

SECTION A: DEPENDANTS

Dependants are:

- Spouse and/or dependant children up to the age of 18 years
- Students up to the age of 25 – please proof full time enrollment
- Adopted / foster child – please add adoption /custody order
- Disabled child – please attach document to confirm the dissability

Dependant Type	1	Spouse <input type="checkbox"/>	Child <input type="checkbox"/>
Surname	<input type="text"/>		
First Name(s) (in full)	<input type="text"/>		
Initials	<input type="text"/>	Title <input type="text"/>	Gender <input type="checkbox"/> M <input type="checkbox"/> F
ID Number	<input type="text"/>		
Date of Birth	<input type="text"/>	<input type="text"/>	Age <input type="text"/>
Relationship to Applicant	<input type="text"/>		

Dependant Type	2	Child <input type="checkbox"/>
Surname	<input type="text"/>	
First Name(s) (in full)	<input type="text"/>	
Initials	<input type="text"/>	Gender <input type="checkbox"/> M <input type="checkbox"/> F
ID Number	<input type="text"/>	
Date of Birth	<input type="text"/>	Age <input type="text"/>
Relationship to Applicant	<input type="text"/>	

Dependant Type	3	Child <input type="checkbox"/>
Surname	<input type="text"/>	
First Name(s) (in full)	<input type="text"/>	
Initials	<input type="text"/>	Gender <input type="checkbox"/> M <input type="checkbox"/> F
ID Number	<input type="text"/>	
Date of Birth	<input type="text"/>	Age <input type="text"/>
Relationship to Applicant	<input type="text"/>	

Dependant Type	4	Child <input type="checkbox"/>
Surname	<input type="text"/>	
First Name(s) (in full)	<input type="text"/>	
Initials	<input type="text"/>	Gender <input type="checkbox"/> M <input type="checkbox"/> F
ID Number	<input type="text"/>	
Date of Birth	<input type="text"/>	Age <input type="text"/>
Relationship to Applicant	<input type="text"/>	

SECTION B: GENERAL QUESTIONS

1	Have you or any insured under this policy ever been refused cover, or were offered cover on special terms or, with a premium loading or exclusions by an insurer, medical society /fund/scheme?	Yes	No
2	Do you or any insured under this policy suffer from any disease: physical, mental or dental impairment: disability or injury: which requires or required medical treatment, tests, therapy?	Yes	No
3	Are you aware of any condition of health as specified above which will need treatment in the next 12 months, or are any of the lives insured in terms of this policy pregnant?	Yes	No

SECTION C: STANDARD QUESTIONS

1	Has any close blood relative ever been diagnosed with heart disease, high blood pressure, high cholesterol, diabetes or any other hereditary disease?	Yes	No
2	Do you or any of your dependents currently receive or expect to receive treatment with any type of medication for longer than 3 months?	Yes	No
3	Are you or any of your dependents currently involved in any third party claim or WCA* claim that may include medical treatment?	Yes	No
4	Do you or any of the dependents smoke?		
5	Current weight and height: Applicant _____ kg _____ m , Spouse _____ kg _____ m		

SECTION D: SPECIFIC HEALTH QUESTIONS

Have you or any insured under this policy ever received treatment or expect to receive treatment for any of the following illnesses?			
1	Blood disorders, e.g. anaemia, bleeding disorders, haemophilia, leukaemia	Yes	No
2	Cancer, growths or tumors whether benign or malignant	Yes	No
3	Cardiovascular disorders, e.g. heart conditions, chest pain, coronary artery disease, high blood pressure, varicose veins, poor circulation	Yes	No
4	Ear, nose and throat disorders, e.g. hearing / speech impairment, ear infections, sinus problems, nasal / throat surgery	Yes	No
5	Endocrine disorders, e.g. high cholesterol, diabetes, thyroid abnormalities	Yes	No
6	Eye related disorders, e.g. glaucoma, blindness, eye surgery, retinitis pigmentosa, cataracts	Yes	No
7	Gastro-intestinal disorders e.g. recurrent indigestión, ulcers, bowel disorders, gallbladder disorders, liver disorders, etc.	Yes	No

