

## APPLICATION FORM

Sirago Policy Inception Date:	<input type="text"/>	Name of Medical Scheme:	<input type="text"/>
Medical Scheme membership no:	<input type="text"/>	Medical Scheme option:	<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"/> If YES, group name: <input type="text"/>			
Previous Gap Cover:	<input type="text"/>		
Date Joined:	<input type="text"/>	Date Terminated:	<input type="text"/>

### 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"/>

### POLICYHOLDER 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"/>	
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 dependent children up to the age of 21 years.
  - Students up to the age of 27, if you are on a different medical scheme. Provide proof of enrolment for full time studies or medical scheme certificate.
  - For families who belong to a single medical scheme and option, we cover beneficiaries of all ages as listed by the scheme. Provide your medical scheme Certificate of Membership (COM).
  - For families who belong to two medical schemes, we cover two adults and all child dependants. Provide both COMs.

#### ADULT DEPENDANT/SPOUSE:

Name and Surname:	<input type="text"/>		
ID / Passport no:	<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Relationship to applicant: <input type="text"/>
Date of birth:	<input type="text"/>	Medical Scheme Membership No:	<input type="text"/>
Name of Medical Scheme:	<input type="text"/>	Medical Scheme Option:	<input type="text"/>

#### OTHER DEPENDANTS:

Name and Surname:	<input type="text"/>		
ID / Passport no:	<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Relationship to applicant: <input type="text"/>
Date of birth:	<input type="text"/>	Relationship to applicant:	<input type="text"/>
Name and Surname:	<input type="text"/>		
ID / Passport no:	<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Relationship to applicant: <input type="text"/>
Date of birth:	<input type="text"/>	Relationship to applicant:	<input type="text"/>
Name and Surname:	<input type="text"/>		
ID / Passport no:	<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Relationship to applicant: <input type="text"/>
Date of birth:	<input type="text"/>	Relationship to applicant:	<input type="text"/>
Name and Surname:	<input type="text"/>		
ID / Passport no:	<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Relationship to applicant: <input type="text"/>
Date of birth:	<input type="text"/>	Relationship to applicant:	<input type="text"/>

I agree to the above sections of the application form ☐

(Refer to the death benefits and/ or premium waivers)

Name and Surname:

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

Contact details: Cell no.:  Email Address:

Relationship to Main member:

## SPECIFIC HEALTH QUESTIONS

The following questions relate to you, your beneficiaries and dependants covered under this policy.

		Yes	No
1	Have you been admitted to hospital in the last 4 months?	<input type="checkbox"/>	<input type="checkbox"/>
2	Are you expecting a hospital admission or aware of any conditions or illness that would require treatment in the next 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
3	Are you or any of your dependants currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
4	Have you taken chronic medication in the past 24 months, or are currently taking chronic medication?	<input type="checkbox"/>	<input type="checkbox"/>
5	Have you been on gap cover before and/ or have had a gap claim? If yes, who was the provider?	<input type="checkbox"/>	<input type="checkbox"/>

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

Question no:	Applicant/ Dependants	Disorder	Medication	Date Diagnosed

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. 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.
- 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.
- 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 information 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 the claims validation process Sirago Underwriting Managers (Pty) Ltd 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.
- Sirago Underwriting Managers (Pty) Ltd reserves the right to call for additional information of a clinical nature. In the event that Sirago requests a PMA (Post Medical Assessment) from my 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 directly.
- 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.

## IMPORTANT INFORMATION

- Please make sure FULL details are given for questions answered YES.
- Application forms may 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 [Policynumber]**
- Effective from January 2024
- In the event of a bereavement-related claim, the Insurer will pay the benefit into the policyholder 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 number 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 policyholder's account.

## OPTION SELECTION

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

Premium per month

\*Intermediary Fee (optional)

\*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.

I agree to the above sections of the application form ☐

#### Declaration and Informed Consent in terms of the Protection of Personal Information Act 4, of 2013 (POPIA)

We at GENRIC Insurance Company Limited (GENRIC) respect your right to privacy. We need to collect and process some of your personal information in terms of various Privacy and Data Management laws and are bound by the terms and provisions of the Protection of Personal Information Act, regarding the acquisition, usage, retention, transmission, and deletion of your personal information.

Your personal information collected is for the primary purpose of providing you with insurance cover and for all other activities and processes incidental to and relevant to this purpose. As this information forms the basis our assessment and terms we offer you, it must be correct, complete, and up to date.

We will always comply with all relevant regulations in dealing with your information and keep it secure and confidential at all times. Your information shall be kept confidential: however, we shall disclose it to certain third parties as required and other insurers for the specific purpose of insurance and to reduce and prevent any form of fraudulent activity. Should you decide to cancel this insurance contract, you further consent to GENRIC, in retaining the information in line with the legally permitted retention period, for statistical and reporting purposes only.

