



DEBIT ORDER AUTHORITY FORM

Please complete this form in black ink and CAPITAL letters

Medical Scheme membership no: Name of Medical Scheme:

Medical Scheme option:

Is this application part of a group? (Place a clear X inside the box) YES NO If YES, group name:

Previous Gap Cover: Date Joined:

Date Terminated: Required Start Date:

Please attach membership certificate

POLICYHOLDER DETAILS

Policy Number:

Name and Surname:

ID number \ Passport: Mr Mrs Miss Dr Other

Date of birth: Email Address:

Contact details Home no: Work no:

Fax no: Cell no:

Postal address:

Code:

Residential address:

Code:

DEPENDANTS

Dependants are: - Spouse and/or dependent children up to the age of 21 years. - Adopted/foster child (please attach documentary proof).
- Students up to the age of 27 (please prove full time enrolment). Provide proof of full time studies or medical scheme certificate if you are on a different medical scheme.
- For families who belong to a single medical scheme and or medical scheme option, we cover beneficiaries of all ages as listed by the scheme.
Please provide us with your medical scheme Certificate of Membership (COM).

Inception Date:

Name and Surname:

ID number \ Passport: Male Female

Date of birth: Relationship to applicant:

Name and Surname:

ID number \ Passport: Male Female

Date of birth: Relationship to applicant:

Name and Surname:

ID number \ Passport: Male Female

Date of birth: Relationship to applicant:

Name and Surname:

ID number \ Passport: Male Female

Date of birth: Relationship to applicant:

The following questions relate to you, your beneficiaries and dependants covered under this policy.

		Yes	No
1	Have you been admitted to hospital in the last 4 months?		
2	Are you expecting a hospital admission or aware of any conditions or illness that would require treatment in the next 12 months?		
3	Are you or any of your dependants currently pregnant?		
4	Have you taken chronic medication in the past 24 months, or are currently taking chronic medication?		
5	Have you been on gap cover before and/ or have had a gap claim? If yes, who was the provider?		

If you answered "YES" to any of the questions, please provide details below.

Question no:	Applicant/ Dependants	Disorder	Medication	Date Diagnosed

Should the above space be insufficient, please add in the notes section.

IMPORTANT INFORMATION

- Please make sure FUL details are given for questions answered YES;
- Application forms may be underwritten and conditions may be excluded for longer than 10 months;
- The onus lies on the insured to make sure that premiums are paid on a monthly basis. References on bank statements read: **MDSIRAGO_MED**;
- Effective from 1 January 2023

DECLARATION BY APPLICANT

I, the undersigned hereby declare:

- That I understand that this is an Accident and Health policy with stated benefits in terms of the Short-term Insurance Act 53 of 1998 and not a Medical Scheme product.
- That sharing of claims information and underwriting information by Insurers is essential to enable the insurance industry to underwrite policies, assess risks fairly, reduce the incidence of fraudulent claims and protect the public interest in terms of limiting excessive premium increases.
- I specifically consent to Sirago Underwriting Managers (Pty) Ltd contacting my current Medical Scheme and/or medical practitioner to verify any medical details as provided in my claim form. I further consent to such information being disclosed to Sirago Underwriting Managers (Pty) Ltd for the purpose of verifying the disclosed information as provided on my application form.
- As part of the claims validation process, we used the services of a contracted third party in order to authenticate medical scheme membership, plan option type, relevant beneficiaries and agreed medical scheme option tariffs amongst other relevant information to validate the claim.
- Sirago Underwriting Managers (Pty) Ltd reserve the right to call for additional information of a clinical nature. In the event that Sirago requests a PMA (Post Medical Assessment) from my doctor as part of the claims assessing and authentication process.
- I authorise Sirago Underwriting Managers to negotiate with service providers on my behalf for my medical claims and/or bill and pay the provider direct.
- In the event of a bereavement-related claim, the Insurer will pay the benefit into the policyholder or nominated beneficiary's account. The beneficiary must be noted on the policy prior to any loss. Sirago will require the full name, surname, and ID to note the beneficiary.
- At the time of a claim, Sirago will require the beneficiary's ID and proof of bank. Should there be no beneficiary noted on the policy prior to the loss, or should Sirago be unable to confirm the identity of the beneficiary, payment will always be made into the policyholder's account.

Declaration and Informed Consent in terms of the Protection of Personal Information Act 4, of 2013 (POPIA)

We at GENRIC Insurance Company Limited (GENRIC) respect your right to privacy. We need to collect and process some of your personal information in terms of various Privacy and Data Management laws and are bound by the terms and provisions of the Protection of Personal Information Act, regarding the acquisition, usage, retention, transmission, and deletion of your personal information. Your personal information collected is for the primary purpose of providing you with insurance cover and for all other activities and processes incidental to and relevant to this purpose. As this information forms the basis our assessment and terms we offer you, it must be correct, complete, and up to date.

We will always comply with all relevant regulations in dealing with your information and keep it secure and confidential at all times. Your information shall be kept confidential; however, we shall disclose it to certain third parties as required and other insurers for the specific purpose of insurance and to reduce and prevent any form of fraudulent activity. Should you decide to cancel this insurance contract, you further consent to GENRIC, in retaining the information in line with the legally permitted retention period, for statistical and reporting purposes only. Should you decide not to accept the proposal, the information collected will be de-identified and only used for statistical and research purposes. I hereby voluntarily consent to GENRIC processing my Personal Information.

I understand the purposes for which my Personal Information is required and for which it will be used.

I give GENRIC permission to process my Personal Information as provided above.

Our Privacy Notice and POPIA Policy provides the details of how we deal with the personal information of our clients, and it is available on our website at the following address: <https://genric.co.za>.

Signature of policyholder

Date:

I agree to the above sections above

NOTES/ ADDITIONAL INFORMATION