



Informed Healthcare Solutions (IHS)

119 Main Road
Heathfield
Cape Town

Tel: +27 21 712-8866
Fax: 0866 200 320
Email: info@medicalaidcomparisons.co.za
Web: www.medicalaidcomparisons.co.za

FAX COVER SHEET

To:	Graham Pike of IHS	From:	
Fax:	0866 200 320	Company:	
Tel:	021 712 8866	Tel:	
Pages:		Date:	
Re:	Gap Cover Application		

Comments:

Instructions:

1. Print this document.
2. Fill in the application form and cover letter.
3. Fax the form to us on 0866 200 320 or scan and email it to forms@medicalaidcomparisons.co.za
4. Sit back while we do all the complicated stuff.

Save time and hassle with your medical aid application and make sure it gets the best possible chance of success



Underwritten by GENRIC Insurance Company Limited

SIRAGO UNDERWRITING MANAGERS (PTY) LTD
REG NO: 1993/001387/07 | VAT NO: 4950188724

PHYSICAL ADDRESS: Midrand Business Park, Building 3,
563 Old Pretoria Main Road, Midrand, 1685
POSTAL ADDRESS: PO Box 1115,
Bromhof, 2154
TEL NO: 010 599 1163 | EMAIL: applications@sirago.co.za

Compliance Officer: Moonstone Compliance (Pty) Ltd
Financial Services Provider No: 4710

APPLICATION FORM 2019

Please complete this form in black ink and CAPITAL letters

Medical Scheme membership no.: Name of Medical Scheme:

Medical Scheme Option:

Is this application part of a group? (Place a clear X inside the box) yes no If YES, group name:

Previous Gap Cover: Date Joined:

Date Terminated: Required Inception Date:

Please attach Membership Certificate

PRINCIPAL INSURED DETAILS

Name and Surname:

ID number \ Passport: Mr Mrs Miss Dr Other

Date of birth: Email Address:

Contact details: Home no.: Work no.:

Fax no.: Cell no.:

Postal address:

Code:

Residential address:

Code:

SPOUSE DETAILS

Name and Surname:

ID number \ Passport: Mr Mrs Miss Dr Other

Date of birth: Email Address:

Contact details: Home no.: Work no.:

Fax no.: Cell no.:

Medical Scheme membership no.: Name of Medical Scheme:

Medical Scheme Option:

DEPENDANTS

Dependants are:

- Spouse and/or dependant children up to the age of 21 years
- Adopted/foster child (please attach documentary proof)
- Students up to the age of 27 (please prove full time enrolment)
- Provide studency proof or medical certificate if you are on the same medical aid

Name and Surname:

ID number \ Passport: Male Female

Date of birth: Relationship to applicant:

Name and Surname:

ID number \ Passport: Male Female

Date of birth: Relationship to applicant:

Name and Surname:

ID number \ Passport: Male Female

Date of birth: Relationship to applicant:

Name and Surname:

ID number \ Passport: Male Female

Date of birth: Relationship to applicant:

SPECIFIC HEALTH QUESTIONS

The following questions are related to the policyholder and or any beneficiaries or dependents on the policy.

YES NO

1	Have you been admitted to hospital in the last 4 months?		
2	Are expecting a hospital admission or aware of any conditions or illness that would require treatment in the next 12 months?		
3	Are you or any of your dependents currently pregnant?		
4	Have you taken or are currently taking chronic medication in the past 24 months?		
5	Have you been on gap cover before and / or have had a gap claim? If yes, who was the provider?		

If you answered "Yes" to any of the questions, please provide details below.

Question no.	Applicant/dependents	Disorder	Medication	Date Diagnosed

DEBIT ORDER DETAILS

Name of account holder:

Account no.:

Bank: Standard Bank ABSA FNB Nedbank Capitec Other

Account type: Cheque Savings Transmission Other

Debit order day: 1st 7th 15th 25th 31st Other

I hereby instruct and authorise you to draw against my bank account the amount necessary for payment of my monthly premium due in respect of the above mentioned insurance, without prejudice to the rights of Sirago Underwriting Managers (Pty) Ltd. I further authorise you to increase the amount in the terms of the policy from time to time and authorise my bank to effect payment.

Signature of account holder Date:

IMPORTANT INFORMATION

- Please make sure FULL details are given for questions answered YES.
- Application forms could be underwritten and conditions may be excluded for longer than 10 months.
- The onus lies on the insured to make sure that premiums are paid on a monthly basis. Reference on bank statements read: MD SIRAGO_MED
- Effective from 1 January 2019.
- In the event of a bereavement related claim the Insurer will pay the benefit into the principal or nominated beneficiaries account. The beneficiary must be noted on the policy prior to any loss. We will require the full name, surname and ID to note the beneficiary. At the time of a claim we will require the beneficiary's ID and proof of bank. Should there be no beneficiary noted on the policy prior to the loss or should we be unable to confirm the identity of the beneficiary, payment will always be made into the principal policyholders account.

