LIBERTY

Application Form

Medical Gap Cover and Premium Waiver

Please complete and return to:

e info@vinnovation.co.za
f 021 673 8911

Postnet Suite 87
Private Bag X1005
Claremont
7735

Product Selection (please tick the correct box)

Medical Gap Cover	Y	N
Medical Premium Waiver - 24 months	Y	N
Medical Premium Waiver - 60 months	Y	N

Principal insured details

Title | First name/s

Last name

Date of birth (D D M M Y Y Y Y) | Gender (M / F) | ID number

Postal address

Postal code

Telephone number (w) | Cellphone number

Email Address

Medical Scheme

Option/Plan

Health questions

(Note: The following question only has to be completed if the Medical Premium Waiver option has been selected.)

Have you ever tested positive or been treated for HIV/Aids? Y N

Debit Order details

Full name of account holder

Bank name | Branch code

Account number | Account type

Date amount to be collected on (D D) of every month | Date of first debit order collection (D D M M Y Y Y Y)

I hereby authorise V-innovation to issue payment instructions to its bank to collect the monthly premium due by debit order from my bank account on condition that the sum of such payment instruction will never exceed my obligation in terms of this application. The debit order will be collected every month on the debit order collection date selected above. In the event that this collection day falls on a Sunday or recognised South African public holiday, the collection day will automatically be the previous ordinary business day. If there are insufficient funds in the nominated account to meet the debit order, V-innovation will be entitled to track my account and re-present the instruction for payment as soon as sufficient funds are available in my account. I acknowledge that this authority may be ceded or assigned to a third party by V-innovation or Guardrisk, but in the absence of such assignment this debit authority cannot be assigned to any third party. I understand that the payment instruction will be processed through a computerised system provided by the South African Banks. I shall not be entitled to any refund of amounts which V-innovation has collected while this debit order authority was in force, if such amounts were legally owed to V-innovation. This authority may be cancelled by giving V-innovation notice of not less than 30 days.

Zest Life Investments (Pty) Ltd is an authorised Financial Services Provider (FSP).

Signed at _____ on this _____ day of _____ 20____

_____
Signature of account holder

Needs analysis

The Medical Gap Cover product meets my needs as my medical scheme may not cover the total medical practitioner costs when I am hospitalised. Medical Gap Cover was recommended as a solution because it will cover the difference between the actual medical practitioner charges (subject to a maximum of five times the Admed Tarrif rate) and the medical scheme payment.

The Medical Premium Waiver policy meets my needs as it will continue to pay the medical scheme contributions for me and/or my medical scheme dependants in the event of my death or disability. The Medical Premium Waiver product was recommended as a solution because it will cover the medical scheme contributions for me and/or my medical scheme dependant for the benefit payment period selected.

I understand that there are other similar products on the market but the intermediary regards this Medical Gap product as the most suitable product for me. Alternatively, the intermediary does not represent any other Medical Gap and Premium Waiver product supplier. I declare that the monthly premium is affordable taking into account my other financial commitments.

Replacement policy

Will any of the following applications replace an existing policy?

Gap Cover	Y	N	Name of current insurer	
Medical Premium Waiver	Y	N	Name of current insurer	

If yes, the intermediary will contact you to complete a replacement policy advice record that will provide you with comprehensive information about the consequences of the replacement as the replacement could potentially be prejudicial.

Declarations 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. NB: A material fact is likely to influence the assessment of this application by Guardrisk. (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 Guardrisk 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 rejecting claims, without refund of premiums if applicable.
3. I confirm that I am currently a member or dependant of a medical scheme and that I understand that it is a prerequisite to remain a member or dependant of a medical scheme to qualify for Medical Gap and/or Premium Waiver cover.
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 Guardrisk contacting my current medical scheme and/or medical practitioner to verify any medical details as provided in my claim form. I further consent to such information being disclosed to Guardrisk for purposes of verifying the disclosure as provided on my claim form.
6. We confirm that by signing this application form you have agreed that we will hold and use your details that you have given us for purposes of providing you with excellent service as a policyholder and that we will also hold your information so that we are able to look after your needs by providing you with appropriate insurance products in the future.

Signed at _____ on this _____ day of _____ 20____

_____
Signature of policyholder

Financial Adviser / Intermediary details

Full name of Adviser	Hester Vaughan
Brokerage name (if applicable)	Oracle
Business telephone number	0217012291
Email	hester@lifestylecoach.co.za
ZestLife code	1F2458