UNITYHEALTH

MEMBER INFORMATION FORM (VOLUNTARY/SMALL GROUPS)

Underwritten by Constantia Insurance Company Limited (CICL), Reg. No. 1952/001514/06, FSP No: 31111 (The Insurer)

2020 APPLICATION FORM

BROKER DETAILS

NAME OF BROKERAGE			
BROKER CODE			
BROKER E-MAIL ADDRESS		BROKER CONTACT NUMBER	

PERSONAL PARTICULARS

APPLICANT *Attach clear copies of identity documents.

GROUP/EMPLOYER NAME							
EMPLOYMENT START DATE				PREFERRED OPTION			
TITLE		SURNAME					
FIRST NAMES							
I.D./PASSPORT NUMBER							
DATE OF BIRTH	DD/MM/YYYY		GENDER	MALE		FEMALE	
COUNTRY OF RESIDENCE			COUNTRY OF NATIONALITY				
FACE TO FACE	YES		NO				

COMMENCEMENT DATE (date cover is to commence)	DD/MM/YYYY

For new employees, commencement date is the 1st of the month if employment commences on the 1st, or the 1st of the following month if employment commences during the month.

DEPENDANTS

*Attach clear copies of identity documents for all dependants, copy of the marriage certificate for a spouse dependant. Where applicable a physician report must be included to confirm disability of handicapped dependants.

FIRST NAME (AND SURNAME IF DIFFERENT)	RELATIONSHIP	I.D./PASSPORT NUMBER	DATE OF BIRTH

CONTACT DETAILS

POSTAL ADDRESS			PHYSICAL ADDRESS (IF DIFFERENT TO POSTAL)		
POSTAL CODE			POSTAL CODE		
*Attach proof of address (not older than 3 months)					
HOME NUMBER	AREA CODE		WORK NUMBER	AREA CODE	
CELL NUMBER	AREA CODE		E-MAIL		

CURRENT MEDICAL PRACTITIONER DETAILS

*Note: please ensure that the below details are correct and completed in full.

DOCTOR NAME		
TELEPHONE NUMBER	AREA CODE	

FICA QUESTIONNAIRE

ARE ANY INSURED PERSONS A DOMESTIC PROMINENT INFLUENTIAL PERSON (DPIP) OR FOREIGN PROMINENT PUBLIC OFFICIAL (FPPO) OR A CLIENT, ASSOCIATE OR FAMILY MEMBER OF A DPIP/FPPO?	YES		NO	
IF "YES", PROVIDE DETAILS BELOW:				
NAME AND SURNAME OF DPIP/FPPO				
POSITION OF DPIP/FPPO				
RELATIONSHIP TO DPIP/FPPO				

NOMINATION OF BENEFICIARY

Nominate a beneficiary to whom the benefit amount under your ACCIDENTAL DEATH BENEFIT will be paid to in the event of your accidental death. If a beneficiary is not nominated the benefit amount will be paid to your estate. In the event of your spouse's accidental death, the benefit amount will be paid to the principal insured person on the policy. Please refer to your policy documentation for full terms and conditions.

TITLE		NAME		SURNAME		ID NUMBER	
RELATIONSHIP				ADDRESS			

TITLE		NAME		SURNAME		ID NUMBER	
RELATIONSHIP				ADDRESS			

Not applicable for Primary Care Only standalone plan options.

As the main applicant, I understand that the beneficiary nominated will receive proceeds from the benefit payable under the ACCIDENTAL DEATH BENEFIT, subject to the terms and conditions of your policy and/or limitations imposed by law at the time of your claimable event.
You also understand that:

- You may nominate a beneficiary of your choice;
- If your nominated beneficiary cannot be located or passes away prior to your claimable event, the benefit amount(s) payable to them will be paid to your estate;
- If at the time of payment your nominated beneficiary is a minor, the benefit amount(s) will be paid to the minor's legal guardian or a trust for the benefit of the minor, or to any person we are authorised to pay under the relevant law;
- You may amend your nomination at any stage, however, nominations are not effective until confirmed in writing by the Insurer; and
- The benefit amount(s) payable to your nominated beneficiary will be based on the latest valid beneficiary nomination received as accepted by the Insurer.

SIGNATURE OF APPLICANT	
DATE	

DISCLOSURES

Unity Health hereby confirms:

a) That the applicant and his/her dependants personal and medical information, (obtained from healthcare providers) will be kept confidential.
b) That both personal and medical information obtained by Unity Health will not be used or sold commercially.
c) That data security measures are in place at Unity Health.
d) That staff of Unity Health as well as its contracted third parties are bound by confidentiality agreements.
e) That the insurer's contractual agreements ensure the confidentiality of data management and administration.

DECLARATION

I declare that I have not withheld any information and I accept that this application and declaration shall be the basis of the contract of insurance between me and the insurer, which will become effective on the first day of the month for which premiums are received. I also acknowledge that I have requested and instructed the broker not to complete a financial needs analysis. Furthermore, I understand and accept that this instruction not to proceed with a full financial needs analysis could have the effect that all my financial needs may not be properly addressed.

I further confirm that the following notable conditions have been explained to me:

a) No benefits will be payable during a general 1-month waiting period for all treatment received except for in-patient hospital treatment or out-patient casualty treatment.
b) No benefits will be payable during a 12-month waiting period for all chronic medication and optometry benefits.
c) No benefits will be payable during a 9-month waiting period for all pre-birth maternity benefits.
d) Not all my dependants are automatically covered under this policy, only my adult dependents and eligible children are covered as per the policy definitions.
e) Waiting periods do not apply to our Emergency and Accident Benefits and Employee Assistance Programme (AP).
By signing this application form, you acknowledge and accept that your policy will be subject to waiting periods for specific medical events.

I, the undersigned applicant:

a) Acknowledge that it is my responsibility to ensure that claims are submitted within the 4 month submission period.
b) Acknowledge that it is my responsibility to ensure that the monthly premium is received by the insurer.
c) Acknowledge and accept that Unity Health reserves the right to cancel the policy if any premium is not paid on the due date.
d) Undertake to inform the insurer within thirty one (31) days should the situation regarding the dependency of any of my dependants change.
e) Hereby consent to all conversations between myself, the insurer or any party as being recorded;
f) I further authorise and instruct the insurer and any medical provider (including emergency and hospital providers) concerned to give any information relating to myself and my dependants to the staff appointed by the insurer, for the purposes of ensuring that the members of the policy receive appropriate and necessary medical services while reducing inappropriate care and wastage of medical resources.
g) I understand that should I request to terminate my policy with Unity Health, I will be required to place 31 days' written notice with the insurer.
h) I confirm that although I have completed this application form, it does not constitute an insurance contract until a policy number is assigned, policy issued and premium is successfully paid.

SIGNATURE OF APPLICANT			
PRINTED NAME OF APPLICANT		DATE	

Please return to your broker or alternatively:

Unity Health
PO Box 1862, Cramerview, 2060
Tel Number 0861366006
Fax Number (011) 706 5568
E-mail Address: membership@unityhealth.co.za