# HEALTH INSURANCE APPLICATION FORM

Application Form for policies incepted from the 1st of March 2020.

## PRINCIPAL INSURED

Title: | Initial/s: | Surname:

First Name: | Gender: M F

Maiden Name: | Language:

ID No: | Date of Birth: Y Y Y Y M M D D | Policy Inception Date: (Debited in advance) Y Y Y Y M M D D

Cell: | Home Phone: | Work Phone:

Email:

Physical Address:

Postal Code:

**DELIVERY ADDRESS FOR ONECARD:**
**PLEASE NOTE: Delivery to below address between 8h00 to 17h00 weekdays**

Building Name:

Street Address and Number: | Postal Code:

Suburb:

City:

Province:

Contact Number for Delivery:

Employer: | Occupation:

Work Address:

Postal Code:

Employment Period From: | Work Phone: | Monthly Household Income: ☐ R 1 500 - R 5000 ☐ R 5 000 - R 10 000 ☐ R 10 000 - R 20 000 ☐ > R 20 000

## DEPENDANTS

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

**PARTNER / SPOUSE INFORMATION:**

Title: | Initial/s: | Surname:

First Name: | Gender: M F

Maiden Name:

ID No: | Cell: | Fax:

Email:

**CHILD 1:**
Surname: | ID No:
First Name: | Gender: M F

**CHILD 2:**
Surname: | ID No:
First Name: | Gender: M F

**CHILD 3:**
Surname: | ID No:
First Name: | Gender: M F

**CHILD 4:**
Surname: | ID No:
First Name: | Gender: M F

OFFICE USE ONLY
Policy Number:

**INITIAL HERE**

## CHOSEN BENEFICIARY DETAILS - In the event of the Principal Insured's Death

Title: Initial/s: Surname:

First Name: Gender: M F

Maiden Name: Language:

ID No: Cell: Home Phone:

Email:

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

Please refer to Appendix A for our plan types

☐ CORE ☐ BLUE ☐ PROFESSIONAL ☐ EXECUTIVE

## ADDITIONAL CARDS

(If you would like to order additional Onecard's for your spouse or dependants, you are welcome to select one of the options below at an additional cost of R160 per card. Please tick the appropriate box, with the full name of whom the card is for)

☐ 1 First Name: R 160

☐ 2 First Name: R 160

☐ 3 First Name: R 160

☐ 4 First Name: R 160

## QUESTIONS

**Provide the details of the 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 |
|---|---|---|---|---|---|
| **Policy holder** | | | | | |
| **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 dependents belonged too. 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 |
|---|---|---|---|---|---|
| **Policy holder** | | | | | |
| **Spouse** | | | | | |
| **Dependant 1** | | | | | |
| **Dependant 2** | | | | | |
| **Dependant 3** | | | | | |
| **Dependant 4** | | | | | |

**INITIAL HERE**

## HEALTH INFORMATION

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Height / Weight | Name | | | | Name | | | |
| | Height | | Weight | | Height | | Weight | |
| | Name | | | | Name | | | |
| | Height | | Weight | | Height | | Weight | |
| | Name | | | | Name | | | |
| | Height | | Weight | | Height | | Weight | |
| Alcohol consumption (1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine) | Name | | | | Name | | | |
| | Units per week | | | | Units per week | | | |
| Smoke | Name | | | | Name | | | |
| | Per day | | | | Per day | | | |
| | Stopped past 24 months | | | | Stopped past 24 months | | | |
| | Reason for stopping | | | | Reason for stopping | | | |

## MEDICAL QUESTIONS

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

| Name & Surname | Condition |
|---|---|
| | |
| | |
| | |
| | |

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

| Name & Surname | Condition |
|---|---|
| | |
| | |
| | |
| | |

**INITIAL HERE**

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

| Name & Surname | Condition |
|---|---|
| | |
| | |
| | |
| | |

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

| Name & Surname | Condition |
|---|---|
| | |
| | |
| | |
| | |

5. **Have you or any of your dependents 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 & Surname | Condition |
|---|---|
| | |
| | |
| | |
| | |

6. **Have you or any of your dependents 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 & Surname | Condition |
|---|---|
| | |
| | |
| | |
| | |

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

| Name & Surname | Condition |
|---|---|
| | |
| | |
| | |
| | |

**INITIAL HERE**

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

| Name & Surname | Condition |
|---|---|
| | |
| | |
| | |
| | |

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

| Name & Surname | Condition |
|---|---|
| | |
| | |
| | |
| | |

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

| Name & Surname | Condition |
|---|---|
| | |
| | |
| | |
| | |

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

| Name & Surname | Condition |
|---|---|
| | |
| | |
| | |
| | |

12. **Are you or any of your dependents aware of any Recurrent symptoms in the last 6 months and/or Any Medical conditions that may require Medical interventions or Diagnostic procedures?**

| Name & Surname | Condition |
|---|---|
| | |
| | |
| | |
| | |

**INITIAL HERE**

**13. Have you or any of your dependents EVER undergone any Surgery or Procedures?**

| Name & Surname | Condition |
|---|---|
| | |
| | |
| | |
| | |

**14. Do you or any of your dependents participate in ANY Combat sports and or belong to a rugby club (Over 18 only)?**

| Name & Surname | Condition |
|---|---|
| | |
| | |
| | |
| | |

**15. Do you or any of your dependents have any Amputations, Paralysis an/or Loss of usage of a Limb, Vision, Hearing or Speech?**

| Name & Surname | Condition |
|---|---|
| | |
| | |
| | |
| | |

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

| Name & Surname | Condition |
|---|---|
| | |
| | |
| | |
| | |

**INITIAL HERE**

# ONEPLAN 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 wording that can be found in the self-service login on the website www.oneplan.co.za 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 myself 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 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 through www.oneplan.co.za in the self-service section of the site.

