SIRAGO UNDERWRITING MANAGERS (PTY) LTD
REG NO: 1993/001387/07 | VAT NO: 4950188724

PHYSICAL ADDRESS: Midrand Business Park, Building 3,
563 Old Pretoria Main Road, Midrand, 1685
POSTAL ADDRESS: PO Box 1115,
Bromhof, 2154
TEL NO: 010 599 1163 | EMAIL: applications@sirago.co.za

Compliance Officer: Moonstone Compliance (Pty) Ltd
Financial Services Provider No: 4710

APPLICATION FORM

Please complete this form in black ink and CAPITAL letters

Medical Scheme membership no.:

Medical Scheme Option:

Is this application part of a group? (Place a clear X inside the box) yes ☐ no ☐

Name of Medical Scheme:

Required Inception Date:

If YES, group name:

PRINCIPAL INSURED DETAILS

Name and Surname:

ID number \ Passport: Mr ☐ Mrs ☐ Miss ☐ Dr ☐ Other

Date of birth: Email Address:

Contact details: Home no.: Work no.:

Fax no.: Cell no.:

Postal address: Code:

Residential address: Code:

SPOUSE DETAILS

Name and Surname:

ID number \ Passport: Mr ☐ Mrs ☐ Miss ☐ Dr ☐ Other

Date of birth : Email Address:

Contact details: Home no.: Work no.:

Fax no.: Cell no.:

Medical Scheme membership no.: Name of Medical Scheme:

Medical Scheme Option:

DEPENDANTS

Dependants are:
- Spouse and/or dependant children up to the age of 21 years
- Adopted/foster child (please attach documentary proof)
- Students up to the age of 27 (please prove full time enrolment)

Name and Surname:

ID number \ Passport: Male ☐ Female ☐

Date of birth : Relationship to applicant:

Name and Surname:

ID number \ Passport: Male ☐ Female ☐

Date of birth : Relationship to applicant:

Name and Surname:

ID number \ Passport: Male ☐ Female ☐

Date of birth : Relationship to applicant:

Name and Surname:

ID number \ Passport: Male ☐ Female ☐

Date of birth : Relationship to applicant:

SPECIFIC HEALTH QUESTIONS

The following questions are related to the policyholder and or any beneficiaries or dependents on the policy.

		YES	NO
1	Have you been admitted to hospital in the last 4 months?		
2	Are expecting a hospital admission or aware of any conditions or Illness that would require treatment in the next 12 months?		
3	Are you or any of your dependents currently pregnant?		
4	Have you taken or are currently taking chronic medication in the past 24 months?		
5	Have you been on gap cover before and / or have had a gap claim? If yes, who was the provider?		

If you answered "Yes" to any of the questions, please provide details below.

Question no.	Applicant/dependents	Full details (including details of disorder, date diagnosed, nature, duration of treatment and details of consulting doctor)

DEBIT ORDER DETAILS

Name of account holder:

Account no.:

Bank: ☐ Standard Bank ☐ ABSA ☐ FNB ☐ Nedbank

Other

Account type: Cheque ☐ Savings ☐ Transmission ☐ Other

Debit order day: 1st ☐ 7th ☐ 15th ☐ 25th ☐

I hereby instruct and authorise you to draw against my bank account the amount necessary for payment of my monthly premium due in respect of the above mentioned insurance, without prejudice to the rights of Sirago Underwriting Managers (Pty) Ltd. I further authorise you to increase the amount in the terms of the policy from time to time and authorise my bank to effect payment.

Signature of account holder

Date:

IMPORTANT INFORMATION

- Please make sure FULL details are given for questions answered YES.
- Application forms could be underwritten and conditions may be excluded for longer than 10 months.
- The onus lies on the insured to make sure that premiums are paid on a monthly basis. Reference on bank statements read: MD SIRAGO_MED
- Effective from 1 January 2018.
- In the event of a bereavement related claim the Insurer will pay the benefit into the principal or nominated beneficiaries account. The beneficiary must be noted on the policy prior to any loss. We will require the full name, surname and ID to note the beneficiary. At the time of a claim we will require the beneficiary's ID and proof of bank. Should there be no beneficiary noted on the policy prior to the loss or should we be unable to confirm the identity of the beneficiary, payment will always be made into the principal policyholders account.

