

ADDITIONAL DEPENDANTS APPLICATION FORM

Please complete this form in black ink and CAPITAL letters

PRINCIPAL INSURED DETAILS

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

DEPENDANTS

Cover is limited to:
 - The Policyholder and maximum of 4 dependants in total - Only one adult dependant is permitted - The only other dependants allowed are child dependants

Dependants are:

Either an adult or child who is dependent upon the Policyholder for access to the benefits available within this policy.

Adult: A person over the age of 21 (twenty-one), except for a full-time student over the age of 21 (twenty-one) who is dependent on the Policyholder and approved by Us as eligible for membership of this policy.

Child: A child is considered as a child dependant up to the age of 21 (twenty-one), however, cover can be extended to the age of 27 (twenty-seven) if they are full-time students. Documented proof of full-time studies is required annually. A child dependant can only include your natural child, your stepchild, a child you have legally adopted or your grandchild.

Immediate Family: The Immediate Family is a defined group of relations, whether over or under the age of 21 (twenty-one) and determines which members of a Policyholder's family may join this policy.

The definition extends to those connected to the Policyholder in the following manner:

- By birth, adoption, stepchildren or grandchildren or any other child who has been placed in the custody of the Policyholder and in respect of whom the Policyholder is liable for care and support.
- Parents/stepparents, grandparents in respect of whom the Policyholder is liable for care and support.
- Siblings, including half-siblings in respect of whom the Policyholder is liable for care and support.
- A Spouse of a Policyholder as defined in this policy.
- Any other relative, who at the Insurers discretion, qualifies for membership under this policy.

Spouse: A person who is a significant other, partner or non-marital partner of that the principal member:

- In a marriage or customary union recognised in terms of the laws of the Republic; or
- In a union recognised as a marriage in accordance with the tenets of any religion; or
- In a same sex or heterosexual union which the Underwriter is satisfied is intended to be permanent.

Please refer to the terms and conditions in the Policy Wording.

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

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

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

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

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

SPECIFIC HEALTH QUESTIONS

The following questions are related to the policyholder and or any dependents on the policy.

YES NO

1	Have you been admitted to hospital in the last 4 months?		
2	Are expecting a hospital admission or aware of any conditions or illness that would require treatment in the next 12 months?		
3	Are you or any of your dependents currently pregnant?		
4	Have you taken or are currently taking chronic medication in the past 24 months?		
5	Is there any additional information not specifically mentioned in this questionnaire that relates to your health state which may influence our decision on cover?		

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

Question no. Applicant/dependents Full details (including details of disorder, date diagnosed, nature, duration of treatment and details of consulting doctor)

Should the above space be insufficient, please add in notes section.

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, or permanently.
- The onus lies on the insured to make sure that premiums are paid on a monthly basis. Reference on bank statements read: GH_Policy Number
- 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 account. 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.

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 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 GENRIC. 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 GENRIC 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.
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. 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.
5. I specifically consent to GENRIC contacting my current medical practitioner to verify any medical details as provided in my application form. I further consent to such information being disclosed to GENRIC Health for purpose of verifying the information disclosed as provided on my application form.
6. That I will advise GENRIC of any changes to my health state between the point of application and actual inception of my policy.
7. As part of the claims validation process GENRIC uses the services of a contracted third party in order to authenticate relevant beneficiaries and other relevant information to validate the claim.
8. GENRIC reserves the right to call for additional information of a clinical nature. In the event that GENRIC requests a PMA (Post Medical Assessment) from my doctor as part of the claims assessing and authentication process
9. I authorise GENRIC to negotiate with service providers on my behalf for my medical claims and or bill and pay the provider directly.
10. I expressly consent to the processing of my information for marketing purposes and may on occasion, receive marketing materials in the form of sms and / or emails and the like from GENRIC.

Yes No

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 of 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://www.genric.co.za>.

Signature of policy holder

Date:

