ONE PLAN™
Gap Cover

APPLICATION FORM

1. Do you have Medical Aid?

YES ☐ NO ☐ If your answer is NO, you must apply to become a member of a Scheme.

2. Do you need cover for yourself or yourself plus dependants?

Myself ☐ My dependants ☐

3. How old are you?

☐

Ages of those being covered:
Note that a child is a person registered as a child on your Scheme policy and include full-time students and permanently disabled children.

4. Personal Information:

Title: ☐ Initial/s: ☐ Surname: ☐

First Name: ☐ Gender: MALE | FEMALE

Maiden Name: ☐ Language: ☐

Pronoun: ☐

SA ID No: ☐

Passport No: ☐ Date of Birth: Y Y Y Y M M D D Policy Inception Date: Y Y Y Y M M D D

Medical Aid: ☐ Medical Aid Plan: ☐

Cell: ☐ Home Phone: ☐

Email: ☐

Physical Address: ☐

☐ Postal Code: ☐

5. Employer Information:

Employer: ☐ Occupation: ☐

Address: ☐

☐ Postal Code: ☐

Employment Period From: Y Y Y Y M M D D Work Phone: ☐

6. Have you or your dependants been covered on a Gap Cover policy in the last 90 days?

YES ☐ NO ☐ If your answer is YES, you must supply your proof of Gap Cover. Email Proof of Gap to uwgap@oneplan.co.za

PROOF can be: A policy schedule, reflecting the duration of cover, a letter of confirmation reflecting the duration, a renewal notice or a bank statement with six months Gap Cover deductions.

If your answer is NO:

WAITING PERIODS:

Waiting periods will apply if you or your dependants were not previously covered on a Gap Cover policy.
Please refer to your policy terms and conditions to review your waiting periods:

2.1 3 MONTH GENERAL
There is an automatic three-month general waiting period for all healthcare services and treatment, except authorised casualty admissions

2.2 ONCOLOGY WAITING PERIODS 6 MONTH WAITING PERIODS
6 month waiting period, anything manifests within this period will be excluded for 12 months.

2.3 PRE-EXISTING CONDITIONS WAITING PERIODS
12 month waiting period.

2.4 30 DAYS
A Calendar Month waiting period.

2.5 LIKE-FOR-LIKE
12 month waiting period will be reduced by the waiting period served on previous Gaps. If known condition when sign up, will only pay 20% of claim (pre-existing).

DEPENDANTS:

Marital Status: Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐ Long-term Relationship: ☐

Partner / Spouse Information:

Title: | Initial/s: | Surname:

First Name: | Gender: MALE FEMALE

Maiden Name: | Language:

Pronoun:

SA ID No:

Email: | Cell:

CHILD 1:

Surname: | ID No: | Gender: MALE FEMALE

First Name:

CHILD 2:

Surname: | ID No: | Gender: MALE FEMALE

First Name:

CHILD 3:

Surname: | ID No: | Gender: MALE FEMALE

First Name:

CHILD 4:

Surname: | ID No: | Gender: MALE FEMALE

First Name:

PLAN SELECTION - Please select a plan by ticking the appropriate box:

Please refer to Appendix A for our plan types. These prices and benefits are effective from 1 December 2024.

☐ Oneplan Core Gap Cover from R220 pm

☐ Oneplan Executive Gap Cover from R285 pm

MEDICAL INFORMATION:

1. Have you or any of your dependants EVER been diagnosed with high blood pressure, Cholesterol and/or Heart conditions?

Name | Condition

Name | Condition

Name | Condition

2. Have you or any of your dependants EVER been diagnosed with Anaemia, blood clots, Aneurysm or any other Blood disorders?

Name | Condition

Name | Condition

Name | Condition

3. Have you or any of your dependants EVER been diagnosed with Asthma, Emphysema/ COPD (Chronic obstructive pulmonary disease) and/or any other lung condition

Name | Condition

Name | Condition

Name | Condition

4. Have you or any of your dependants EVER been diagnosed with Diabetes, thyroid, gallstones, hernias or ulcers and/or any other digestive system, spleen, liver or pancreas conditions?

Name | Condition

Name | Condition

Name | Condition

5. Have you or any of your dependants EVER been diagnosed and or experienced symptoms of Epilepsy, Migraine or a Stroke and/or any other Brain or Nerve conditions and/or Psychological disorders?

