

HEALTH INSURANCE APPLICATION FORM

Application form for policies incepting from the 1st of February 2026.

PRINCIPAL INSURED

Title:	<input type="text"/>	Initial/s:	<input type="text"/>	Surname:	<input type="text"/>		
First Name:	<input type="text"/>				Gender:	<input type="checkbox"/> M <input type="checkbox"/> F	
Maiden Name:	<input type="text"/>				Language:	<input type="text"/>	
ID No:	<input type="text"/>	Date of Birth:	<input type="text"/>	Policy Inception Date: (Debited in advance)	<input type="text"/>		
or Passport No:	<input type="text"/>	Cell:	<input type="text"/>	Work Phone:	<input type="text"/>		
Email:	<input type="text"/>						
Physical Address:	<input type="text"/>						
	<input type="text"/>					Postal Code:	<input type="text"/>

DELIVERY ADDRESS FOR ONEPLAN CLAIM CARD (only if Oneplan Claim Card selected):

PLEASE NOTE: Delivery to below address between 08h00 to 17h00 weekdays

Building Name:	<input type="text"/>					
Street Address and Number:	<input type="text"/>				Postal Code:	<input type="text"/>
Suburb:	<input type="text"/>					
City:	<input type="text"/>					
Province:	<input type="text"/>					
Contact Number for Delivery:	<input type="text"/>					

DEPENDANTS

PARTNER / SPOUSE INFORMATION:

Title:	<input type="text"/>	Initial/s:	<input type="text"/>	Surname:	<input type="text"/>		
First Name:	<input type="text"/>				Gender:	<input type="checkbox"/> M <input type="checkbox"/> F	
Maiden Name:	<input type="text"/>						
ID No:	<input type="text"/>	Passport No:	<input type="text"/>	Cell:	<input type="text"/>		
Email:	<input type="text"/>						
CHILD 1:							
Surname:	<input type="text"/>	ID/Passport No:	<input type="text"/>				
First Name:	<input type="text"/>				Gender:	<input type="checkbox"/> M <input type="checkbox"/> F	
CHILD 2:							
Surname:	<input type="text"/>	ID/Passport No:	<input type="text"/>				
First Name:	<input type="text"/>				Gender:	<input type="checkbox"/> M <input type="checkbox"/> F	
CHILD 3:							
Surname:	<input type="text"/>	ID/Passport No:	<input type="text"/>				
First Name:	<input type="text"/>				Gender:	<input type="checkbox"/> M <input type="checkbox"/> F	
CHILD 4:							
Surname:	<input type="text"/>	ID/Passport No:	<input type="text"/>				
First Name:	<input type="text"/>				Gender:	<input type="checkbox"/> M <input type="checkbox"/> F	

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(010) 0010141 www.oneplan.co.za

2nd Floor, South Tower, Nelson Mandela Square, Corner Maude & 5th Street, Sandton City, Johannesburg, 2196

Oneplan™ is administered by Oneplan Underwriting Managers (Pty) Ltd, an authorised financial services provider FSP43628. Oneplan is not a benefit option regulated by the Medical Schemes Act, but a non-life insurance product underwritten by Bryte Insurance Company Limited a licensed insurer and an authorised FSP (17703).

Underwritten By



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

Please refer to Appendix A for our plan types

HEALTH PLAN
 CORE
 CORE PLUS
 BLUE
 PROFESSIONAL
 EXECUTIVE

ADDITIONAL CARDS

(If you would like to order additional Oneplan Claim Cards for your spouse or dependants, you are welcome to request them below at an additional cost of R160 per card. Please specify the full name of whom the card is for)

1	First Name:	<input type="text"/>	R 160
2	First Name:	<input type="text"/>	R 160
3	First Name:	<input type="text"/>	R 160
4	First Name:	<input type="text"/>	R 160

QUESTIONS

Provide the details of any medical doctor/ specialist that you or any dependants have consulted with in the past 12 months.

	Name	Dr	Type (GP/Specialist)	Contact details	Last consultation
Policyholder					
Spouse					
Dependant 1					
Dependant 2					
Dependant 3					
Dependant 4					

Provide details and proof of membership of all previous medical schemes cover that you and any of your dependants belonged to. Membership certificates, which reflects the termination date and/or condition specific waiting periods imposed, must be submitted with application. Should membership certificates not be provided underwriting will be imposed, including:

A 3-month general waiting period for hospital cover, except in the event of an accident;
 A maximum 12-month exclusion for all pre-existing conditions;
 A late joiner penalty

	Name	Medical Aid	Member number	Start date	End date
Policyholder					
Spouse					
Dependant 1					
Dependant 2					
Dependant 3					
Dependant 4					

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MEDICAL QUESTIONS

1. Have you or any of your dependants been diagnosed with or received treatment for any chronic illness/es in the past 12 months?

