



Universal
Cover | Gap

Stonebridge Trading 37 (Pty) Ltd, trading as Universal Cover
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Sunninghill Park, Sandton, 2191
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HEALTH INSURANCE COVER APPLICATION FORM

Stonebridge Trading 37 (Pty) Ltd, trading as Universal Cover, FSP No. 43274

Underwritten by Hollard Group Risk (HGR), a division of The Hollard Insurance Company Limited, Reg. No. 1952/003004/06, FSP No: 17698 (The Insurer)

Administered by Ambledown Risk and Underwriting Managers (Proprietary) Limited, Reg. No. 2004/006271/07, FSP No. 10287

A POLICY HOLDER DETAILS

Applicant (Must be the principal member of a medical aid scheme)

Surname: First name(s):

Title: ID no.: Date of birth: ^D^D^M^M^Y^Y^Y^Y

Physical address: Postal address:

Postal code: Postal code:

Telephone no.: Home: Work: Cell:

E-mail: Fax:

Name of employer:

Date employed:

Name of medical aid scheme: Plan option:

Date joined: Medical aid no.:

B DEPENDANTS DETAILS (IF ADDITIONAL SPACE IS REQUIRED GIVE DETAILS ON SEPARATE SHEET)

	First name (and surname if different)	ID/Passport	Date of birth	Relationship
1.				
2.				
3.				
4.				
5.				

C AGE OF ENTRY IS 18 - 65 (TICK THE APPLICABLE BOX)

All applications should be received 10 working days prior to the selected inception date

Option Selected: Gap cover - R110 per month (Individuals) Gap Plus cover - R130 per month (Individuals)

Date of inception: ^D^D^M^M^Y^Y^Y^Y Debit order will be deducted the 1st day of every month ^D^D^M^M^Y^Y^Y^Y 0 1

Discounts for groups on compulsory participation quoted separately.

D OPTION CHANGE (IF APPLICABLE)

Current policy number: Date of Option change: ^D^D^M^M^Y^Y^Y^Y

Change from: GAP GAP PLUS to GAP GAP PLUS

E MEDICAL QUESTIONNAIRE - UNDERWRITING MAY BE APPLICABLE

1. Do you or any of your dependants suffer from any chronic or recurring illness or any other serious ailment? Y/N

If "YES" please specify:

2. Have you or any of your dependants received treatment or advice from a medical practitioner in the last 12 months? Y/N

If "YES" please specify:

Name of family's general medical practitioner: Contact no.:

3. Have you or any of your dependants been hospitalised during the preceding 12 months? Y/N

Name	Date hospitalised	Reason for hospitalisation

4. Do you or any of your dependants expect to be hospitalised during the next 12 months? Y/N

If "YES" to the above please specify the condition for which hospitalisation is necessary:

Name	Expected date of hospitalisation	Reason for hospitalisation

5. Are you or any of your dependants currently pregnant? Y/N

F DEBIT ORDER DETAILS (PLEASE NOTE THAT PREMIUMS ARE COLLECTED IN ADVANCE)

Account holder name: Bank:

Account number: Branch name:

Branch code: Account type: Current Transmission Savings

I/We hereby authorise the Insurer and/or its Agents to debit my/our banking account (wherever it may be) with the amount necessary for any contribution and changes in relation to this agreement, as from inception date, **monthly in advance**. Such authorisation shall remain in force and effect until cancelled by myself, in writing with one calendar month's notice. I further authorise the Insurer and/or its Agents 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.

SIGNATURE OF ACCOUNT HOLDER

Date:

D	D	M	M	Y	Y	Y	Y

G 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 myself 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:

- No benefits will be payable during a general 3-month waiting period for all treatment received unless the treatment was required as a result of an accident (external violent physical means)
- No benefits will be payable for treatment during the first 12 months of the policy if treatment or advice was received 12 months prior to inception of the policy that related to the subsequent treatment
- Childbirth is excluded during the first 12 months of the policy

I confirm that although I have completed this application form, it does not constitute an insurance contract until a membership number is assigned, policy issued and premium is successfully paid.

SIGNATURE OF APPLICANT

NAME OF APPLICANT

Date:

D	D	M	M	Y	Y	Y	Y

Please return to:

Stonebridge Trading 37 (Pty) Ltd, trading as Universal Cover, FSP number: 43274

PO Box 1411, RIVONIA, 2128

Tel number: +27 11 208 1000 (Universal)

Fax number: 086 532 6595

E-mail address: cover@universal.co.za

For Claims queries please phone Ambledown Risk and Underwriting Managers on 0861 262 533.

H BROKER DETAILS

Brokerage name:

Representative name:

FSP no.:

Vat no.:

Broker code:

Broker accreditation no.:

Broker e-mail address:

Unique identifier:

Consultant name:

(if necessary)

Consultant code:

Broker contact no.: