UNITYHEALTH

Unity Health is a division of Ambledown Financial Services (Pty) Ltd. FSP 10287

#StayHealthy

Unity Health Call Centre: 0861 366 006

INDIVIDUAL DEBIT ORDER APPLICATION FORM

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

2021 APPLICATION FORM

BROKER DETAILS

All Unity Health applications must be submitted through a recognised broker authorised to market Unity Health products.

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

PRODUCT SUMMARY

PREMIUM RATES 2021

PRIMARY CARE	PLAN C	
PRINCIPAL	R390	
ADULT	R260	
CHILD	R115	
ADDITIONAL PREMIUM PER PERSON *ENTRY AGE 56 OR OLDER	R183	

HOSPITAL CARE	PLAN B		PLAN C	
PRINCIPAL	R137		R167	
ADULT	R73		R90	
CHILD	R25		R37	
ADDITIONAL PREMIUM PER PERSON *ENTRY AGE 61 OR OLDER	R37		R43	

PRIMARY + HOSPITAL CARE	PLAN C	
PRINCIPAL	R495	
ADULT	R355	
CHILD	R138	
ADDITIONAL PREMIUM PER PERSON *ENTRY AGE 56 OR OLDER	R213	

The additional premiums at entry apply if an applicant has not had medical scheme or primary healthcare insurance coverage for 15 or more consecutive years of cover since the age of 35. These premiums may be waived if the applicant can demonstrate otherwise in writing.

PERSONAL PARTICULARS

APPLICANT *Attach clear copies of identity documents.

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

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		

DEPENDANTS

WE COVER: you, your spouse, eligible child and adult dependents for whom you are a parent or legal guardian of; your child dependant aged 20 or younger at a child dependant premium; your child dependant aged 21 or older at an adult dependant premium if your dependant is financially dependant on you and proof is submitted every year. We accept proof of full-time studies from an educational facility or 3 months' stamped copies of your dependant's most recent bank statements.

*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	RELATIONSHIP	I.D./PASSPORT NUMBER	GENDER	DATE OF BIRTH

CURRENT MEDICAL PRACTITIONER DETAILS

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

DOCTOR NAME		
TELEPHONE NUMBER	AREA CODE	

PREMIUM PAYMENT

DEBIT ORDER DETAILS

ACCOUNT HOLDERS NAME		BANK / BUILDING SOCIETY		
ACCOUNT NUMBER		BRANCH		
BRANCH CODE		ACCOUNT TYPE		CURRENT
				TRANSMISSION
				SAVINGS

PLEASE SELECT PREFERRED DEBIT ORDER COLLECTION DATE					
FIRST WORKING DAY OF THE MONTH		LAST WORKING DAY OF THE MONTH		25TH OF THE MONTH	

Please note that premiums are collected in advance on your selected debit order date indicated above.

***Attach copies of your latest bank statement or proof of account details from your bank.**

Having applied for the above mentioned Unity Health Policy and on acceptance of my application by the Insurer, I hereby authorise the Insurer or its representative to debit my account with the premiums payable under the above plan on the chosen day of each month in accordance with the Debit order system. Such authorisation shall remain in force and effect until cancelled by myself, in writing with 31 days notice. I further authorise the Insurer to increase the amount due in terms of the policy from time to time and authorise my bank to effect payment on relevant increases. Notwithstanding the fact that I grant the Insurer permission to collect premiums, I acknowledge that I need to ensure that premiums are collected for cover to remain in force. In the event that the collection day falls on a Sunday, or recognised South African public holiday, the collection day will automatically be the very next ordinary business day.

I declare that the contents of the form are true, correct and complete. I have read the terms and conditions and I accept the contents thereof.

YES	NAME AND SURNAME:	

SIGNATURE OF APPLICANT	

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		I.D. NUMBER	
RELATIONSHIP				ADDRESS			

TITLE		NAME		SURNAME		I.D. NUMBER	
RELATIONSHIP				ADDRESS			

Not applicable for Primary Care 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.

I declare that the contents of the form are true, correct and complete. I have read the terms and conditions and I accept the contents thereof.

YES	NAME AND SURNAME:	

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.

USE OF PERSONAL INFORMATION DECLARATION

I hereby consent to Unity Health processing my personal information, including but not limited to, the administrative functions listed below.

- Processing this application;
- Processing of future instructions submitted;
- Communications with me in relation to any matters in relation to my policy.

I consent to Unity Health disclosing and transferring my personal information to any contracted third party for the purposes of collecting premiums, claim assessments and statutory reporting in connection with this contract.

I acknowledge I have the right to:

- Object to the processing of my personal information on reasonable grounds unless legislation allows for such processing, in the manner prescribed by the POPI Act;
- lodge a complaint with the Information Regulator;
- request from Unity Health details of any of my personal information Unity Health holds on my behalf and details of how my personal information has been processed.

Unity Health will use its best endeavors to ensure your personal information is reliable, however it remains your responsibility to advise Unity Health of any changes to your personal information in a timely manner. The information supplied to Unity Health must be complete, correct and up to date.

I understand why my personal information is required and the purpose it will be used and I, hereby, give Unity Health consent to process my personal information as provided above.

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 2-month waiting period for all treatment received except for inpatient hospital treatment or outpatient 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 Assistance Programme (AP).
f) 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 my spouse, eligible adult and child 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	

YES I declare that the contents of the form are true, correct and complete. I have read the terms and conditions and I accept the contents thereof.

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