

TRANSFER OF COVER APPLICATION FORM 2020

Please complete this form in black ink and CAPITAL letters

Medical Scheme membership no.:	<input type="text"/>	Name of Medical Scheme:	<input type="text"/>
Medical Scheme Option:	<input type="text"/>	If YES, group name:	<input type="text"/>
Is this application part of a group? (Place a clear X inside the box)	yes <input type="checkbox"/> no <input type="checkbox"/>	Date Joined:	<input type="text"/>
Please attach Medical Scheme Membership Certificate		Date Cancelled:	<input type="text"/>

PRINCIPAL INSURED DETAILS

Name and Surname:	<input type="text"/>		
ID number \ Passport:	<input type="text"/>	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Dr <input type="checkbox"/> Other <input type="text"/>	<input type="text"/>
Date of birth:	<input type="text"/>	Email Address:	<input type="text"/>
Contact details:	Home no.: <input type="text"/>	Work no.:	<input type="text"/>
	Fax no.: <input type="text"/>	Cell no.:	<input type="text"/>
Postal address:	<input type="text"/>		
	<input type="text"/>	Code:	<input type="text"/>
Residential address:	<input type="text"/>		
	<input type="text"/>	Code:	<input type="text"/>

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)
 - Provide studency proof or medical certificate if you are on the same medical aid

Name and Surname:	<input type="text"/>		
ID number \ Passport:	<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="text"/>
Date of birth :	<input type="text"/>	Relationship to applicant:	<input type="text"/>

Name and Surname:	<input type="text"/>		
ID number \ Passport:	<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="text"/>
Date of birth :	<input type="text"/>	Relationship to applicant:	<input type="text"/>

Name and Surname:	<input type="text"/>		
ID number \ Passport:	<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="text"/>
Date of birth :	<input type="text"/>	Relationship to applicant:	<input type="text"/>

Name and Surname:	<input type="text"/>		
ID number \ Passport:	<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="text"/>
Date of birth :	<input type="text"/>	Relationship to applicant:	<input type="text"/>

DEBIT ORDER DETAILS

Name of account holder:	<input type="text"/>		
Account no.:	<input type="text"/>		
Bank:	<input type="checkbox"/> Standard Bank	Account type:	<input type="checkbox"/> Cheque
	<input type="checkbox"/> ABSA		<input type="checkbox"/> Savings
	<input type="checkbox"/> FNB		<input type="checkbox"/> Transmission
	<input type="checkbox"/> Nedbank		<input type="text"/>
	<input type="checkbox"/> Capitec		Other
	<input type="text"/>		
Debit order day:	<input type="checkbox"/> 1st	<input type="checkbox"/> 7th	<input type="checkbox"/> 15th
	<input type="checkbox"/> 25th	<input type="checkbox"/> 31st	Other <input type="text"/>

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 2020.
- 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.

OPTION SELECTION

<input type="checkbox"/> ULTIMATE GAP COVER	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> 0 - 54	<input type="checkbox"/> 55 - 64	<input type="checkbox"/> 65+	<input type="checkbox"/> FAMILY
<input type="checkbox"/> PLUS GAP COVER	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> 0 - 54	<input type="checkbox"/> 55 - 64	<input type="checkbox"/> 65+	<input type="checkbox"/> FAMILY
<input type="checkbox"/> GAP ASSIST COVER	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> 0 - 54	<input type="checkbox"/> 55 - 64	<input type="checkbox"/> 65+	<input type="checkbox"/> FAMILY
<input type="checkbox"/> GAP-LITE COVER	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> 0 - 54	<input type="checkbox"/> 55 - 64	<input type="checkbox"/> 65+	<input type="checkbox"/> FAMILY
<input type="checkbox"/> GOV-GAP COVER	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> FAMILY			
<input type="checkbox"/> EXACT COVER	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> 0 - 54	<input type="checkbox"/> 55 - 64	<input type="checkbox"/> 65+	<input type="checkbox"/> FAMILY
<input type="checkbox"/> EXACT WITH GAP AND CO-PAY COVER	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> 0 - 54	<input type="checkbox"/> 55 - 64	<input type="checkbox"/> 65+	<input type="checkbox"/> FAMILY

OPTION BY APPLICANT:

Premium per month

TOTAL PREMIUM PAYABLE

*Intermediary Fee (Optional)

* The Intermediary fee will only be collected subject to us receiving a signed contract between the Intermediary and Policyholder

* 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

INTERMEDIARY DETAILS

Intermediary Group:	<input type="text"/>	Intermediary Code:	<input type="text"/>
Sales Person:	<input type="text"/>	Sales Code:	<input type="text"/>
Tel no.:	<input type="text"/>	Cell no.:	<input type="text"/>

DECLARATION BY APPLICANT

I, the undersigned, hereby declare:

- 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.)
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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
- 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.
- 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:

DEBIT ORDER AUTHORITY - PRINCIPAL INSURED DETAILS

Policy Number:	<input type="text"/>					
Name and Surname:	<input type="text"/>					
ID number / Passport:	<input type="text"/>	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Miss <input type="checkbox"/>	Dr <input type="checkbox"/>	Other <input type="text"/>
Date of birth:	<input type="text"/>	Email Address: <input type="text"/>				
Contact details:	Home no.: <input type="text"/>	Work no.: <input type="text"/>				
	Fax no.: <input type="text"/>	Cell no.: <input type="text"/>				
Postal address:	<input type="text"/>					
	<input type="text"/>				Code: <input type="text"/>	
Residential address:	<input type="text"/>					
	<input type="text"/>				Code: <input type="text"/>	

I/We hereby confirm acceptance of the below mentioned insurance policy, and authorise Sirago Underwriting Managers (Pty) Ltd to issue and deliver payment instructions to their Banker, to draw on my/our account at the under mentioned institution in any manner agreed on between Sirago Underwriting Managers (Pty) Ltd and such institution, the amount of the premium payable on condition that the sum of such payment instructions will never exceed my/our obligations as agreed to in the Agreement and commencing on and request the aforesaid institution to debit my/our account with all debits drawn against it by Sirago Underwriting Managers (Pty) Ltd.

All such withdrawals from my/our bank account by Sirago Underwriting Managers (Pty) Ltd shall be treated as though they had been signed by me/us personally.

I/We understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African Banks. I also understand the details of each withdrawal will be printed on my Bank statement bearing a specific reference number which will reflect Sirago and your policy number as confirmed in the policy documents.

This authority may be cancelled by me/us by giving Sirago Underwriting Managers (Pty) Ltd thirty days' notice in writing, however I/we understand that I/we shall not be entitled to any refund of amounts which Sirago Underwriting Managers (Pty) Ltd has withdrawn while this authority was in force, if such amounts were legally owing to Sirago Underwriting Managers (Pty) Ltd.

BROKER FEE AGREEMENT

I (Full Name) with ID number
acknowledge that my broker / advisor is (Company Name)
with FSP number is authorised to request Sirago Underwriting Managers with FSP number 4710 to collect
an additional broker fee of R with my monthly premium on this policy for the services listed below.

List of Services

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

I agree to the payment of these fees until such time as the policy is cancelled and/or I revoke the above authority.

I am aware that the fees are in addition to any premium payable and commission that the broker earns and are for the provision of the services above.

Signature

Signature

Brokerage

Client

Date

Date