* Workmens Compensation Act

8	Gynaecological and obstetrical disorders, e.g. ectopic pregnancy, caesarean section, fibroids, endometriosis, menstrual irregularities, abnormal pap smear and hysterectomy – the date and reason.	Yes	No
9	Musculo-skeletal disorders, e.g. arthritis, back problems, gout, and osteoporosis, joint, e.g. knee, shoulder etc.	Yes	No
10	Neurological disorders, e.g. epilepsy, muscular weakness, stroke. Brain or spinal cord disorders, chronic fatigue	Yes	No
11	Psychological disorders, e.g. anxiety, depression, stress, panic attacks, alcohol or drug dependency, attention deficit	Yes	No
12	Renal (Kidney) disorders, e.g. blood in the urine, kidney stones, recurrent infections, kidney failure	Yes	No
13	Respiratory disorders, e.g. asthma, allergic rhinitis, chronic bronchitis, emphysema, tuberculosis	Yes	No
14	Skin disorders, e.g. eczema, psoriasis, melanoma, skin cancer	Yes	No
15	State whether you or any of your dependents have received medical advice or treatment for any infectious diseases, e.g. gonorrhoea, genital herpes, syphilis, TB, Hepatitis or tested for HIV/AIDS	Yes	No
16	Male Genito-urinary system e.g. testes, prostate, abnormalities of the penis, scrotum, reproductive system.	Yes	No
17	In the past years, have you or any of your dependents had any x-rays, electrocardiogram or examinations including genetic testing or tumor markers operations or have you or any dependents ever been hospitalised.	Yes	No

SECTION E: FULL DETAILS

Section	Question	Applicant/Dependents	Full details (Including details of disorder, date diagnosed, nature and duration of treatment and details of consulting doctor)

Should the above space be insufficient, please add an extra page to this application form

DEBIT ORDER DETAILS

Account Name

Bank Name Branch Code

Account No. Branch Name

Account Type

Debit order date 1st 5th 10th 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 Resolution Underwriters (Pty) Ltd. I further authorise you to increase the amount due in terms of the policy from time to time and authorise my bank to effect payment.

Signature of Account Holder: _____

Date

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 hand writing or not, is true and I have not withheld any material fact which are known to me. (NB: A material fact is likely to influence the assessment of this application by underwriters. 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 Underwriters 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 cancellation of this policy or the rejecting of claims, without refund of premiums if applicable.
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. that I acknowledge that the sharing of claims information and underwriting (including credit information) by Insurers is essential to enable the insurance industry to underwrite policies and assess risk fairly and reduce the incidence of fraudulent claims, in the public interest and a view to limiting premiums. I hereby waive any rights to privacy in any claims information supplied by me or on my behalf in respect of any insurance claim made or lodged by me and I consent to such information being disclosed to any other insurance company or its agent. I also waive any rights of privacy and consent to the disclosure of any information relevant to claims concerning me or any person I represent. I also acknowledge that information provided by me may be verified against other legitimate sources or databases.
5. I specifically consent to Resolution Underwriters (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 Resolution Underwriters (Pty) Ltd for purposes of verifying the disclosure as provided on my application form.

		<table border="1" style="border-collapse: collapse; width: 100%; height: 20px;"> <tr> <td style="text-align: center;">D</td> <td style="text-align: center;">D</td> <td style="text-align: center;">M</td> <td style="text-align: center;">M</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y			
Applicant	Spouse (If married in community of property)									

INTERMEDIARY DETAILS

Intermediary		Brokerage Code	
Email Address			
Telephone No.	()		Fax No. ()

Consultant	
------------	--

IMPORTANT INFORMATION

- A family means two adults, and three children under the age of 18. Concessions can be made for children whom are financially dependant (21), or full time students (25). A letter from the insured should be sent to prove that the child is financially dependant, and a letter from a recognised educational institution to prove full time studency.
- Adult dependants (ex. mother, grandfather) would need a separate application.
- Please make sure FULL details are given for questions answered YES. Hence, what, when, how severe, what's current status?
- Application forms could be underwritten and conditions may be excluded for longer than 12 months, or permanently. A concession letter would be sent to the insured to confirm this.
- This policy can be taken with any medical aid. Family members could be on different medical aids, and still have the same Resolution Underwriters policy.
- The onus lies on the insured to make sure that premiums go off on a monthly basis. Reference on bank statements read: multid for safcam

