Sanlam

Public Servants Association (PSA)

UNDERWRITTEN BY CENTRIQ INSURANCE

Employee Application Form

Important note

Please complete and sign this form and return to your Broker who will submit to our administrators Kaelo on your behalf. Kaelo will only accept applications received by a broker. Applications received after the 15th of the current month will only be activated on the 1st of the following month. Dedicated Sanlam Gap email address: sanlamapps@kaelo.co.za.

A. Applicant Details

- ☐ I do not currently have Gap Cover
- ☐ I am currently a Sanlam Gap Policyholder but wish to transfer my cover through my employer
- ☐ I currently have Gap Cover with another provider but I wish to transfer my cover to Sanlam Gap through my employer

If you have Gap Cover with another provider but wish to transfer to Sanlam Gap, please submit your proof of cover. Waiting periods may apply.

Plan Option:

- ☐ Sanlam Gap Comprehensive
- ☐ Sanlam Gap Comprehensive with added Mediclinic Extender option

Cover Start Date: _____

First Name: _____

Surname: _____

ID Number (compulsory field): _____ Cellphone: _____

Gender: _____ Date of Birth: _____

Email: _____

Address: _____

_____

Employer Details:

Employer Name: Public Servants Association

Employer Branch: _____ Employee Number: _____

Employment Date: _____

B. Insured Party Details:

Should you have dependants, please provide us with a copy of your Medical Scheme membership certificate. Cover will apply to you, your spouse and your children up to the maximum age of 27. Children will only be covered until they reach the age of 27. If any of your dependants are on another Medical Scheme, please provide a copy of their membership certificate. Financially dependant parents excluded.

First Name:	Surname:	Relationship:	Date of birth/ ID number:	Inception Date

C. Waiting Periods

A 3 month General Waiting Period and 12 month Condition Specific Waiting Period will be applied to voluntary membership within a corporate group. No waiting periods will apply to compulsory corporate groups. If you are transferring your cover from another Gap Cover provider with similar benefits, only the balance of the applicable waiting periods will apply.

D. Debit Order Details

(If your employer is deducting premiums from payroll, please complete section E below)

If you are responsible for the payment of your Premium as part of an employer group, please complete the below section. If your employer is paying the Premium on your behalf, please do not complete this section. The reference reflected on your bank statement is Sanlam Gap and your Policy number.

Account Name: _____ Account Number: _____

Branch Name: _____ Bank Name: _____

Account Type: _____ Bank Code: _____

Premium: _____

Name and Surname of Premium Payer: _____

Debit Order date: Please specify the date you would like for your debit order to take place each month.

☐ 1st ☐ 7th ☒ 15th ☐ 25th ☐ last working day

I, the Premium payer, hereby authorise Centriq to draw against the above bank account all amounts due to Centriq in terms of this insurance cover. Should the relevant Premiums be adjusted, I hereby confirm that the adjusted amount may be drawn from the above account subject to the notice period outlined in the Policy. This request is to remain in force unless cancelled by one month's written notice.

Premium Payer Signature: _____

Debit order deductions or Payment Terms are in Arrears or Advance
(This is dependent on the strike date chosen. 1st, 7th, 15th is collected in advance and 25th, 31st is collected in arrears).

E. Employer deduction from payroll

Premium to be collected monthly in arrears via a company payroll deduction:

R **N/A (R204 via Debit order deduction)**

F. Broker Details

Broker House Name: **Optivest Health Services** Broker Code: **S486283**

Broker Name: **corpnbsupport@optivest.co.za**

G. Medical Scheme Cover Detail

Medical Scheme: _____ Option: _____

Start date of medical scheme membership: D D M M Y Y Y Y

Membership number: _____

Please note *that cover can only be granted if you are a member of a medical aid scheme and not health insurance.*
Health insurance policies are not medical aid schemes which are goverened by the Medical Schemes Act (No. 131 of 1988)

H. Declaration

I, _____ (full name) hereby declare that this application form, whether in my handwriting or not, is accurate and complete and forms the basis of the contract of insurance between the Underwriter and myself. I hereby apply for the insurance product/s and agree to abide by its Policy rules and/or those of its Underwriter and any amendments thereto which may be made from time to time. I confirm that all the information provided herein is complete and true and that I have not concealed any relevant or pertinent information that may affect the evaluation of risk considered under this Policy of cover. I understand that the provision of any false, misleading or missing information could result in my application being rejected or my Policy being cancelled or claims being rejected. Should this occur, I agree to refund all Benefit payments that I have received in relation to this Policy of insurance. I consent to Centriq Insurance, and its operators, processing, and further processing, my personal information in accordance with the Protection of Personal Information Act, for the purposes of concluding, and performing in terms of, this insurance contract.

I hereby provide irrevocable authority for Kaelo, our administrator and its Underwriter to obtain any of my or my beneficiaries' medical history from any Medical Service Provider, Medical Scheme, insurance company or healthcare broker for the purposes of assessing this application for insurance as well as the underwriting of any future risk or the assessment of any claim that relates to this insurance cover. Premiums due to Centriq are payable monthly. Premiums that are in arrears will result in my Policy being suspended or possibly terminated. In the event that any Policy Benefit becomes payable subsequent to or as a result of my death, I hereby provide an irrevocable authority for such Benefits to be paid directly to my surviving Spouse or failing such circumstance to the nominated guardians or trustees responsible for the future care of my minor Children or failing either of the preceding events to my estate. Where applicable, I hereby authorise Centriq to draw against the above bank account all amounts due to Centriq in terms of this insurance cover. Should the relevant Premiums be adjusted by the Underwriters, I hereby confirm that the adjusted amount may be drawn from the above account subject to the notice period outline in the Policy. This request is to remain in force unless cancelled by one month's written notice.

Full Name: Signature:

Date: D D M M Y Y Y Y

POPIA Consent

☐ I consent to Centriq Insurance, and its operators, processing, and further processing, my personal information in accordance with the Protection of Personal Information Act, for the purposes of concluding, and performing in terms of, this insurance contract.

For further information please read our Privacy Notice, which can be found on www.centriq.co.za

Once signed, this application form should be returned to your servicing Financial planner.

This is not a Medical Scheme and the cover is not the same as that of a Medical Scheme.
This Policy is not a substitute for Medical Scheme membership.

T 0861 111 167
E **sanlamapps@kaelo.co.za**