Name | Condition

Name | Condition

Name | Condition

6. Have you or any of your dependants EVER been diagnosed and/or been treated for Bladder infections, Kidney stones, Kidney failure or Dialysis and/or any other Bladder or kidney conditions

Name		Condition	
Name		Condition	
Name		Condition	

7. Have you or any of your dependants EVER been diagnosed with Eye, Nose, Mouth, Throat and/or Dental conditions?

Name		Condition	
Name		Condition	
Name		Condition	

8. Have you or any of your dependants EVER been diagnosed with Neck or Back problems, Arthritis and/or any Bone, Joints, Muscle or Skin disorders?

Name		Condition	
Name		Condition	
Name		Condition	

9. Are you currently pregnant or have you EVER been diagnosed with endometriosis, ovarian cysts and or any other gynaecological conditions?

Name		Condition	
Name		Condition	
Name		Condition	

10. Have you or any of your dependants EVER been diagnosed with Prostate or any other Genital conditions?

Name		Condition	
Name		Condition	
Name		Condition	

11. Have you or any of your dependants EVER been diagnosed with Cancer, HIV and or any other Immune deficiency conditions?

Name		Condition	
Name		Condition	
Name		Condition	

12. Are you or any of your dependants aware of any Recurrent symptoms and/or Medical conditions that may require Medical interventions or Diagnostic procedures?

Name		Condition	
Name		Condition	
Name		Condition	

13. Have you or any of your dependants undergone any Surgery or Procedures?

Name		Condition	
Name		Condition	
Name		Condition	

14. Do you or any of your dependants have any Amputations, Paralysis an/ or Loss of usage of a Limb, Vision, Hearing or Speech

Name		Condition	
Name		Condition	
Name		Condition	

15. Are you aware of other diseases, operations and disabilities, including accidents or work related medical conditions not already mentioned?

Name		Condition	
Name		Condition	
Name		Condition	

ONEPLAN STANDARD TERMS AND CONDITIONS:

I, the undersigned, hereby warrant:

DISCLOSURES

That all intermediary (Oneplan Brokers (Pty) Ltd), Administrator (Oneplan Underwriting Managers Pty Ltd) and Insurer (Bryte Insurance Company Limited) information has been made available to me and that I have made an informed decision to take out this policy without the benefit of a full financial needs analysis. Further, I warrant that I have taken note and understand the cover limits, waiting periods and the limitations of this policy. Should there be any dispute as to the information provided, the policy schedule that may be accessed via the Oneplan App or a current copy which can be requested from the customer care department on 010 010 0010 141, will be deemed to be correct and will be the basis of this agreement.

In no way do I expect that the policy will provide unlimited cover in the event of medical occurrences unless expressly indicated as such. This is an application for a binding insurance contract on the intermediary and me and no further acceptance of terms and conditions or any other documents will be necessary for this contract to become binding. I fully understand that the Oneplan Gap Insurance Policy is based on short term insurance cover and is not a medical aid and that the policy is a month-to-month contract. The cover in this policy has no surrender/ cancellation/maturity values and if my premium is unpaid, the cover applicable to the policy will lapse, subject to the Grace Period offered by the Administrator. I further declare that all the information entered by me on my behalf is true and correct and should any further information be required, I will make this available to the Administrator or Insurer as necessary for my policy or any query related to the policy. The disclosure of medical conditions is true and correct and I am in no way entering this agreement with the knowledge of undisclosed conditions or expected future conditions. The policy wording necessary for this policy to be binding on the parties will be made available to me the Oneplan App or via a copy which can be obtained through the Customer Call Centre.

PAYMENT OF COVER

I accept that the payment of any cover due to a valid claim will first be paid to me, for distribution to the service provider (hospital risk claims only) upon presentation of valid invoices and /or statements for services rendered to an Insured person of this policy. I further accept that to qualify for benefits under this policy, I must be a member, and my insured family must be dependants of a medical scheme approved in terms of the Medical Schemes Act and my dependants must be registered as dependants on the policy.

ACCEPTANCE

The Administrator will advise me of the acceptance of the terms of the above policy and if there are any terms and conditions that require additional disclosure for my individual policy.

ITC RATING CHECK

I authorise the Administrator to submit my details to ITC to properly rate my account and credit record. The Administrator warrants that all information received from ITC in this regard will be treated as confidential and to the purpose of administering my policy and will not be disclosed to any third parties.

PAYMENT INSTRUCTIONS

I hereby authorise Oneplan Underwriting Managers (Pty) Ltd or appointed collection agent to deduct premiums, excess amounts or any amounts as per the policy schedule or terms and conditions of the parties. I acknowledge that failure / rejection of said debits may result in my policy being suspended or cancelled. I agree that all payment instructions issued by the Underwriter will be treated by my nominated bank as if the instruction has been issued by me personally.

