Physical Address: Irene Link Precinct, 7 Impala Avenue
Centurion, 0157
Postal Address: PO Box 1115, Bromhof, 2154
Tel: 086 144 4462
Web Address: www.genric.co.za

GENRIC Insurance Company

PRODUCT AMENDMENT FORM

Please complete this form in black ink and CAPITAL letters

PRINCIPAL INSURED DETAILS

Policy Number: | When should upgrade start date be:

Name and Surname:

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

Date of birth: | Email Address:

Contact details: Home no.: | Work no.:

Fax no.: | Cell no.:

Postal address:

Code:

Residential address:

Code:

OPTION SELECTION

GOLDEN HOUR	ADULT ☐	ADULT DEPENDANT ☐	CHILD ☐	0 - 60 ☐	60 + ☐	
HOSPITAL PLAN	ADULT ☐	ADULT DEPENDANT ☐	CHILD ☐	0 - 60 ☐	60 + ☐	
PRIMARY STANDARD	ADULT ☐	ADULT DEPENDANT ☐	CHILD ☐	0 - 60 ☐	60 + ☐	
COMPREHENSIVE STANDARD	ADULT ☐	ADULT DEPENDANT ☐	CHILD ☐	0 - 60 ☐	60 + ☐	
COMPREHENSIVE PLUS	ADULT ☐	ADULT DEPENDANT ☐	CHILD ☐	0 - 60 ☐	60 + ☐	
COMPREHENSIVE ADVANCED	ADULT ☐	ADULT DEPENDANT ☐	CHILD ☐	0 - 60 ☐	60 + ☐	
COMBINED: PRIMARY STANDARD & HOSPITAL PLAN	ADULT ☐	ADULT DEPENDANT ☐	CHILD ☐	0 - 60 ☐	60 + ☐	

Premium per month: R

TOTAL PREMIUM PAYABLE: R

*Intermediary Fee (Optional): R

* The 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
Please return the completed form to health_applications@genric.co.za.

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
5. and protect the public interest in terms of limiting excessive premium increases.
   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
6. GENRIC for purpose of verifying the information disclosed as provided on my application form.
7. That I will advise GENRIC of any changes to my health state between the point of application and actual inception of my policy.
8. As part of our claims validation process we use the services of a contracted third party in order to authenticate relevant beneficiaries and other relevant information to validate the claim.
   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
9. authentication process
10. I authorise GENRIC Health 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 GENRIC.

Yes ☐ No ☐

Signature of policy holder | Date:

Spouse (If married in community of property) | Date: