



CAREGIVER

APPLICATION FORM

BROKER NAME :	INCEPTION DATE REQUIRED:
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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 any of the questions 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	
Insured/Spouse	R

PAYMENT METHOD	
Please debit my bank account :	Cheque <input type="checkbox"/> Savings <input type="checkbox"/> Transmission <input type="checkbox"/>
Name of Account Holder:	Name Of Bank :

Branch:	Branch code:	Account no:																		
I authorise Health & Accident Underwriting Managers (Pty) Ltd (or its appointed agents) to debit our account the monthly payment and administration fees required in terms of the cover chosen. We understand this will apply for each month or until cancelled by us in writing.																				
Account holder's signature										Date										
If you have a cheque account please enclose a copy of a cancelled cheque.																				

DECLARATION	
PLEASE READ CAREFULLY. FAILURE TO DISCLOSE MATERIAL INFORMATION CAN RESULT IN IMMEDIATE CANCELLATION OF YOUR POLICY	
<p>1. Failure to disclose material information or the provision of incorrect information can result in immediate cancellation of my Policy.</p> <p>2. I declare that any false statement in the above application or the non-disclosure of any material information will render the Policy and the cover afforded thereby null and void.</p> <p>3. I hereby authorise any Hospital, Physician or any other person who has attended or examined me or any other Insured's covered by the Policy to furnish to Health & Accident Underwriting Managers (Pty) Ltd or their authorised representative all information with respect to any illness, injury or medical history, consultation, prescription or treatment and or medical copies of all hospital or medical history, consultation, prescription, or treatment and copies of all hospital or medical records.</p> <p>4. I hereby acknowledge that any benefits paid out on my / Insured's Behalf, not covered by the terms and conditions of the policy cover, will be refunded to the Health & Accident Underwriting Managers (Pty) Ltd.</p>	<p>5. I hereby apply for the insurance cover and agree that any benefits due will be payable provided all relevant premiums are paid to date.</p> <p>6. I accept benefits will be payable directly into my authorised bank account.</p> <p>7. I authorise Health & Accident Underwriting Managers (Pty) Ltd to pay the benefits according to my authorised beneficiaries.</p> <p>8. Note: This policy includes consent to the disclosure of private underwriting and claims information per the applicable policy terms and conditions.</p>
Signature of Applicant	Date

