Sanlam

UNDERWRITTEN BY CENTRIQ INSURANCE

Retail Application Form

Important note

Please complete and sign this form and return to your Broker who will submit to our administrators Kaelo on your behalf. Kaelo will only accept applications received by a broker. Applications received after the 15th of the current month will only be activated on the 1st of the following month. Dedicated Sanlam Gap email address: sanlamapps@kaelo.co.za.

A. Applicant Details

☐ I do not currently have Gap Cover

☐ I currently have Gap Cover with another provider but I wish to transfer my cover to Sanlam Gap

If you have Gap Cover with another provider but wish to transfer to Sanlam Gap, please submit your proof of cover. Waiting periods may apply.

Policy Type:

☐ **Single Policy**
If you are joining as a single Policyholder, you accept that cover will only apply to yourself and that should any changes be required, you must notify our adminstrator Kaelo, within 90 days. This includes the addition of dependants. Premiums are payable monthly.

☐ **Family Policy**
If you are joining as a family, you accept that Cover will apply to you, your spouse and your children up to the maximum age of 26. Cover for children only applies until they reach the age of 27 years. Should any changes be required, you must notify our adminstrator Kaelo, within 90 days. This includes the addition of dependants. Premiums are payable monthly.

Plan Option:

☐ Sanlam Gap Comprehensive

☐ Sanlam Gap Comprehensive with added Mediclinic Extender option

Cover Start Date: _____

First Name: _____

Surname: _____

ID Number (compulsory field): _____ Cellphone: _____

Gender: _____ Date of Birth: _____

Email: _____

Address: _____

_____

B. Employer

Name: _____ Branch: _____

Employment Date: _____

C. Medical Scheme Cover Detail

Medical Scheme: _____ Option: _____

Start date of medical scheme membership: D D M M Y Y Y Y

Membership number: _____

Please note *that cover can only be granted if you are a member of a medical aid scheme and not health insurance. Health insurance policies are not medical aid schemes which are governed by the Medical Schemes Act (No. 131 of 1998)*

D. Insured Party Details:

Should you have dependants, please provide us with a copy of your Medical Scheme membership certificate. Cover will apply to you, your spouse and your children up to the maximum age of 27. Children will only be covered until they reach the age of 27. If any of your dependants are on another Medical Scheme, please provide a copy of their membership certificate. Financially dependant parents excluded.

First Name:	Surname:	Relationship:	Date of Birth/ ID Number:	Inception Date

E. Waiting Periods

A 3 month General Waiting Period and 12 month Condition Specific Waiting Period will be applied for all new applications. If you are transferring your cover from another Gap Cover provider with similar benefits, only the balance of the applicable waiting periods will apply.

F. Debit Order Details

The following reference will be reflected on your bank statement: Sanlam Gap. If you are joining as a family, you accept that cover will apply to you, your spouse and your children up to the maximum age of 27. Should any changes be required, you must notify our administrator Kaelo within one calendar month. This includes the addition or removal of Dependants.

Account Name: _____ Account Number: _____

Branch Name: _____ Bank Name: _____

Account Type: _____ Bank Code: _____

Premium: _____

Name and Surname of Premium Payer: _____

Individuals:

- ☐ R246 per month (younger than 60 years)
- ☐ R494 per month (older than 60 years)
- ☐ R43 per month (younger than 60) add Mediclinic Extender
- ☐ R80 per month (older than 60) add Mediclinic Extender

Families:

- ☐ R429 per month (younger than 60 years)
- ☐ R864 per month (older than 60 years)
- ☐ R98per month (younger than 60) add Mediclinic Extender
- ☐ R166 per month (older than 60) add Mediclinic Extender

Debit Order date: Please specify the date you would like for your debit order to take place each month.

☐ 1st ☐ 7th ☐ 15th ☐ 25th ☐ last working day

I, the Premium payer, hereby authorise Centriq to draw against the above bank account all amounts due to Centriq in terms of this insurance cover. Should the relevant Premiums be adjusted, I hereby confirm that the adjusted amount may be drawn from the above account subject to the notice period outlined in the Policy. This request is to remain in force unless cancelled by one month's written notice.

Premium Payer Signature: _____

Debit order deductions or Payment Terms are in Arrears or Advance
(This is dependent on the strike date chosen. 1st, 7th, 15th is collected in advance and 25th, 31st is collected in arrears).

