LIONHEALTH

# INDIVIDUAL APPLICATION FORM

## 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 member must be younger than 55 years old.

Inception Date:

| | | | |
|---|---|---|---|
| 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 | | | | | | | | | | | | | |

## Medical 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 or been hospitalised in the last 5 years? | YES | | NO | |
| 7 | 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 |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| Have you or your spouse or dependents ever been on a medical aid/scheme? YES/NO | | |

## Do you have a preferred General Practitioner?

| | |
|---|---|
| First name | |
| Surname | |
| Contact Number | |

| Payment Method | Debit Order ☐ Stop Order ☐ |
|---|---|
| | I acknowledge I have been provided with all information, service provider and plan details, or any additional information I may have requested. I acknowledge 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 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 "LionLife", its service providers, or appointed representatives for the purpose of rendering a service in relation to the policy. 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 "LionLife".<br><br>This will become a valid medical health insurance policy once Lion of Africa Life Assurance Company Limited "Lion Life" accepts the application and the first premium has been received. |

| | |
|---|---|
| | |
| Signature of main member | Date: |

**Member Number:**

**Lion of Africa Life Assurance Company Limited "LionLife"**

# DEBIT ORDER MANDATE:

I, the undersigned, request LION OF AFRICA LIFE ASSURANCE COMPANY LIMITED **"LionLife"** to arrange with my bank to collect the payments due on the plan (as they may be amended from time to time) from my bank account (wherever it may be) by debit order.

**Authority given by:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Address | | | | | | | | Postal Code | | | |
| Contact Number(s) | (C) | | | (H) | | | | (W) | | | |
| Bank Name | | | | | | | | Branch Name | | | |
| Account Number | | | | | | | | | | | |

**Type of Account**

☐ Current Cheque ☐ Savings ☐ Transmission

Abbreviated name as registered with the bank: **LIONHEALTH**

This signed Authority and Mandate refers to our contract as dated _____ ("the Agreement"). I / We hereby authorise you to issue and deliver payment instructions to the bank for collection against my / our abovementioned account at my / our above mentioned bank (or any other bank or branch to which I / We may transfer my / our account) on condition that the sum of such payment instructions will never exceed my / our obligations as agreed to in the Agreement, and commencing on the commencement date and continuing until this Authority and Mandate is terminated by me / us by giving you notice in writing of no less than 20 ordinary working days, and sent by prepaid registered post or delivered to your address indicated below.

The individual payment instructions so authorised to be issued must be issued and delivered as follows. On the _____ day ("payment day") of each and every month commencing on _____ an amount of R _____ will be deducted.

If the payment day falls on a Saturday, Sunday or recognised South African public holiday, the payment day will automatically be the very next ordinary business day.

I / We understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African Banks and I also understand that details of each withdrawal will be printed on my bank statement. Each transaction will contain a number, which must be included in the said payment instruction and if provided to you should enable you to identify the Agreement. A payment reference is added to this form before the issuing of any payment instruction. I / We shall not be entitled to any refund of amounts which you have withdrawn while this authority was in force if such amounts were legally owing to you.

PREMIUM ADJUSTMENTS

Should the relevant premium rate be adjusted as a result of a premium review or an inflation related increase, I confirm that the adjusted premium rate may be deducted from my bank account until such time as I cancel this authorisation or until I substitute it with a new authorisation.

MANDATE

I / We acknowledge that all payment instructions issued by you shall be treated by my / our above mentioned bank as if the instructions had been issued by me / us personally.

CANCELLATION

I / We agree that although this Authority and Mandate may be cancelled by me / us, such cancellation will not cancel the Agreement. I / We shall not be entitled to any refund of amounts which you have withdrawn while this authority was in force if such amounts were legally owing to you.

ASSIGNMENT

I / We acknowledge that this Authority may be ceded to or assigned to a third party if the agreement is also ceded or assigned to that third party, but in the absence of such assignment of the Agreement, this Authority and Mandate cannot be assigned to any third party.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Signature of Payer | | Date | | Signed at | | On this | | Day of | | 20 | |

# STOP ORDER AUTHORITY:

**I the undersigned**,

| Full Name | | Surname | | Identity Number | |
|---|---|---|---|---|---|

hereby, authorise the Accountant of my Department to deduct from my salary a monthly premium equal to R _____

The first deduction is to be made at the end of the month of _____ 20 _____

The premium stated must be remitted to Lion of Africa Life Assurance Company Limited "LionLife" form whom I have purchased a Health Insurance Plan.
Should the premium be adjusted by the company as a result of a general decrease/increase in the premium or I request the company to decrease/increase the premium for a certain reason, I agree that the adjust premium may be deducted from my salary, until such a time I cancel this authority in writing or until I substitute it with a new authority.

EMPLOYEE'S CONSENT

I hereby understand that should a deduction not be made for some reason or another from my salary/wages, my monthly premium shall not be paid over to Lion of Africa Life Assurance Company Limited "LionLife" by my employer and further that I shall be responsible for payment. Should my payment as stated and agreed upon on the stop order not be received by Lion of Africa Life Assurance Company Limited "LionLife" on the next payment dated and every month thereafter, my benefit shall cease.

| Occupation | | Employer Number | | Department | | Persal Number | |
|---|---|---|---|---|---|---|---|

| Name of Institute | | Pay Point | |
|---|---|---|---|

| Signature of Payer | | Date | | Signed at | | On this | | Day of | | 20 | |
|---|---|---|---|---|---|---|---|---|---|---|---|

| Agent Name | | Agent Surname | |
|---|---|---|---|

| Agent Number | | Agent Signature | | Date | |
|---|---|---|---|---|---|