List of chronic illnesses:

- Cholesterol
- High blood pressure / Hypertension
- Emphysema/ COPD (Chronic obstructive pulmonary disease)
- Asthma
- Diabetes
- Epilepsy
- Arthritis
- HIV

Name & Surname	YES	NO	Condition

2. Have you or any of your dependants undergone any medical procedures or surgeries in the past 12 months?

List of medical procedures:

- Gallstones
- Hernias
- Spleen conditions
- Liver conditions
- Pancreas conditions
- Heart and/or vascular surgery:
- Lungs or respiratory
- Abdominal surgery (for example digestive system, spleen, liver, gallbladder, pancreas)
- Brain or nerve surgery
- Kidney disorders and/ or surgery
- Dental/ Ear/ Nasal/ Throat/ Jaw
- Bone and/or Muscle and/or Skin surgery:
- Reproductive system including breast surgery
- Eye

Name & Surname	YES	NO	Condition

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3. In the past 12 months or currently, have you or any of your dependants suffered from any other medical conditions, injuries, or experienced any symptoms (diagnosed or not) that were treated or might require treatment?

- Heart attack/condition
- Anaemia
- Blood clots
- Aneurysm or any other blood disorders?
- Other lung condition
- Thyroid
- Ulcers
- Migraine/recurring headaches
- Stroke
- Brain conditions
- Psychological disorder
- Kidney stones
- Kidney failure / Dialysis
- Bladder or kidney Infection
- Eye and/or vision problems
- Nose, mouth, throat conditions
- Dental conditions
- Neck and/or back problems
- Bone, joints, muscle disorders
- Skin disorders
- Current pregnancy
- Endometriosis/Fibroids
- Ovarian cysts
- Prostate (Male only)
- Any other genital conditions
- Cancer
- Any other immune deficiency conditions?
- Recurrent symptoms / medical conditions
- Amputations - Comment on limb - left or right in notes
- Paralysed
- Vision/Hearing/Speech

Name & Surname	YES	NO	Condition

3. Have you or any of your dependants used any tobacco or nicotine products (including cigarettes, cigars, pipe tobacco, vaping, e-cigarettes, nicotine gum, or patches) in the past 12 months?

Name & Surname	YES	NO

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ONEPLAN TERMS AND CONDITIONS

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 Health 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 the Administrator trust account held in my name, for distribution to the service provider (hospital risk claims only) and/or the Insured Person upon presentation of valid invoices for services rendered to an Insured person of this policy. I hereby issue power of attorney and a mandate to Oneplan Underwriting Managers (Pty) Ltd to act on my behalf for each claim. I understand that no additional charge will be levied against me for the services offered in assisting me with my claim.

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 advance 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.

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ONEPLAN MOBILE APP

I understand that utilisation of the automated claims process is provided by Oneplan Underwriting Managers (Pty) Ltd and is a formal submission of a claim which require claim validation.

MOBILE CLAIM VALIDATION

I accept the terms and conditions of the Oneplan Claim Card and the Administrator, as well as the conditions of the policy wording upon utilisation of my Oneplan Claim Card. I understand that I may be required to furnish a valid proof of payment to validate a claim. Should I fail to provide the requested documentation, I accept that my cover will be suspended after the 48-hour notice period. Should it be found that the claim was invalid or fraudulent I understand that Oneplan Underwriting Managers will utilise whatever means available in law to recover monies paid for fraudulent claims either by debit order or through other recovery mechanisms and that failure to recover will result in adverse credit listings being brought against the Principal Insured of the policy and may further incur legal charges for the collection of monies, which charges shall be borne by me (the Principal Insured).

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 medical aid 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 (thirty-one) days before any such changes come into effect.

POLICY INITIATION FEE

I consent to my account being debited with the once-off policy initiation fee and card 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 less an early termination penalty fee, calculated on the days you have enjoyed cover 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.

REACTIVATION FEE

Should the policy status become cancelled or suspended for whatever reason, a reactivation charge of R160.00 (One Hundred and Sixty Rand) will be charged.

ONEPLAN CLAIM CARD (not applicable to Old School clients)

Cards are issued per individual policyholder. Dependant cards are available at an extra charge of R160.00 (One Hundred and Sixty Rand) per card. This fee, upon request, will be deducted from my account upon a signed request received for new cards.

OLD SCHOOL

By opting not to utilise the Oneplan Mobile App and Oneplan Claim Card facility to process claims, all claims will be paid to my nominated bank account. I therefore understand I will not receive a Oneplan Claim Card. I may change the option later in writing; all Oneplan Claim Card fees will then apply.

POLICY DELIVERY:

The policy documents, policy guides and associated documents will be delivered via email within 30 days of conclusion of the sale, and the Oneplan Claim Card will be hand delivered within thirty (30) days after receipt of the initiation fee and successful collection of my 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.

DISCLAIMER FROM ONEPLAN:

Where required, Oneplan or its representatives will only provide factual information to assist in completing this application. No advice or recommendations will be given during this process, and the application must be completed based on your own independent needs and decision-making.

