SIRAGO UNDERWRITING MANAGERS (PTY) LTD
REG NO: 1993/001387/07 | VAT NO: 4950188724

PHYSICAL ADDRESS: Midrand Business Park, Building 3,
563 Old Pretoria Main Road, Midrand, 1685
POSTAL ADDRESS: PO Box 1115, Bromhof, 2154
TEL NO: 010 599 1163 | EMAIL: applications@sirago.co.za

Compliance Officer: Moonstone Compliance (Pty) Ltd
Financial Services Provider No: 4710

Document no.

10 000

Please complete this form in black ink and CAPITAL letters

APPLICATION FORM

Medical Scheme membership number: ______ Name of Medical Scheme: ______

Medical Scheme Option: ______ If YES, group name: ______

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

PRINCIPAL INSURED DETAILS

First name(s) (in full): ______

Surname: ______ Initials: ______

ID number.: ______ 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: ______

SPOUSE DETAILS

First name(s) (in full): ______

Surname: ______ Initials: ______

ID number.: ______ Mr [ ] Mrs [ ] Miss [ ] Dr [ ] Other ______

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

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

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

Email address: ______

DEPENDANTS

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

Full name and surname: ______

ID number: ______ Male [ ] Female [ ]

Date of Birth: ______ Relationship to applicant: ______

Full name and surname:

ID number: Male Female

Date of Birth: Relationship to applicant:

Full name and surname:

ID number: Male Female

Date of Birth: Relationship to applicant:

Full name and surname:

ID number: Male Female

Date of Birth: Relationship to applicant:

Full name and surname:

ID number: Male Female

Date of Birth: 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 ☐ 15th ☐ 25th ☐

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

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

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: MD SIRAGO_MED
- Effective from 1 January 2017.

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 I will advise Sirago Underwriting Managers (Pty) Ltd of any changes to my health state between the point of application and actual inception of my policy.
7. As part of our claims validation process we used the services of a contracted third party in order to authenticate medical scheme membership, plan option type, relevant beneficiaries and agreed medical scheme option tariffs amongst other relevant information to validate the claim.

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

Applicant

Spouse (If married in community of property)

INTERMEDIARY DETAILS

Intermediary Group: C M A C

Intermediary Code:

Sales Person: A R T H U R E A S T O N

Sales Code:

Tel no.: (0 8 6) 1 1 1 1 5 0 1 Cell no.: (0 8 1) 5 0 0 3 7 7 3

OPTION SELECTION

GAP COVER:	INDIVIDUAL	☐	FAMILY	☐		
PLUS GAP COVER:	INDIVIDUAL	☐	FAMILY	☐		
ULTIMATE GAP COVER:	INDIVIDUAL	☐	FAMILY	☐		
SIRAGO DENTAL:	INDIVIDUAL	☐	SPOUSE	☐	CHILD	☐
SIRAGO PRIMARY:	INDIVIDUAL	☐	SPOUSE	☐	CHILD	☐

OPTION BY APPLICANT:

Premium per month R ___ , ___ . 0 0

*Intermediary Fee (Optional) R ___ , ___ . 0 0

TOTAL 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 Sirago Underwriting Managers (Pty) Ltd. 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)

MARKETING CONSENT

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 Sirago Underwriting Managers (Pty) Ltd.

Please contact me via:

E-mail ☐ SMS ☐ Sirago Underwriting Managers (Pty) Ltd may not contact me. ☐

CMAC
HEALTHCARE CONSULTING
& FINANCIAL SERVICES
www.cmac.co.za

RECORD OF ADVICE: MEDICAL / OTHER INSURANCE PRODUCTS

CLIENT DETAILS

Name and Surname			
Marital status		**Mobile contact**	
Phone (w)		**Phone (h)**	
E-mail address			
ID No.			

MEDICAL / OTHER INSURANCE PRODUCTS: These are not medical scheme products. Medical aid schemes are governed by the council for medical Schemes and health insurance is governed by either the Long Term insurance Act or the Short Term insurance Act. A health insurance policy does not offer the same amount of cover as a medical aid does.
MEDICAL GAP COVER: Can be combined with any medical scheme option. Cover will be provided as long as a member remains a principal member or dependant of the registered medical scheme. It is the member's responsibility to cancel the policy should membership of a medical scheme be terminated (not in the event of changing between medical schemes).

GAP COVER			
PRODUCT	OPTION	FAMILY OR INDIVIDUAL	PREMIUM PER MONTH
MEDICALL			
ONLY DAY TO DAY COVER?	ONLY HOSPITAL COVER?	OR COMBINED COVER?	PREMIUM PER MONTH
CMAC EVAC			
ADDITIONAL FUNERAL COVER?	ADDITIONAL PANIC BUTTON?	ADDITIONAL CARDS?	PREMIUM PER MONTH
FUNERAL			
PRODUCT	OPTION	FAMILY OR INDIVIDUAL	PREMIUM PER MONTH

Reason for recommendation

Have you cancelled any policies in the last four months or will you cancel an existing policy as a result of this sale: **Y** **N**
INFORMATION DISCLOSED OR DISCUSSED
In addition to providing comprehensive and truthful information on the product suppliers' terms and conditions as applicable to your needs and circumstances, financial

If YES, please provide reason for replacement

or otherwise, the following information was also addressed

	3 Months general waiting period		Consequences of non-disclosures
	Condition specific waiting periods		Claim procedures
	Policy exclusions		Other:

Section 4: Financial services provider details:
We are representatives of CMAC Healthcare Consultants (Pty) Ltd Reg. No. 2015/150462/07. CMAC holds a category 1 Financial Services Provider Licence with FSP reference number 17112. This licence authorizes CMAC to provide financial services with respect to product categories 1.1 to 1.9, 1.14 and 1.16 to 1.20. CMAC has contract with various product suppliers across the different approved product categories. The business has not earned more than 30% commission from any one of the product suppliers within the past 12 months, and also does not hold more than 10% shares in any product supplier. We hold professional indemnity insurance cover but due to the fact that we do not collect premiums from clients, we consider it unnecessary to hold fidelity insurance cover. Our business address is 14/2 Midas Avenue, Olympus and our telephone number is (012) 991 0446. We have a complaints resolution system available that you can obtain at our office or by requesting it via e-mail at cmac@mweb.co.za or by fax at 086 552 3917. If you have any queries or concerns, please don't hesitate to contact us.

Section 5: Internal Compliance officer
Pieter Swart; Postal Address: P.O. Box 38060, Faerie Glen, 0043; Physical Address: 14/2 Midas Avenue, Olympus, Pretoria East, 0043 Fax: 086 552 3917; Tel: (012) 991 0446; Email Address: pieter@cmac.co.za

Section 6: Cession
In the event that CMAC changes its juristic profile, is sold to another FSP or stops to exist for whatever reason, the client hereby authorizes the transfer of this contractual obligation to another FSP.

Section 7: Declaration by the advisor
I declare that the Advice Record is an accurate and complete record of the recommendations and advice that I provided the client with based upon the information provided by the client.

Section 8: Declaration by the client
I confirm having been duly and properly advised of the full implications of my actions and, having considered same, I fully understand the course of action that I am about to undertake. I declare that I am aware of the fact that I must carefully consider whether the product selected is appropriate considering my objectives, circumstances and needs.

______________________________ ______________________ ______________________
Names and signature of advisor **Signature of client** **Date**