



SURGERY IPP

APPLICATION FORM	
BROKER NAME :	INCEPTION DATE REQUIRED:

PERSONAL DETAILS	
Surname:	Title: Male Female
First Names:	
Postal Address:	Postal Code:
Residential Address:	Postal Code:
Telephone Number (home):	Telephone Number (work):
Cellular Number:	Fax Number or e-mail:
Occupation:	Married Divorced Single Widowed
Date of Birth:	Citizenship / Nationality:
Identity Number:	Signature:

Existing MediCard Holder?	Yes No	Card No:
Family member to be covered : (Spouse)		
First Names:		
I.D. Number or Date of Birth :		
Spouse or Child	Yes No	
Spouse or Child	Yes No	

Please give the name and address of your general practitioner as well as any specialist you may have recently consulted.	
Doctor's Name:	Specialist's Name:
Address:	Address:
Phone No:	Phone No:

SPECIFIC HEALTH QUESTIONS			
1.	Do you or any of your dependents expect to receive any treatment, surgery in the next 12 months and do you or your dependents expect to be, or are currently, hospitalized?	Yes	No
If "Yes" answered to the question above, please supply full details below.			
Question	Applicant	Full details (including details of disorder, date diagnosed, nature and duration of treatment and the consulting doctor's contact details)	

N.B. Any misinterpretation or non-disclosure of material medical or factual information will render all benefits granted by Health and 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 and Accident Underwriting Managers (Pty) Ltd.

PREMIUM	
PRINCIPAL MEMBER	R
PRINCIPAL + SPOUSE	R
PRINCIPAL + CHILDREN (N/A FOR SENIOR)	R
WHOLE FAMILY (N/A FOR SENIOR)	R