PAYMENT

I hereby agree and authorise the above account to be debited every month through the Debicheck authenticated collections with the premium amount starting on the inception date or the next business day. I acknowledge that premiums are collected in advance and not in arrears.

DECLINED / FAILED PAYMENTS

Will be debited on the next debit order date, or by debit order that may be run at any time from the date of notification by our collection agent of the failed / returned payment as mentioned above.

I acknowledge that in the event of declined / failed debits, I may incur additional bank charges as levied by my bank. Should the payment be returned once, the policy cover will be suspended, and the policy may be re-dated to begin on the first of the following month. No claim will be entertained until the premium has been paid to the Administrator within the Grace Period. I hereby grant permission to the Administrator to double debit my account in the event of a rejected payment. If this double payment is returned, no further attempts will be made to collect premiums and cover will be cancelled with immediate effect.

LATE JOINER PENALTY

I accept that my monthly premium may be loaded with a "late joiner penalty" as per prescribed legislation. The penalty will only apply to me should I be 35 years or older and/ or did not have previous gap cover or had a break in membership for more than ninety (90) days since 2001 and prior to joining Oneplan.

PREMIUM INCREASES/POLICY AMENDMENTS
The Administrators reserve the right to increase premiums or amend the policy cover at their discretion. Notice of any premium increases or cover amendments will be given in writing 31 days (one calendar month) before any such changes come into effect.

POLICY INITIATION FEE
I consent to my account being debited with the once-off policy initiation fee of R160.00 (One Hundred and Sixty Rand) on the same date as my first policy debit order.

PREMIUM REFUNDS
Should a policy be cancelled in writing within the first seven (7) days of the date of application (cooling off period), Oneplan will refund you your premium if it has been deducted from your nominated bank account. If the policy is cancelled after the seven (7) days cooling off period, a one calendar month written notification period will apply and the policy will only be cancelled thirty (30) days after the first day of the following month. I understand that my premium will only be refunded thirty (30) days after it has been deducted and I may need to submit supporting documentation before any refunds are granted.

CANCELLATION
Cancellations requested after the cooling off period is subject to a full calendar month notice period and must be submitted in writing to cancel@oneplan.co.za.

POLICY DELIVERY
The policy documents, policy guides and associated documents will be emailed to you within thirty (30) days after the receipt of the initiation fee and successful collection of the first premium. The information in the policy schedule as well as in all declarations made will form the basis of the contract, and it is warranted by Oneplan Underwriting Managers (Pty) Ltd that such information is accurate. This policy, however, shall not be invalidated on account of any incorrect statement made in good faith, unless the incorrectness of such statement is of such a nature as to be likely to have materially affected the assessment of the risk under the Policy at the time the policy was issued.

CONSENT
I acknowledge that the sharing of claims information and underwriting (including credit information) by insurers is essential to enable the insurance industry to underwrite policies and assess risk fairly and reduce the incidence of fraudulent claims, in the public interest and with a view to limiting premiums. I hereby waive any rights to privacy of any claim information supplied by me or on my behalf in respect of any insurance claim made or lodged by me and I consent to such information being disclosed to any other insurance company or its agent. I also waive any rights to privacy and consent to the disclosure of any information relevant to claims concerning me or any person I represent. I also acknowledge that information provided by me may be verified against other legitimate sources or databases.

I specifically give consent to Oneplan Underwriters to contacting my current Scheme and healthcare providers, as well as the current Scheme and healthcare providers of my dependants on this policy, to confirm any health information relating to underwriting and claims for Oneplan Underwriters, upon request. I understand that Oneplan Underwriters will regard any health information supplied by my, or my dependants Scheme or healthcare providers as confidential and will only disclose it to another party upon my express consent.

PAYMENT INSTRUCTIONS:

Please note we accept payment only via monthly Debit Order (Oneplan will appear on your bank statement)

Account Type: Cheque ☐ Savings ☐ Transmission ☐

Monthly Deduction Amount: ☐

Debit Deduction Date: 1st ☐ 25th ☐ 28th ☐

Bank: ☐ Account Number: ☐

Account Name: ☐ Branch: ☐ Branch Code:

Account Holders Signature

I hereby authorise the deduction of my monthly contribution for Gap Cover and acknowledge that these premiums will be deducted monthly on the selected debit order date from the account above.

I, ☐ hereby acknowledge that I have received, read and understood this document

Principal Insured's Signature _____ Date: Y Y Y Y M M D D