Branch Code					
Account No.							
Name of account holder						Signature	
Date	<input type="text" value="D"/>	<input type="text" value="D"/>	<input type="text" value="M"/>	<input type="text" value="M"/>	<input type="text" value="Y"/>		

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 Essential Med Medical Insurance 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.

Initials and Surname		Signature	
Application Date	<input type="text" value="D"/>	<input type="text" value="D"/>	<input type="text" value="M"/>
	<input type="text" value="M"/>	<input type="text" value="M"/>	<input type="text" value="Y"/>
	<input type="text" value="Y"/>	<input type="text" value="Y"/>	<input type="text" value="Y"/>