Should you decide not to accept the proposal, the information collected will be de-identified and only used for statistical and research purposes.

I hereby voluntarily consent to GENRIC processing my Personal Information.

I understand the purposes for which my Personal Information is required and for which it will be used.

I give GENRIC permission to process my Personal Information as provided above.

Our Privacy Notice and POPIA Policy provides the details of how we deal with the personal information of our clients, and it is available on our website at the following address:

<https://genric.co.za>.

Signature of policyholder

Date:

#### DEBIT ORDER DETAILS AND DEBIT AUTHORITY CONSENT

Name of account holder:  
(as appears on bank card)

Abbreviated name as registered  
with the bank

Account no.:

Bank:

<input type="checkbox"/> Standard Bank	<input type="checkbox"/> Nedbank
<input type="checkbox"/> Absa	<input type="checkbox"/> Capitec
<input type="checkbox"/> FNB	<input type="text"/> Other

Account type:

<input type="checkbox"/> Cheque
<input type="checkbox"/> Savings
<input type="checkbox"/> Transmission

Amount to be deducted: R

Branch name:

Other

Branch code:

Agreement Reference Number:

Debit order day:

<input type="checkbox"/> 1st	<input type="checkbox"/> 5th	<input type="checkbox"/> 7th	<input type="checkbox"/> 10th	<input type="checkbox"/> 15th	<input type="checkbox"/> 20th	<input type="checkbox"/> 25th	<input type="checkbox"/> 31st
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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. 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 certify that the above bank details are correct. If these banking details have not been provided accurately, or if the details change at any time in the future and I/we fail to notify such changes or if payments are not made in accordance with the Debit Order Instruction, the responsibility of payment will rest with me/us. I acknowledge that any fees and charges levied by the bank on account of the debit order or any debit order payments which may be rejected for any reason whatsoever will be for my account. 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 my 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. I/We agree that although this authority and mandate may be cancelled by me/us, such cancellation will not cancel the Agreement. I/We also understand that I/We cannot reclaim amounts, which have been withdrawn from my/our account (paid) in terms of this authority and mandate if such amounts were legally owing to you. I/We acknowledge that this authority may be ceded or assigned to a third party if the Agreement is also ceded or assigned to that third party.

Signature of policyholder

Date:

#### STANDARD TERMS AND CONDITIONS

Scan the QR Code below for the full list of Policy Specific Exclusions and the Standard Short-term Policy Exclusions.



SCAN ME

I agree to the above sections of the application form ☐

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

  
  
  
  
  
  
  


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

## WAITING PERIODS & TRANSFER OF COVER

### WAITING PERIODS

#### GENERAL WAITING PERIODS

- A 3-month waiting period is applicable on any newly inception policies and/ or additional dependants to the current policy, except in the event of an accident;
- In the event that the policyholder has held a sirago policy for 12 months without a break in a cover and wants to upgrade to a higher option, all additional benefits will be subject to a 3-month waiting period.
- If the policyholder has held a Sirago policy for less than 12 months and intends to upgrade to a higher option, the balance of the relevant waiting periods in the higher option per benefit category are applicable;
- A 10-month waiting period on pre-existing conditions, diseases or illness.

#### POLICY SPECIFIC WAITING PERIODS APPLICABLE TO CERTAIN PROCEDURES

The following conditions are excluded within the first 6 months of inception of the policy:

- Myringotomy and grommets;
- Adenoidectomy;
- Tonsillectomy;
- Hysterectomy (except where malignancy can be proven);
- Spinal, back, neck and joint related procedures (repairs, scopes, joint replacement) except in the case of an accident. This includes treatments related to any and/ or investigations including MRI scans, CT scans and scopes.

Thereafter, benefits will be payable at a rate of:

- 50% of benefits available from month 7 to 10;
- From month 11, the policy benefits will be fully available except where there are condition-specific exclusions and when a new beneficiary joins the policy, and is subject to underwriting terms.

#### SPECIFIC WAITING PERIODS APPLICABLE TO CERTAIN BENEFIT CATEGORIES AND CERTAIN CONDITIONS AND/ OR RELEVANT OPTIONS

- 10-month waiting period for pregnancy and confinement;
- Total permanent disability and premium waivers are subject to a 6-month waiting period;
- Initial cancer diagnosis and Accidental Death is subject to a 3-month waiting period;
- A 12-month waiting period on all pre-existing cancer related treatments.

#### TRANSFER OF COVER

- If you have had a gap cover policy for a period of 12 consecutive months or more, a 3-month waiting period applies on all additional benefits;
- If you had a gap cover policy for less than 12 consecutive months, a 3-month waiting period applies for all additional benefits, plus the difference between the waiting periods of the previous gap cover policy and the waiting period on the new policy will be carried over.

I have read, understood, and agree to the terms and conditions outlined above. ☐