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PLAN SELECTION

APPENDIX A - PLAN TYPES - Please select a plan by marking the appropriate box with a tick

HEALTH PLAN

SINGLE	R	250	<input type="checkbox"/>
Single Insured + 1 Child	R	450	<input type="checkbox"/>
Single Insured + 2 Children	R	645	<input type="checkbox"/>
Single Insured + 3 Children	R	845	<input type="checkbox"/>
Single Insured + 4 Children	R	1 035	<input type="checkbox"/>
COUPLE	R	500	<input type="checkbox"/>
Couple + 1 Child	R	695	<input type="checkbox"/>
Couple + 2 Children	R	895	<input type="checkbox"/>
Couple + 3 Children	R	1 090	<input type="checkbox"/>
Couple + 4 Children	R	1 290	<input type="checkbox"/>

CORE PLAN

SINGLE	R	535	<input type="checkbox"/>
Single Insured + 1 Child	R	935	<input type="checkbox"/>
Single Insured + 2 Children	R	1 290	<input type="checkbox"/>
Single Insured + 3 Children	R	1 610	<input type="checkbox"/>
Single Insured + 4 Children	R	1 900	<input type="checkbox"/>
COUPLE	R	1 070	<input type="checkbox"/>
Couple + 1 Child	R	1 445	<input type="checkbox"/>
Couple + 2 Children	R	1 780	<input type="checkbox"/>
Couple + 3 Children	R	2 090	<input type="checkbox"/>
Couple + 4 Children	R	2 395	<input type="checkbox"/>

CORE PLAN PLUS

SINGLE	R	735	<input type="checkbox"/>
Single Insured + 1 Child	R	1 165	<input type="checkbox"/>
Single Insured + 2 Children	R	1 575	<input type="checkbox"/>
Single Insured + 3 Children	R	1 940	<input type="checkbox"/>
Single Insured + 4 Children	R	2 285	<input type="checkbox"/>
COUPLE	R	1 420	<input type="checkbox"/>
Couple + 1 Child	R	1 835	<input type="checkbox"/>
Couple + 2 Children	R	2 225	<input type="checkbox"/>
Couple + 3 Children	R	2 590	<input type="checkbox"/>
Couple + 4 Children	R	2 945	<input type="checkbox"/>

ADD ON
EXCESS BUSTER
R15 PER PERSON PER MONTH

ADD ON
EXCESS BUSTER
R15 PER PERSON PER MONTH

BLUE PLAN

SINGLE	R	1 080	<input type="checkbox"/>
Single Insured + 1 Child	R	1 755	<input type="checkbox"/>
Single Insured + 2 Children	R	2 400	<input type="checkbox"/>
Single Insured + 3 Children	R	3 020	<input type="checkbox"/>
Single Insured + 4 Children	R	3 630	<input type="checkbox"/>
COUPLE	R	2 140	<input type="checkbox"/>
Couple + 1 Child	R	2 775	<input type="checkbox"/>
Couple + 2 Children	R	3 280	<input type="checkbox"/>
Couple + 3 Children	R	3 750	<input type="checkbox"/>
Couple + 4 Children	R	4 195	<input type="checkbox"/>

PROFESSIONAL PLAN

SINGLE	R	1 595	<input type="checkbox"/>
Single Insured + 1 Child	R	2 550	<input type="checkbox"/>
Single Insured + 2 Children	R	3 340	<input type="checkbox"/>
Single Insured + 3 Children	R	4 040	<input type="checkbox"/>
Single Insured + 4 Children	R	4 735	<input type="checkbox"/>
COUPLE	R	3 045	<input type="checkbox"/>
Couple + 1 Child	R	3 720	<input type="checkbox"/>
Couple + 2 Children	R	4 325	<input type="checkbox"/>
Couple + 3 Children	R	4 920	<input type="checkbox"/>
Couple + 4 Children	R	5 440	<input type="checkbox"/>

EXECUTIVE PLAN

SINGLE	R	2 175	<input type="checkbox"/>
Single Insured + 1 Child	R	3 185	<input type="checkbox"/>
Single Insured + 2 Children	R	4 100	<input type="checkbox"/>
Single Insured + 3 Children	R	4 820	<input type="checkbox"/>
Single Insured + 4 Children	R	5 520	<input type="checkbox"/>
COUPLE	R	3 855	<input type="checkbox"/>
Couple + 1 Child	R	4 780	<input type="checkbox"/>
Couple + 2 Children	R	5 675	<input type="checkbox"/>
Couple + 3 Children	R	6 355	<input type="checkbox"/>
Couple + 4 Children	R	7 045	<input type="checkbox"/>

ADD ON
EXCESS BUSTER
R25 PER PERSON PER MONTH

ADD ON
EXCESS BUSTER
R40 PER PERSON PER MONTH

ADD ON
EXCESS BUSTER
R40 PER PERSON PER MONTH

Principal Insured's Signature _____

Date

Y	Y	Y	Y	M	M	D	D
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PAYMENT INSTRUCTIONS

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

Account Type: Cheque Savings Transmission

Monthly Deduction Amount: R _____

Deduction Date: 1st 25th 28th Day of the month

Bank: _____ Account Number: _____

Account Name: _____ Branch: _____ Branch Code: _____

Account Holder's Signature: _____

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

Principal Insured's Signature

Date

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