G. Broker Details

Broker House Name: BS CONSULTING

Broker Code: 373

Broker Consultant Name: BRADLEY SAYERS

H. Declaration

I, _____ (full name) hereby declare that this application form, whether in my handwriting or not, is accurate and complete and forms the basis of the contract of insurance between the Underwriter and myself. I hereby apply for the insurance product/s and agree to abide by its Policy rules and/or those of its Underwriter and any amendments thereto which may be made from time to time. I confirm that all the information provided herein is complete and true and that I have not concealed any relevant or pertinent information that may affect the evaluation of risk considered under this Policy of cover. I understand that the provision of any false, misleading or missing information could result in my application being rejected or my Policy being cancelled or claims being rejected. Should this occur, I agree to refund all Benefit payments that I have received in relation to this Policy of insurance. I consent to Centriq Insurance, and its operators, processing, and further processing, my personal information in accordance with the Protection of Personal Information Act, for the purposes of concluding, and performing in terms of, this insurance contract.

I hereby provide irrevocable authority for Kaelo, our administrator and its Underwriter to obtain any of my or my beneficiaries' medical history from any Medical Service Provider, Medical Scheme, insurance company or healthcare broker for the purposes of assessing this application for insurance as well as the underwriting of any future risk or the assessment of any claim that relates to this insurance cover. Premiums due to Centriq are payable monthly. Premiums that are in arrears will result in my Policy being suspended or possibly terminated. In the event that any Policy Benefit becomes payable subsequent to or as a result of my death, I hereby provide an irrevocable authority for such Benefits to be paid directly to my surviving Spouse or failing such circumstance to the nominated guardians or trustees responsible for the future care of my minor Children or failing either of the preceding events to my estate. Where applicable, I hereby authorise Centriq to draw against the above bank account all amounts due to Centriq in terms of this insurance cover. Should the relevant Premiums be adjusted by the Underwriters, I hereby confirm that the adjusted amount may be drawn from the above account subject to the notice period outline in the Policy. This request is to remain in force unless cancelled by one month's written notice.

Full Name: _____ Signature: _____

Date: D D M M Y Y Y Y

POPIA Consent

☐ I consent to Centriq Insurance, and its operators, processing, and further processing, my personal information in accordance with the Protection of Personal Information Act, for the purposes of concluding, and performing in terms of, this insurance contract.

For further information please read our Privacy Notice, which can be found on www.centriq.co.za

Once signed, this application form should be returned to your servicing Financial planner.

T 0861 111 167
E sanlamapps@kaelo.co.za

Sanlam Reality Application form
for Bonitas medical aid members.

Once completed, please submit with your medical aid application form.
Please tick all boxes where applicable.

☐ New medical aid member ☐ Current medical aid member

Personal details

First name: (As per ID) _____

Preferred name: _____

Full names: (As per ID) _____

Surname: _____

Identity number: _____

Sanlam Reality membership

Please select your membership option.

(Refer to our website or call 0860 732 5489 for more information.)

Membership option	Single option		Family option	
Reality Club	R35 pm	☐	n/a	
Reality Core	R70 pm	☐	R100 pm	☐
Reality Health	R160 pm	☐	R200 pm	☐

Note: By selecting the family option we will automatically add your dependants as per your medical aid.

Money Saver Card:

☐ Money Saver card only ☐ Add the Money Saver card to my membership

Note: There is no card admin fee for the first three months, thereafter R50 per month will apply. More cards can be ordered for family members.

Sanlam Reality communication options

I prefer to receive communication via the following channels:

Email ☐ SMS ☐ Phone ☐ Mail ☐

I would like to receive information about discounts and special offers available only to members:

Yes ☐ No ☐

Permission to use medical aid information

Sanlam Reality will use your personal information (as supplied by your medical aid scheme) to complete your Sanlam Reality registration. Sanlam Reality will keep your personal and/or health information, as well as the information of your spouse and dependant/s, confidential. However, by signing this form, you agree to the disclosing and use of disclosed information, including that of your spouse and/or dependant/s that you have provided, so that Sanlam Reality may collect, process, store, and share all confidential information, as contained in this application and provided to us after the inception of your Sanlam Reality membership. This information may be used to:

- Administer the Sanlam Reality programme.
- Provide any services that you or your spouse or any dependant/s may require.
- Enable any contracted third party that requires such information to render a service or provide goods to you or your spouse or any dependant/s on your Sanlam Reality membership, but only if such contracted third party agrees to keep the information confidential.
- Enable any other entity within the Sanlam Group, where you or your spouse or your dependant/s have applied for a product, to administer the product.
- Health data may be shared/utilised in order to qualify for specific benefits.

☐ I hereby agree and give permission.

Intermediary details

Complete this section if an intermediary introduced you to Sanlam Reality.

Surname: Sayers

First name: Bradley

Intermediary code: 21110

Contact number: 0829558957

Debit order authorisation

☐ I hereby authorise that Sanlam Reality can use the banking details provided for my medical aid claims refunds.

