kaelogap

shortfall cover

Membership Application Form

IMPORTANT NOTE: Complete, sign and return the application to service@kaelo.co.za. Applications received after the 27th of the current month will only activate the 1st of the following month.

A Application Status

Please indicate the status of your application by selecting one of the relevant options below. (Not applicable for a compulsory group)

Cover Start Date: | | | | | | | | |

- ◯ I do not currently have Gap Cover but wish to join ◯ in my private capacity ◯ via my Employer
- ◯ I am currently a Kaelo member but I am leaving my employer and wish to continue cover in my private capacity.
  - *Only complete Section E and changes if applicable to sections B & C*
- ◯ I currently have Gap Cover with another provider but I wish to transfer my cover to Kaelo.
  - *Waiting periods may apply to your cover*
  - *Proof of cover with the other Provider must be provided*
- ◯ If applicable, I wish to join as a ◯ single member ◯ a family

B Principal Member Details

Surname: _____ Name: _____

ID Number: | | | | | | | | | | | | | Telephone: | | | | | | | | | | |

Cellphone: | | | | | | | | | | E-mail: _____

Employer Name: _____ Branch Name: _____

Date of Employment: | | | | | | | | | Medical Scheme: _____

Membership No: _____ Benefit Option: _____

C Dependant Details:

- Cover applies to your spouse and/or children only.
- Children are covered up to a maximum age of 26.
- Spouse or children financially dependent on principal member but that participate on other medical aids would be covered on this policy.
- Please provide membership certificates to confirm the above.
- Should you have more that 3 dependants please complete a second form and submit the forms together.

Full Name			
Surname			
ID/Passport No			
Relationship			
Inception Date			
Cell Number			
Email Address			

D Health Questionnaire

In answering the questions below, consider any dental treatment, family planning, consultations with any doctors, existing ailments and/or prescribed chronic medicine.

1. **Are you or any of your dependants aware of any reason that you or any of your dependants may require hospitalisation or cancer treatment within the next 12 months?** Yes No
2. **Have you or any of your dependants received any medical advice within the last 12 months?** Yes No
3. **Have you or any of your dependants consulted with any doctors within the last 12 months?** Yes No
4. **Do you or any of your dependants have any existing medical conditions?** Yes No
5. **Are you or any of your dependants currently pregnant or planning to become pregnant?** Yes No

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If you have answered yes to any of the questions in the health questionnaire, please provide the full details in the space provided below:

Question Number	Dependant Name	Details of Condition/Treatment/ Disorder	Last Date of Consultation	Details of Future Treatment

E Debit Order Details

Only complete this section if your employer is not deducting premiums from payroll

Account Name: _____ **Bank Name:** _____

Account Number: _____ **Account Type:** ◯ Cheque ◯ Transmission ◯ Savings

Branch Name: _____ **Bank Code:** _____

D Intermediary Details

Name & Surname: _____ **Designation:** _____

Brokerage: _____ **Region:** _____

Cellphone: _____ **E-mail:** _____

E Declaration by Principal Member

I, (full name) _____ hereby declare that this application form, whether in my handwriting or not, is accurate and complete and forms the basis of the contract of insurance between the Underwriter and myself. I hereby apply for the insurance product/s and agree to abide by its policy rules and/or those of its Underwriter and any amendments thereto which may be made from time to time. I confirm that all the information provided herein is complete and true and that I have not concealed any relevant or pertinent information that may affect the evaluation of risk considered under this policy of cover. I understand that the provision of any false, misleading or missing information could result in my application being rejected or my membership being canceled or claims being rejected. Should this occur, I agree to refund all benefit payments that I have received in relation to this policy of insurance. In the event that my employer to make such cover nomination of my behalf and furthermore indemnify Kaelo and the underwriter against liability for any loss that may result from an incorrect nomination of such cover by the employer. I hereby provide irrevocable authority for Kaelo and its Underwriter to obtain any of my or my beneficiaries' medical history from any Medical Service Provider, medical scheme, insurance company or healthcare intermediary for the purposes of assessing this application for insurance as well as the underwriting of any future risk or the assessment of any claim that relates to this insurance cover. Premiums due to Centriq are payable monthly. Premiums that are in arrears will result in my membership being suspended or possibly terminated. In the event that any policy benefit becomes payable subsequent to or as a result of my death, I hereby provide an irrevocable authority for such benefits to be paid directly to my surviving spouse or failing such circumstance to the nominated guardians or trustees responsible for the future care of my minor children or failing either of the preceding events to my estate. Where applicable, I hereby authorise Centriq to draw against the above bank account all amounts due to Centriq in terms of this insurance cover. Should the relevant premiums be adjusted by the underwriters, I hereby confirm that the adjusted amount may be drawn from the above account subject to the notice period outline in the policy document. This request is to remain in force unless canceled by one month's written notice. Where my employer deducts the premium from my salary. I hereby provide authority for my Employer to deduct such premium and pay this across to Centriq. I accept that any notice given to my employer is deemed to have been given to me.

Signature: _____ **Date:** _____