

Fax to: 0866 764 947

Consultant Ref:

APPLICATION FORM

Intermediary Code

Company Date

Option 1: R99 per month (maximum benefit per year R 1000 000 - 4 x Scheme Tariff)

Option 2: R85 per month (maximum benefit per year R 150 000 - 4 x Scheme Tariff)

A. Principal Member Details

Joining Date	<input type="text"/>		
Title	<input type="text"/> Initial <input type="text"/>	Surname	<input type="text"/>
First Names	<input type="text"/>		Date of Birth <input type="text"/>
ID Number	<input type="text"/>		Gender <input type="text"/>
Telephone (W)	<input type="text"/>		Fax <input type="text"/>
Telephone (H)	<input type="text"/>		Cellular <input type="text"/>
E-mail Address	<input type="text"/>		
Postal Address	<input type="text"/>		
Residential Address	<input type="text"/>		

B. Spouse Details

Title	<input type="text"/> Initial <input type="text"/>	Surname	<input type="text"/>
First Names	<input type="text"/>		<input type="text"/>
ID No.	<input type="text"/>		

C. Children's Details

Title	<input type="text"/> Initial <input type="text"/>	Surname	<input type="text"/>
First Names	<input type="text"/>		<input type="text"/>
ID No.	<input type="text"/>		
Title	<input type="text"/> Initial <input type="text"/>	Surname	<input type="text"/>
First Names	<input type="text"/>		<input type="text"/>
ID No.	<input type="text"/>		
Title	<input type="text"/> Initial <input type="text"/>	Surname	<input type="text"/>
First Names	<input type="text"/>		<input type="text"/>
ID No.	<input type="text"/>		
Title	<input type="text"/> Initial <input type="text"/>	Surname	<input type="text"/>
First Names	<input type="text"/>		<input type="text"/>
ID No.	<input type="text"/>		

E. Banking Details (Debit Order)

Name of account holder	<input type="text"/>										
Name of Bank	<input type="text"/>										
Branch Name	<input type="text"/>					Branch Code	<input type="text"/>				
Account Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Type of Account	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Debit Order date	1st <input type="checkbox"/>	5th <input type="checkbox"/>	10th <input type="checkbox"/>	15th <input type="checkbox"/>	28th <input type="checkbox"/>						

I, (full name) _____ hereby give authority for the deduction of my monthly contribution for the Optivest GapCover, marketed and administered by Optivest Health Services. I acknowledge that these premiums will be deducted monthly in advance from the following account:

Signature of Account Holder

Date

DECLARATION BY APPLICANT

I, the undersigned, hereby declare:

1. that to the best of my knowledge and belief the information provided in connection with this application whether in my own hand writing or not, is true and I have not withheld any material fact which are known to me. NB: A material fact is likely to influence the assessment of this application by underwriters. (If you are in any doubt as to whether a fact is material or not, you should disclose it.)
2. that I understand that any relevant material fact omitted in this proposal form may lead to Underwriters not meeting claims, should the omitted fact have been of such importance that the risk may not have been accepted in the first instance, in terms of the policy. This may lead to cancellation of this policy or rejecting claims, without refund of premiums if applicable.
3. that I understand that this is an accident and health policy with stated benefits in terms of the Short Term Insurance Act 53 of 1998 and not a Medical Scheme product.
4. that I acknowledge that the sharing of claims information and underwriting (including credit information) by Insurers is essential to enable the insurance industry to underwrite policies and assess risk fairly and reduce the incidence of fraudulent claims, in the public interest and a view to limiting premiums. I hereby waive any rights to privacy in any claims information supplied by me or on my behalf in respect of any insurance claim made or lodged by me and I consent to such information being disclosed to any other insurance company or its agent. I also waive any rights of privacy and consent to the disclosure of any information relevant to claims concerning me or any person I represent. I also acknowledge that information provided by me may be verified against other legitimate sources or databases.
5. I specifically consent to Optivest Health Services contacting my current Medical Scheme and/or medical practitioner to verify any medical details as provided in my application form. I further consent to such information being disclosed to Optivest Health Services for purposes of verifying the disclosure as provided on my application form.

Applicant

Date

GapCover marketed by Optivest Health Services • Optivest Health Services is an authorised financial services provider - FSB nr: 13475

Tel: 021 970 6889 • **Fax:** 0866 764 947 • **Client Services:** 0860 860 860