

Individual Policyholder Application Form

IMPORTANT NOTE: Please complete and sign this form and return it to your broker who will submit it to Kaelo on your behalf. Kaelo will only accept applications received by a broker. Applications received after the 15th of the current month will only activate on the 1st of the following month. Email address: kaelogap@kaelo.co.za.

A Applicant Details:

I do not currently have Gap Cover

I currently have Gap Cover with another provider but I wish to transfer my cover to Kaelo Gap

If you have Gap Cover with another provider but wish to transfer to Kaelo Gap, please submit your proof of cover. Waiting periods may apply.

Policy Type:

Single Policy

If you are joining as a single Policyholder, you accept that cover will only apply to yourself and that should any changes be required, you will notify Kaelo within 90 days. This includes the addition of dependants. Premiums are payable monthly.

Family Policy

If you are joining as a family, you accept that cover will apply to you, your spouse and your children. Cover for children only applies up to the age of 26 years. Should any changes be required, you will notify Kaelo within 90 days. This includes the addition of dependants. Premiums are payable monthly.

Select Plan:

Kaelo Gap Optima

Kaelo Gap Core

Plan Add-on:

Lifestyle Benefits

Cover Start Date: _____

First Name: _____

Surname: _____

ID Number: _____

Cellphone: _____

Gender: _____

Date of Birth: _____

Email: _____

Date of Employment: _____

Address: _____

B Insured Party Details:

Should you have dependants, please provide us with a copy of your Medical Scheme membership certificate. Cover will apply to you, your spouse and your children. Cover for children only applies up to the age of 26 years. If any of your dependants are on another Medical Scheme, please provide a copy of their membership certificate.

First Name	Surname	Relationship	Date of birth/ID number	Inception Date

C Waiting Periods:

A three-month General Waiting Period and 12-month Condition-Specific Waiting Period will be applied for all new applications. If you are transferring your cover from another Gap Cover provider with similar benefits, only the balance of the applicable waiting periods will apply.

D Debit Order Details:

You will see the following reference on your bank statement: KAELOGAP. If you are joining as a family, you accept that cover will apply to you, your spouse and your children up to the maximum age of 26. Should any changes be required, you will notify Kaelo within one calendar month. This includes the addition or removal of dependants.

Account Name: _____ Account Number: _____
Branch Name: _____ Bank Name: _____
Account Type: _____ Bank Code: _____
Debit Order Date: Last working day of the month Premium: _____

Name and Surname of Premium Payer: _____

Please note Premiums are due in arrears.

Please submit a copy of your bank statement or a bank confirmation letter not older than three months with this form.

I, the Premium payer, 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, I confirm that the adjusted amount may be drawn from the above account subject to the notice period outlined in the Policy. This request is to remain in force unless cancelled by one month's written notice.

Premium Payer Signature: _____

E Broker Details:

Broker House Name: _____ Broker Consultant Name: _____

F Mandatory Documents:

Please ensure that the following documents are submitted with your application form:

- A clear copy of either the ID or birth certificate of all Insured Parties being registered.
- A clear copy of the Medical Scheme membership certificate is required.
- Proof of cover if you currently have cover with another Gap provider (if applicable)

G Declaration:

I, _____ (full name) 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 Insurer and myself. I apply for the insurance product/s and agree to abide by its Policy rules and/or those of its Insurer and any amendments which may be made from time to time. I confirm that all the information provided is complete and true and that I have not concealed any relevant 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, my Policy being cancelled 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.

I provide irrevocable authority for Kaelo and its Insurer to obtain any of my or my dependant's medical history from any healthcare provider, Medical Scheme, insurance company or healthcare broker to assess this application for insurance and 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 Policy being suspended or possibly terminated. If any Policy Benefit becomes payable after or as a result of my death, I 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.

I consent to Centriq and its operators processing and further processing my personal information in accordance with the Protection of Personal Information Act to conclude and perform in terms of this insurance contract.

For further information please read our Privacy Notice, which can be found on www.centriq.co.za

Signature: _____ Date: _____