



2025 OPTION CHANGE 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 2025

| PRIMARY CARE -VAT incl. | PLAN C | | PLAN C Pre-auth Waiver | R59 | HOSPITAL CARE -VAT incl. | | | | HOSPITAL CARE PLUS -VAT incl. | | | | | |
|---|--------|--|------------------------------|-----|---|--------|--|------|----------------------------------|--|---|-----|--|--|
| | PLAN C | | | | PLAN B | PLAN C | | | | | | | | |
| PRINCIPAL | R435 | | | | PRINCIPAL | R165 | | R195 | | | PRINCIPAL | R90 | | |
| ADULT | R345 | | | | ADULT | R100 | | R119 | | | ADULT | R90 | | |
| CHILD | R139 | | | | CHILD | R46 | | R56 | | | CHILD | R30 | | |
| ADDITIONAL PREMIUM PER PERSON *ENTRY AGE 56 OR OLDER | R221 | | | | ADDITIONAL PREMIUM PER PERSON *ENTRY AGE 56 OR OLDER | R46 | | R56 | | | ADDITIONAL PREMIUM PER PERSON *ENTRY AGE 56 OR OLDER | R30 | | |

*The Hospital Care Plus product can only be taken with Hospital Care Plan C.

MEMBER DETAILS

| | | | | | |
|------------------------------|-----|---------|----|--|--|
| MEMBER NUMBER | | | | | |
| COMPANY NAME (if applicable) | | | | | |
| TITLE | | SURNAME | | | |
| FIRST NAMES | | | | | |
| I.D./PASSPORT NUMBER | | | | | |
| FACE TO FACE | YES | | NO | | |

EFFECTIVE DATE (date of option change)

DD/MM/YYYY

DISCLOSURES

Unity Health hereby confirms:

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

USE OF PERSONAL INFORMATION DECLARATION

Unity Health processes information as we set out in our privacy policy. By accepting these terms and conditions or by providing personal information to us, you agree to and permit us to use the personal information provided as set out in our privacy policy. Unity Health may change the privacy statement. The current version can be found [here](#).

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 for, and I hereby give Unity Health consent to process my personal information as provided above.

DISCLOSURES

I declare that I have not withheld any information and I accept that this request 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.

| | | | |
|---------------------------|--|------|--|
| 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 0861 366 006
 E-mail Address: membership@unityhealth.co.za



Unity Health is a division of Ambledown Financial Services (Pty) Ltd, an authorised Financial Service Provider, FSP No. 10287.



Underwritten by Bryte Insurance Company Limited a licensed insurer and an authorised FSP (17703)

*This product is not a medical scheme and the required cover (benefits and contributions) are not the same as that of a medical scheme. *Terms and Conditions Apply.