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 handwriting or not, is true and I have not withheld any material facts which are known to me. (A material fact is likely to influence the assessment of this application by Sirago Underwriting Managers (Pty) Ltd. 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 Sirago Underwriting Managers (Pty) Ltd 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 the cancellation of this policy or rejection of claims without refund of premiums.
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 Insurance Act 18 of 2017 and not a Medical Scheme product.
4. The sharing of claims information and underwriting information by Insurers is essential to enable the insurance industry to underwrite policies, assess risks fairly, reduce the incidence of fraudulent claims and protect the public interest in terms of limiting excessive premium increases. You hereby waive any right to privacy of any insurance information provided by you or on your behalf, in respect of any insurance policy or claims you lodge. You also consent to this information being disclosed to any other insurance company and/or verified against other legitimate source or a database.
5. I specifically consent to Sirago Underwriting Managers (Pty) Ltd 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 Sirago Underwriting Managers (Pty) Ltd for purpose of verifying the disclosure as provided on my application form.
6. That I will advise Sirago Underwriting Managers (Pty) Ltd of any changes to my health state between the point of application and actual inception of my policy.
7. As part of our claims validation process we used the services of a contracted third party in order to authenticate medical scheme membership, plan option type, relevant beneficiaries and agreed medical scheme option tariffs amongst other relevant information to validate the claim.
8. We reserve the right to call for additional information of a clinical nature. In the event that Sirago requests a PMA (Post Medical Assessment) from your doctor as part of the claims assessing and authentication process
9. I authorise Sirago Underwriting Managers to negotiate with service providers on my behalf for my medical claims and or bill and pay the provider direct.

Signature of policyholder Date:

Spouse (If married in community of property) Date:

INTERMEDIARY DETAILS

Intermediary Group: **INFORMED HEALTHCARE SOLUTIONS** Intermediary Code: **S44336**
 Sales Person: **GRAHAM PIKE** Sales Code:
 Tel no.: **021 712 8866** Cell no.:

OPTION SELECTION

<input type="checkbox"/> ULTIMATE GAP COVER	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> 64 UNDER	<input type="checkbox"/> 65+	<input type="checkbox"/> FAMILY
<input type="checkbox"/> PLUS GAP COVER	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> 64 UNDER	<input type="checkbox"/> 65+	<input type="checkbox"/> FAMILY
<input type="checkbox"/> GAP COVER	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> 64 UNDER	<input type="checkbox"/> 65+	<input type="checkbox"/> FAMILY
<input type="checkbox"/> GAP-LITE COVER	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> 64 UNDER	<input type="checkbox"/> 65+	<input type="checkbox"/> FAMILY
<input type="checkbox"/> GOV-GAP COVER	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> FAMILY		
<input type="checkbox"/> EXACT COVER	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> 64 UNDER	<input type="checkbox"/> 65+	<input type="checkbox"/> FAMILY
<input type="checkbox"/> EXACT WITH CO-PAY COVER	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> 64 UNDER	<input type="checkbox"/> 65+	<input type="checkbox"/> FAMILY
<input type="checkbox"/> EXACT COVER WITH GAP	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> 64 UNDER	<input type="checkbox"/> 65+	<input type="checkbox"/> FAMILY
<input type="checkbox"/> EXACT WITH GAP AND CO-PAY COVER	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> 64 UNDER	<input type="checkbox"/> 65+	<input type="checkbox"/> FAMILY

OPTION BY APPLICANT:

Premium per month
 TOTAL PREMIUM PAYABLE
 *Intermediary Fee (Optional)

* The Intermediary fee will only be collected subject to us receiving a signed contract between the Intermediary and Policyholder

* This Intermediary fee is optional and is paid to the intermediary on top of the statutory commission on your approval

Please return the completed form to applications@sirago.co.za or by fax to 086 508 2292

NOMINATED BENEFICIARY (related to death benefits and/or premium waivers)

Name and Surname:
 ID number / Passport: Mr Mrs Miss Dr Other
 Date of birth: Email Address:
 Contact details: Home no.: Work no.:
 Fax no.: Cell no.:
 Relationship to Main member:

BANKING DETAILS FOR REFUNDS

SHOULD YOU NOT COMPLETE THIS SECTION IT WILL RESULT IN US USING YOUR DEBIT ORDER DETAILS

Name of account holder:
 Account no.:
 Bank: Standard Bank ABSA FNB Nedbank Capitec Other
 Account type: Cheque Savings Transmission Other
 Signature of account holder Date

STATISTICS

Race: Indian/Asian Black Coloured White Other
 Gender: Male Female
 Income Bracket: 0 - 2 500 2 501 - 5 000 5 001 - 7 500 10 001 - 12 500 12 501 - 15 000 15 001 +

Disclaimer: We believe in protecting your privacy and will not share, rent or sell any personal information or any statistical data received to third parties outside of Sirgo Underwriting Managers, except as described in this policy.



Sirago Underwriting Managers (Pty) Ltd is an authorised Financial Services Provider (FSP:4710) Underwriting Agency for GENRIC Insurance Company Limited (FSP: 43638). GENRIC is an authorised financial services provider and registered Short-term insurer.



I (Full Name)....., with ID number

acknowledge that my broker / advisor is (Company Name)..... with FSP number, is authorised to request Sirago Underwriting Managers with FSP number 4710 to collect an additional broker fee of Rwith my monthly premium on this policy for the services listed below.

List Of Services

.....
.....
.....
.....
.....
.....

I agree to the payment of these fees until such time as the policy is cancelled and/or I revoke the above authority.

I am aware that the fees are in addition to any premium payable and commission that the broker earns and are for the provision of the services above.

Sign.....

Sign.....

Brokerage.....

Client.....

Date.....

Date.....

