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

#StayHealthy
Unity Health Call Centre: 0861 366 006

ADDITION OF DEPENDANT FORM

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

2021 APPLICATION FORM

BROKER DETAILS

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

PERSONAL PARTICULARS

MEMBER DETAILS

MEMBER NUMBER							
COMPANY NAME (if applicable)							
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

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

DEPENDANTS

*Attach clear copies of identity documents and birth certificates for children.

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

Note: For a spouse dependant kindly attach a copy of the marriage certificate.
Where applicable: For handicapped children, please submit a physician report to confirm disability as well as proof of financial dependency. Extended family are excluded from cover.

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				

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
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Fax Number (011) 706 5568
E-mail Address: membership@unityhealth.co.za