



PINNACLE IPP

APPLICATION FORM				
BROKER NAME :			INCEPTION DATE REQUIRED:	
New Application		Professional Application	Comprehensive Application	Cover Amendment

PROPOSER				
Name of Business:				
Business Address:				
			Postal Code:	
Telephone Number (work):				
Fax Number or e-mail:				
Policy Tax Status:	Individual	Taxable Company/Institution	Non -Taxable Company/Institution	

INSURED CLIENTS DETAILS					
Surname:		Title:		Male	Female
First Names:					
Occupation:		Married	Divorced	Single	Widowed
Date of Birth:		Citizenship / Nationality:			
Identity Number:		Signature:			

INSURED ADDRESS AND CONTACT DETAILS				
Postal Address:			Postal Code:	
Residential Address:			Postal Code:	
Telephone Number (home):		Telephone Number (work):		
Cellular Number:		Business Fax Number or e-mail:		

INSURED OCCUPATION DETAILS					
Name of Business:					
Nature of Business:					
Annual Salary:	R				
Highest educational qualification:	No Matric	Matric	3 year Degree	3 + year Degree	
Nominated Occupation:	Since:	Y	E	A	R
Previous Occupation :	Since:	Y	E	A	R
Industry work in:					

OCCUPATIONAL DETAILS (Continued)					
Job Description					
Administration:		%	Duties:		
Supervisory:		%	Duties:		
Manual:		%	Duties:		
Travel:		%	Duties:		
Face to Face:		%	Duties:		
1.	Are there any other occupations you are or may become involved in?			Yes	No
If YES, Please give details:					
2.	Is there any direct or indirect hazard associated with your occupation?			Yes	No
If YES, Please give details:					
3.	During the past 5 years have you been absent from work for a continuous period of more than that one month as a result of an accident or illness?			Yes	No
If YES, state nature or incapacity:					



State periods and dates of incidents:			
4.	Is the business based at home?	Yes	No
5.	Have you ever been declared Insolvent?	Yes	No
6.	Do you participate in high risk occupation, sport, hobby or pastime which may expose you to a higher than average risk of injury (eg: Motor racing, aviation, diving, etc)?	Yes	No
If YES, Please give details:			
7.	Do you derive an income from any sport-related activities?	Yes	No
If YES, Please give details:			
8.	Are you Self-Employed	Yes	No

MEDICAL DETAILS			
Have you ever experienced, been treated for, or are you currently suffering from or have you had any indication of the following conditions:			
1.	Your heart or circulation (eg. Blood pressure, chest pains, heart murmur, rheumatic fever, stroke)?	Yes	No
2.	Your lungs (eg. Persistent cough, shortness of breath, tuberculosis, asthma, bronchitis)?	Yes	No
3.	Your digestive system or liver (eg. Recurrent indigestion, ulcers, bleeding from the bowel, hepatitis, gallstones)?	Yes	No
4.	Your kidneys, bladder or reproductive organs (eg. Stones, infections, bilharzias, prostate problem)?	Yes	No
5.	Your nervous system including psychiatric disorders (eg. Concussion, paralysis, fits, blackouts, anxiety, depression, persistent headaches)?	Yes	No
6.	Your eyes (excluding errors of refraction), ears, nose or throat (eg. Deafness, ear discharge)?	Yes	No
7.	Your skeleton, bones, joints or muscles (eg. Rheumatism, arthritis, back or neck trouble, gout)?	Yes	No
8.	Your glands or blood (eg. Diabetes, thyroid, spleen, bleeding disorder, leukaemia)?	Yes	No
9.	Your skin, including cancers, growths and tumours of any kind?	Yes	No
10.	Any other condition not mentioned above?	Yes	No
11.	Have you sought medical advice during the past 5 years in connection with any symptom or condition, or been a patient in a hospital or nursing home or undergone any medical examination (including ECG, X-ray examination or specialized laboratory tests) not mentioned above?	Yes	No
12.	Do you intend to seek medical treatment or advice within the next 12 weeks?	Yes	No
13.	Are you taking, or have you taken drugs, tranquillisers or any other medication in any form for a continuous period or more than 2 weeks?	Yes	No
14.	Have you ever been tested for or received advice, counseling or treatment in connection with HIV/AIDS or any infection by one of the HIV/AIDS viruses, hepatitis B or any sexually transmitted disease (eg. Gonorrhoea, syphilis or any venereal disease) other than for an application for insurance purposes	Yes	No
15.	Has any policy or proposal for life, health, sickness, accident or disability insurance on your life been declined, deferred, withdrawn or accepted on special terms and at special rates?	Yes	No
16.	Have you ever claimed any benefit against a sickness, accident or disability policy?	Yes	No
17.	Are you aware of any health or other factors (past or present), which may influence the risk attached to this policy?	Yes	No
18.	Please provide your family medical history in the table below (including any parents or siblings of yours who have suffered diabetes, cancer, stroke, heart complaint, high blood pressure, raised cholesterol, porphyria, mental disorders, haemophilia or any other hereditary disease):	Yes	No

