INDIVIDUAL APPLICATION FORM

2025 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 2025

PRIMARY CARE -VAT incl.	PLAN C		PLAN C Pre-auth Waiver	
PRINCIPAL	R435		R59	
ADULT	R345			
CHILD	R139			
ADDITIONAL PREMIUM PER PERSON *ENTRY AGE 56 OR OLDER	R221			

HOSPITAL CARE -VAT incl.	PLAN B		PLAN C	
PRINCIPAL	R165		R195	
ADULT	R100		R119	
CHILD	R46		R56	
ADDITIONAL PREMIUM PER PERSON *ENTRY AGE 56 OR OLDER	R46		R56	

HOSPITAL CARE PLUS -VAT incl.		
PRINCIPAL	R90	
ADULT	R90	
CHILD	R30	
ADDITIONAL PREMIUM PER PERSON *ENTRY AGE 56 OR OLDER	R30	

The additional premiums at entry will apply if an applicant has not had medical scheme or primary healthcare insurance coverage for 15 or more consecutive years since the age of 35. These premiums may be waived if the applicant can demonstrate otherwise in writing. The applicant must provide proof of 15 credible years of cover at the time of joining and there should be no break in cover of 3 or more months when joining. The Hospital Care Plus product can only be taken with Hospital Care Plan C. The GP pre-auth waiver and Hospital Care Plus cannot be selected separately and needs to be taken for all members on the policy

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

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CONTACT DETAILS

*At least one or more method of communication must be selected e.g. email or contact number.

PHYSICAL ADDRESS			POSTAL 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, your parents, in-laws and adult dependants 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; additional premium rates apply for parents or in-laws 56 years or older.

*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 incapacitated dependants.

FIRST NAME AND SURNAME	RELATIONSHIP	ID/PASSPORT NUMBER	GENDER	DATE OF BIRTH
				DD/MM/YYYY
				DD/MM/YYYY
				DD/MM/YYYY
				DD/MM/YYYY

ARE YOU OR ANY OF YOUR DEPENDANTS CURRENTLY PREGNANT?	YES	NO

CURRENT MEDICAL PRACTITIONER DETAILS

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

DOCTOR'S INITIALS & SURNAME		
TELEPHONE NUMBER	AREA CODE	

DEBIT ORDER DETAILS

ACCOUNT HOLDER'S NAME		BANK / BUILDING SOCIETY		
ACCOUNT NUMBER		BRANCH		
BRANCH CODE		ACCOUNT TYPE		CURRENT
ACCOUNT HOLDER SIGNATURE				TRANSMISSION
				SAVINGS

PLEASE SELECT PREFERRED DEBIT ORDER COLLECTION DATE			
1ST	15TH	25TH	31ST

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

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 the above 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. Please refer to your policy documentation for full terms and conditions.

Nomination by Principal Member

TITLE		NAME		SURNAME		I.D. NUMBER	
RELATIONSHIP			ADDRESS				
CONTACT			EMAIL				

Nomination by Spouse

TITLE		NAME		SURNAME		I.D. NUMBER	
RELATIONSHIP			ADDRESS				
CONTACT			EMAIL				

*Not applicable for Primary Care standalone plan options.

Nominate a beneficiary to whom the benefit amount under your HOSPITAL CARE PLUS DAILY CASH 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. Please refer to your policy documentation for full terms and conditions.

Nomination by Principal Member

TITLE		NAME		SURNAME		I.D. NUMBER	
RELATIONSHIP			ADDRESS				
CONTACT			EMAIL				

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As the main applicant, I understand that the beneficiary nominated will receive proceeds from the benefit payable under the ACCIDENTAL DEATH BENEFIT and/or HOSPITAL CARE PLUS DAILY CASH BENEFIT, subject to the terms and conditions of the policy and/or limitations imposed by law at the time of my claimable event.

I also understand that:

- I may nominate a beneficiary of my choice;
- My nominated beneficiary cannot be located or passes away prior to the claimable event, the benefit amount(s) payable to my nominated beneficiary will be paid to my estate;
- If at the time of payment my 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 Unity Health is authorised to pay under the relevant law;
- I may amend my nomination at any stage, however, nominations are not effective until confirmed in writing by the Insurer; and
- The benefit amount(s) payable to my 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

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.

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.

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

a) No benefits will be payable during a general two (2) month waiting period for all treatment received except for inpatient hospital treatment or outpatient casualty treatment for members who have added the GP pre-auth waiver. Members who have not added the GP pre-auth waiver will have a general (1) month waiting period.
b) No benefits will be payable during a twelve (12) month waiting period for all chronic medication and optometry benefits.
c) No benefits will be payable during a nine (9) month waiting period for all pre-birth maternity benefits.
d) No benefits will be payable during a twelve (12) month waiting period for all childbirth benefits.
e) Not all my dependants are automatically covered under this policy, only my adult dependents and eligible children are covered as per the policy definitions.
f) Waiting periods do not apply to our Emergency and Accident Benefits and Assistance Programme (AP).
g) By signing this application form, I acknowledge and accept that my policy will be subject to waiting periods for specific medical events.
h) If I have not selected the GP pre-authorisation waiver on Primary Care C plan, I will be required to obtain authorisation prior to each network GP visit.

I, the undersigned applicant:

a) Acknowledge that it is my responsibility to ensure that claims are submitted within the four (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 thirty one (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, a policy is 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: 0861 366 006
E-mail Address: membership@unityhealth.co.za