RCP
Advisory Services

"The Professional Link"

RCP ADVISORY SERVICES
REGISTRATION NO: 2016/237159/07 **VAT NO:** 4140263411
PHYSICAL ADDRESS: 71 Madeline Road, Morningside, Durban, 4001.
POSTAL ADDRESS: PO Box 22267, Glenashley, 4022
TEL: 031 312 5088 **FAX:** 086 545 2062
E-MAIL: cookie@rcpsa.co.za

Financial Services Provider (FSP: 8634)

Document no.
10 300

Please complete this form in black ink and CAPITAL letters

APPLICATION FORM

Medical Scheme membership number:

Name of Medical Scheme:

Is this application part of a group? (Place a clear **X** inside the box) Y [ ] N [ ]

If YES, group name:

PRINCIPAL INSURED DETAILS

First name(s) (in full):

Surname:

Initials:

ID no.:

Mr [ ] Mrs [ ] Miss [ ] Dr [ ] Other

Date of birth: D D / M M / Y Y Y Y

Required inception date: D D / M M / Y Y Y Y

Contact details: Home no.: ( ) Work no.: ( )

Fax no.: ( ) Cell no.: ( )

Email address:

Postal address:

Code:

Residential address:

Code:

DEPENDANTS

Dependants are:
- Spouse and/or dependent children up to the age of 21 years
- Students up to the age of 27 (*please prove full time enrolment*)
- Adopted/foster child (*please attach documentary proof*)

Full name and surname:

ID no.: M [ ] F [ ] Relationship to applicant:

Full name and surname:

ID no.: M [ ] F [ ] Relationship to applicant:

Full name and surname:

ID no.: M [ ] F [ ] Relationship to applicant:

Full name and surname:

ID no.: M [ ] F [ ] Relationship to applicant:

Full name and surname:

ID no.: M [ ] F [ ] Relationship to applicant:

SPECIFIC HEALTH QUESTIONS

Have you or any insured under this policy ever received treatment or expect to receive treatment for any of the following:

		Y	N
1	Do you or any dependant suffer from any health condition, disorder, disease or illness?		
2	Have you or any dependant in the past been hospitalised, or had any examinations, testing or diagnostic procedures done?		
3	Is any female applicant currently pregnant?		
4	Are you aware of any condition/illness that would require any future treatment?		
5	Have you ever been advised to seek medical treatment after an abnormal diagnostic test, or any other reason?		
6	Have you or any of your dependant's had a blood relative diagnosed with cancer?		
7	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 attach a separate page.

DEBIT ORDER DETAILS

Name of account holder:

Account no.:

Bank: Standard Bank ☐ ABSA ☐ FNB ☐ Nedbank ☐ Other

Account type: Cheque ☐ Savings ☐ Transmission ☐ Other

Debit order day: 1st ☐ 7th ☐ 10th ☐ 15th ☐

I hereby instruct and authorise you to draw against my bank account the amount necessary for payment of my monthly premium due in respect of the above mentioned insurance, without prejudice to the rights of Sirago Underwriting Managers (Pty) Ltd. I further authorise you to increase the amount in the terms of the policy from time to time and authorise my bank to effect payment.

Signature of account holder Y

Date: D D / M M / Y Y Y

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 Sirago Underwriting Managers (Pty) Ltd. 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 Sirago Underwriting Managers (Pty) Ltd 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. You hereby waive any right to privacy of any insurance information provided by you or on your behalf, in respect of any insurance policy or claims you lodge. You also consent to this information being disclosed to any other insurance company and/or verified against other legitimate source or a database.
5. I specifically consent to Sirago Underwriting Managers (Pty) Ltd contacting my current Medical Scheme and/or medical practitioner to verify any medical details as provided in my application form. I further consent to such information being disclosed to Sirago Underwriting Managers (Pty) Ltd for purpose of verifying the disclose as provided on my application form.
6. That in order for the Insurer to assess any claim it may be necessary for the Insurer to obtain personal medical information from the policyholder's medical scheme, health care provider(s) and/or other persons.
7. That I hereby irrevocably authorise the Insurer, or the duly appointed representative of the Insurer, to obtain from any person any personal medical information the Insurer needs and similarly authorise such person to provide the Insurer with such information requested. This authorisation relates not only to me but also to all my dependants on my medical scheme and covered under this policy and extends so beyond the death of myself and/or any of my dependants.

Date: D D / M M / Y Y Y Y

Applicant

Spouse (If married in community of property)

RCP ADVISORY SERVICES

Intermediary: | Intermediary Code: G 1 9 8 5

Email address: cookie@rcpsa.co.za | Additional address:

Tel no.: (031) 312 5088

PRODUCT	INDIVIDUAL	FAMILY	BROKER FEE
BASIC GAP COVER:			
GAP COVER:			
PLUS GAP COVER:			
ULTIMATE GAP COVER:			
ULTIMATE GAP COVER FOR GROUPS:			

OPTION BY APPLICANT:

Premium per month **GAP**	R , . 0 0
Premium per month **INCOME BOOSTER**	R , . 0 0
OPTIONAL BENEFIT COVER	R , . 0 0
*Intermediary Fee (Optional)	R , 4 0 . 0 0
TOTAL MONTHLY PREMIUM PAYABLE	**R** , . 0 0

* This Intermediary fee is optional and is paid to the intermediary on top of the statutory commission on your approval

DECLARATION BY APPLICANT

I, the undersigned, hereby declare, that to the best of my knowledge and belief the information provided in connection with this application whether in my own hand writing or not, is true and I have not withheld any material fact which are known to me. (A material fact is likely to influence the assessment of this application by RCP Advisory Services. If you are in any doubt as to whether a fact is material or not, you should disclose it.)

Full name:

ID no.:

Date: D D / M M / Y Y Y Y

Applicant | Spouse (If married in community of property)

SUBMIT

RCP Advisory Services

"The Professional Link"

GENRIC Insurance Company