	Age	If alive, briefly describe health condition	If deceased, cause of death
Father			
Mother			
Brothers			
Sisters			

19.	Height (Meters)	Weight (Kg)		
20.	Has your weight changed by more than 5kg in the last 12 months?		Yes	No
21.	Do you exercise regularly?		Yes	No
22.	Are you a member of a medical aid?		Yes	No
23.	Do you consume any alcohol?		Yes	No
24.	Have you habitually taken more alcohol in the past?		Yes	No
25.	Have you ever received medical advice to reduce or discontinue alcohol consumption?		Yes	No
26.	Do you currently smoke, or have you smoked in the past 12 months?		Yes	No
27.	Have you ever received medical advice to reduce or discontinue smoking?		Yes	No
28.	Are you left or right handed		L	R
If 'Yes' answered to any of the questions above, please supply full details below.				
Question Number	Applicant	Full details (including details of disorder, date diagnosed, nature and duration of treatment and the consulting doctor's contact details)		



* CURRENT DOCTOR/PRESENT DOCTOR			
Name of Doctor:			
Contact Number:		Fax Number:	
Address:			Code:
*Please provide details and telephone numbers of your consulting doctors for the past 5 years. Please indicate how many years you have been consulting the relevant doctor(s) (Please note that your current/previous doctor must not be a member of your immediate family, or a friend or business associate/partner).			

OTHER LIFE/DISABILITY INSURANCE			
1.	Do you have any existing insurance against accident, sickness, disablement or dread disease?	Yes	No
2.	Is any negotiation for other insurance on your life now pending or contemplated?	Yes	No
If the space provided is insufficient, please attach additional information to this application.			
N.B Any misinterpretation or non-disclosure of material medical or factual information will render all benefits granted by Health & Accident Underwriting Managers (Pty) Ltd null and void. In addition, any payment made due to such actions will be required to be repaid by the insured to Health & Accident Underwriting Managers (Pty) Ltd			

BENEFIT OPTIONS (Comprehensive & Professional)

COMPREHENSIVE BENEFIT OPTIONS					
MAY INSURE UP TO 100% OF PERSONAL INCOME		MAY INSURE UP TO 125% OF PERSONAL INCOME IF A SOLE BUSINESS OWNER			
	Cover amount	6 months	12 months	24 months	Premium
Income benefit payable from day 1 7 day waiting period - Accident 14 day waiting period - Illness (R1 000 per month - R40 000 per month)					
Income benefit payable from day 31 Benefit pays out from day 31 (R1 000 per month - R70 000 per month)					
Income benefit payable from day 91 Benefit pays out from day 91 (R1 000 per month - R70 000 per month)					
Note: Maximum benefit total may not exceed R70 000					SUBTOTAL
Accidental Permanent Total Disability Accidental Death Cover Mobility Benefit (Accidental)		R100 000 (Compulsory Core) R10 000 R15 000			R10.00
Administration Fee					R15.00
					TOTAL MONTHLY PREMIUM : R

PROFESSIONAL BENEFIT OPTIONS					
MAY INSURE UP TO 100% OF PERSONAL INCOME		MAY INSURE UP TO 125% OF PERSONAL INCOME IF A SOLE BUSINESS OWNER			
	Cover amount	6 months	12 months	24 months	Premium
Income benefit payable from day 1 7 day waiting period - Accident 14 day waiting period - Illness (R1 000 per month - R100 000 per month)					
Note: Maximum benefit total may not exceed R100 000					SUBTOTAL
Accidental Permanent Total Disability Accidental Death Cover Mobility Benefit (Accidental)		R100 000 (Compulsory Core) R10 000 R15 000			R10.00
Administration Fee					R15.00
					TOTAL MONTHLY PREMIUM : R

PLAN COMMENCEMENT DATE

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Y	E	A	R
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