DECLARATION BY APPLICANT

I, the undersigned, hereby declare:

1. That to the best of my knowledge and belief the information provided in connection with this application whether in my own handwriting or not, is true and I have not withheld any material facts which are known to me. (A material fact is likely to influence the assessment of this application by Sirago Underwriting Managers (Pty) Ltd. If you are in any doubt as to whether a fact is material or not, you should disclose it.)
2. That I understand that any relevant material fact omitted in this proposal form may lead to Sirago Underwriting Managers (Pty) Ltd not meeting claims, should the omitted fact have been of such importance that the risk may not have been accepted in the first instance, in terms of the policy. This may lead to the cancellation of this policy or rejection of claims without refund of premiums.
3. That I understand that this is an Accident and Health policy with stated benefits in terms of the Short-term Insurance Act 53 of 1998 and not a Medical Scheme product.
4. The sharing of claims information and underwriting information by Insurers is essential to enable the insurance industry to underwrite policies, assess risks fairly, reduce the incidence of fraudulent claims and protect the public interest in terms of limiting excessive premium increases. You hereby waive any right to privacy of any insurance information provided by you or on your behalf, in respect of any insurance policy or claims you lodge. You also consent to this information being disclosed to any other insurance company and/or verified against other legitimate source or a database.
5. I specifically consent to Sirago Underwriting Managers (Pty) Ltd contacting my current Medical Scheme and/or medical practitioner to verify any medical details as provided in my application form. I further consent to such information being disclosed to Sirago Underwriting Managers (Pty) Ltd for purpose of verifying the disclose as provided on my application form.
6. That I will advise Sirago Underwriting Managers (Pty) Ltd of any changes to my health state between the point of application and actual inception of my policy.
7. As part of our claims validation process we used the services of a contracted third party in order to authenticate medical scheme membership, plan option type, relevant beneficiaries and agreed medical scheme option tariffs amongst other relevant information to validate the claim.
8. We reserve the right to call for additional information of a clinical nature. In the event that Sirago requests a PMA (Post Medical Assessment) from your doctor as part of the claims assessing and authentication process
9. I authorise Sirago Underwriting Managers to negotiate with service providers on my behalf for my medical claims and or bill and pay the provider direct.
10. By agreeing to the terms of this consent form, I expressly consent to the processing of my information for marketing purposes and know & understand that by agreeing to same that I may on occasion, receive marketing materials in the form of sms and / or emails and the like from Sirago Underwriting Managers (Pty) Ltd.

Signature of policy holder

Date:

Spouse (If married in community of property)

Date:

INTERMEDIARY DETAILS

Intermediary Group:

Intermediary Code:

Sales Person:

Sales Code:

Tel no.:

Cell no.:

OPTION SELECTION

GAP COVER:	☐	INDIVIDUAL	☐	64 Under	☐	65+	☐	FAMILY ☐
PLUS GAP COVER:	☐	INDIVIDUAL	☐	64 Under	☐	65+	☐	FAMILY ☐
ULTIMATE GAP COVER:	☐	INDIVIDUAL	☐	64 Under	☐	65+	☐	FAMILY ☐
EXACT COVER:	☐	INDIVIDUAL	☐	64 Under	☐	65+	☐	FAMILY ☐
GOV GAP COVER	☐	INDIVIDUAL	☐	FAMILY	☐			

OPTION BY APPLICANT:

Premium per month	R
*Intermediary Fee (Optional)	R
TOTAL PREMIUM PAYABLE	R

* This Intermediary fee is optional and is paid to the intermediary on top of the statutory commission on your approval

Please return the completed form to applications@sirago.co.za or by fax to 086 508 2292. | In what Language would you like your policy documents in? English ☐ Afrikaans ☐

NOMINATED BENEFICIARY (related to death benefits and/or premium waivers)

Name and Surname:

ID number / Passport: Mr ☐ Mrs ☐ Miss ☐ Dr ☐ Other

Date of birth :

Email Address:

Contact details: Home no.: Work no.:

Fax no.: Cell no.:

Relationship to Main member:

BANKING DETAILS FOR REFUNDS

SHOULD YOU NOT COMEPLETE THIS SECTION IT WILL RESULT IN US USING YOUR DEBIT ORDER DETAILS

Name of account holder:

Account no.:

Bank: ☐ Standard Bank ☐ ABSA ☐ FNB ☐ Nedbank

Other

Account type: Cheque ☐ Savings ☐ Transmission ☐ Other

Signature of account holder Date:

NOTES / ADDITIONAL INFORMATION