## 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 serivice 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 and every 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 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 wording 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 with the premium amount starting on the inception date or the next business day. However, should the ITC rating above indicate that it is necessary for the policy to be debited through the advanced debit order mechanism (NAEDO), the debit order date will fall between the 25th of the month prior to inception date and the 7th of the month of the inception date. The inception date is deemed to mean the next occurrence of the date chosen. Should this date have passed, the policy inception date will fall into the next calendar month. 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 alternatively through the advanced debit order collection mechanism (NAEDO) that may be run at any time from the date of notification by our collection agent of the failed / returned payment as mentioned above. This

OFFICE USE ONLY
Policy Number:

**INITIAL HERE**

will carry an administration charge of R50.00 (fifty rand), which will be levied to my account and collected with my premium. 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. The Administrator reserves its right to collect cancellation fees with whatever means in law necessary to offset the costs of marketing collateral issued and charges as contained herein.

### MOBILE CLAIMS PROCESS:

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 may require claim validation.

### MOBILE CLAIM VALIDATION:

I accept the terms and conditions of the Onecard and the Administrator, as well as the conditions of the policy wording upon utilisation of my Onecard. 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 through NAEDO (the advanced debit order mechanism previously mentioned) 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 Regulations. 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 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 30 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 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.

### 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.

### TRANSACTIONAL CARDS:

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.

### POLICY DELIVERY:

The policy documents, Onecard transactional cards, policy guides and associated documents will be sent out within thirty days after the receipt of the initiation fee and successful collection of my first premium collection. The information in the policy wording 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.

**INITIAL HERE**

## PLAN SELECTION

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

| CORE | | BLUE | | PROFESSIONAL | | EXECUTIVE | |
|---|---|---|---|---|---|---|---|
| **SINGLE** | R 380 ☐ | **SINGLE** | R 750 ☐ | **SINGLE** | R 1 000 ☐ | **SINGLE** | R 1 300 ☐ |
| Single Insured + 1 Child | R 640 ☐ | Single Insured + 1 Child | R 1185 ☐ | Single Insured + 1 Child | R 1 600 ☐ | Single Insured + 1 Child | R 1 900 ☐ |
| Single Insured + 2 Children | R 885 ☐ | Single Insured + 2 Children | R 1 615 ☐ | Single Insured + 2 Children | R 2 095 ☐ | Single Insured + 2 Children | R 2 445 ☐ |
| Single Insured + 3 Children | R 1 105 ☐ | Single Insured + 3 Children | R 2 040 ☐ | Single Insured + 3 Children | R 2 540 ☐ | Single Insured + 3 Children | R 2 875 ☐ |
| Single Insured + 4 Children | R 1 305 ☐ | Single Insured + 4 Children | R 2 450 ☐ | Single Insured + 4 Children | R 2 975 ☐ | Single Insured + 4 Children | R 3 295 ☐ |
| **COUPLE** | R 735 ☐ | **COUPLE** | R 1 445 ☐ | **COUPLE** | R 1 915 ☐ | **COUPLE** | R 2 305 ☐ |
| Couple + 1 Child | R 990 ☐ | Couple + 1 Child | R 1 875 ☐ | Couple + 1 Child | R 2 340 ☐ | Couple + 1 Child | R 2 850 ☐ |
| Couple + 2 Children | R 1 220 ☐ | Couple + 2 Children | R 2 215 ☐ | Couple + 2 Children | R 2 720 ☐ | Couple + 2 Children | R 3 390 ☐ |
| Couple + 3 Children | R 1 435 ☐ | Couple + 3 Children | R 2 535 ☐ | Couple + 3 Children | R 3 090 ☐ | Couple + 3 Children | R 3 790 ☐ |
| Couple + 4 Children | R 1 645 ☐ | Couple + 4 Children | R 2 830 ☐ | Couple + 4 Children | R 3 415 ☐ | Couple + 4 Children | R 4 210 ☐ |
| ADD ON EXCESS BUSTER R15 Per Person Per Month | Y ☐ N ☐ | ADD ON EXCESS BUSTER R25 Per Person Per Month | Y ☐ N ☐ | ADD ON EXCESS BUSTER R40 Per Person Per Month | Y ☐ N ☐ | ADD ON EXCESS BUSTER R40 Per Person Per Month | Y ☐ N ☐ |

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

OFFICE USE ONLY
Policy Number:

INITIAL HERE

## PAYMENT INSTRUCTIONS

Please note we accept payment only via monthly Debit Order.

**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 Holders Signature:** _____

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

_____ _____

Principal Insured's Signature Date

OFFICE USE ONLY
Policy Number: _____

_____

**INITIAL HERE**

ONEPLAN™ Health Insurance

(010) 001 0141 www.oneplan.co.za
54 Maxwell Drive, Woodmead North Office Park, Woodmead 2021



Underwritten By Bryte