LIONHEALTH

EMPLOYEE APPLICATION FORM

Current employer		Employment status (circle one)	PERMANENT	CONTRACT
What day of the month do you get paid?				
Employer contact (HR Department)				
Employer cover start date				

Please select what scheme you are applying for

☐ Day-to-Day Plan ☐ Hospital Plan ☐ Combined Plan

* Please note that by ticking a scheme option, you are agreeing that the product was explained to you and that you agree to the deduction applicable to the scheme chosen.

Main Member Information

The main member MUST BE AN EMPLOYEE as payment for the scheme will run as a payroll deduction.
The member must also be younger than 65 years old for the Day-to-Day Plan and 55 years old for the Hospital Plan.

Title (Mr/Mrs/Doctor/Other)		Gender	
First name		Surname	
Date of birth		ID Number	
Address		Town	
City		Postal Code	
Cell #		Home #	
Work #			
Email address			

Spouse Information

Title (Mr/Mrs/Doctor/Other)			
First name		Surname	
ID Number		Relationship to main member	
Cell #		Home #	
Email address			

continued ➡

Dependent Information

You are allowed to include 4 (four) dependents in your cover, please note that these dependents have to be below the AGE of 21.

First name		Surname		Gender		Age		ID												
First name		Surname		Gender		Age		ID												
First name		Surname		Gender		Age		ID												
First name		Surname		Gender		Age		ID												

Additional Information

Please ensure you answer these questions as they will determine your waiting period and exclusions.

1.	Are you or any of your dependents on any form of Chronic medication?	YES		NO	
2.	Are you or any of your dependents currently receiving treatment for and other medical condition?	YES		NO	
3.	Are you or any of your dependents currently receiving dental treatments?	YES		NO	
4.	Are you concerned about any current condition that may need immediate attention?	YES		NO	
5.	Are you or your spouse pregnant?	YES		NO	
6.	Have you or any of your dependents undergone major surgery in the last 5 years?	YES		NO	
7.	Have you or any of your dependents been admitted to hospital in the last 5 years?	YES		NO	
8.	Have you or your spouse or dependents ever been on a medical aid/scheme?	YES		NO	
9.	Have you or your spouse had an HIV test in the past 3 months?	YES		NO	

Detailed Medical Information

If you answered YES to any of the above, please provide us with further information below.

Question Number	Person	Details

Do you have a preferred General Practitioner?

First name	
Surname	
Contact Number	

Employee Declaration and consent

I warrant that I have been provided with all information, service provider and plan details, or any additional information I may have requested. I warrant that all details and facts provided herein are accurate and properly disclosed even if completed by a representative on my behalf. I hereby accept the terms and conditions and I understand that the benefits offered where such benefits relate to the medical insurance product are insurance based and not a medical aid. I acknowledge that all contributions/premium will be deducted via payroll and hereby authorise my employer to deduct from my salary the agreed contributions/premiums. In the event I cease to work for my employer, I will have 31 days to complete a debit order form or my policy will be cancelled. I understand that additional debit order fees may be charged. I consent to the disclosure, processing and usage of any relevant and personal information (as defined in the Protection of Personal Information Act 4 of 2013) by Lion of Africa Life Assurance Company Limited, its holding company, its subsidiaries, its service providers, or appointed representatives for the purpose of rendering a service in relation to the policy. I acknowledge that the LionHealth products/policies is insurance and is not a medical aid.

I confirm that I have read and understood the terms and conditions on this application form as well as policy rules. I confirm that I understand the nature of the products/services provided by Lion of Africa Life Assurance Company Limited.

Signature of Main member	Date
Signature of Authorised Employer	Date