OR

☐ Sanlam Reality may create a debit order instruction based on the information indicated below for the specific amount which will be deducted on the first of every month unless otherwise requested. I undertake to inform Sanlam Reality of any changes to my bank details and authorise Sanlam Reality to verify such details. (Total 'SL' Debit or Real Futures Pty Ltd will reflect on your bank statement for this deduction.)

Debit order information:

Account name: _____

Bank: _____

Bank code: _____

Account number: _____

Account type:

Savings ☐ Transmission ☐ Cheque ☐

Signature:

I hereby confirm that the above information is true and correct. I agree that by joining the Sanlam Reality programme I am bound by Sanlam Reality's rules as set out by the programme. For full T&Cs, visit **www.sanlamreality.co.za**.

Signed: _____

at _____ on _____

Print name: _____

Print name: _____

Sanlam

UNDERWRITTEN BY CENTRIQ INSURANCE

Claim Form

1. Please note that this is not an automatic process, and you will be required to submit a separate Claim form to the Claim that has been submitted to your Medical Scheme.
2. You have six months from the last day that you were hospitalised to submit your Claim and relevant documentation. Any Claim received for the first time after the six month period has expired, will not be honoured.
3. Please note that if you are a VAT registered vendor, this insurance claim settlement could potentially create a liability to pay output VAT to SARS i.t.o. S8 (8) of the VAT Act.
4. Claims are assessed on a line by line basis. Each line has a code on your service provider's account that accumulates to the total amount charged. Your medical aid must pay a portion of the cost per line from your hospital benefit in order for that claim line shortfall to be reviewed by your Gap cover.
5. Claims flagged as Prescribed Minimum Benefit (PMB) may be investigated with your medical aid or discussed with your service provider. PMBs are a set of defined benefits that medical aids are required to cover by law. This means that as a medical aid member, you shouldn't incur any out-of-pocket medical expenses related to a PMB.
6. Processing of insurance information is done in accordance with applicable legislation, as well as our Privacy Policy which can be found in our Compliance and Trust Centre on our website: www.kaelo.co.za and www.centriq.co.za.
7. When submitting the Claim form, you will need to provide supporting documents as detailed below in the checklist. Claims can be emailed to **sanlamclaims@kaelo.co.za**. Once received, your Claim will be processed and if all requirements have been met, the Benefit amount will be paid within 7 to 14 working days. Please direct all queries to the Sanlam Gap Service Centre on **0861 111 167**. Visit **https://www.kaelo.co.za/quick-links/** to view the Claims Journey.

In order for us to assess your Claim without any delays, please ensure you submit the following documents:

Claims Checklist	Where to get it?	Shortfalls & Co-Payments Accidental Casualty & Child Illness	Family Booster	Hospital Booster	Family Protector	Contribution Waiver	Mediclinic Extender & Cancer Lump Sum
Sections to complete		A - E & J	A - D, H & J	A - D, G & J	A - D, F & J	A - D, F & J	A - D, I & J
Claim form		✓	✓	✓	✓	✓	✓
Hospital account *(not statement)*	Hospital	✓		✓			
Doctor account *(not quote)*		✓					
Medical aid statement *(Including rejection reasons)*	Medical Aid	✓					
Death certificate						✓	
Accident report *(if reported to SAPS)*						✓	
Letter confirming expected vs actual delivery date	Medical doctor		✓				
Medical reports	Oncologist						✓
Histology reports	Pathologist or Oncologist						✓
Oncology treatment plan	Medical Aid						✓

Important note

Please complete, sign and return the Claim Form to: sanlamclaims@kaelo.co.za.

A. Policyholder Details

Title: _____ Full Name: _____

ID Number: _____

Medical Scheme Name: _____ Medical Scheme Plan: _____

Medical Scheme No: _____ Gap Policy No: _____

Cell No: _____ Email Address: _____

Postal Address: _____

_____ Postal Code: _____

B. Payment Instructions

Payments will only be made to the Policyholder's account.

No payments will be made to credit card accounts.

The company will not be liable for the loss of funds due to the provision of incorrect bank details by the Policyholder.

Account Name: _____ Account Number: _____

Bank: _____ Account Type: _____

Branch Code: _____ Account Holder Signature: _____

C. Patient Details

Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Child Other: _____

Do not complete this section if the Patient is the Policyholder.

Title: _____ Full Name: _____

ID Number: _____

D. Event Details

If you are claiming for the Medical Scheme Contribution Waiver and Family Protector Benefits, please do not complete this section.

Where did the procedure take place: ☐ In-Hospital ☐ Doctors Rooms ☐ Casualty Ward

Reason for treatment: ☐ Accident ☐ Oncology ☐ Illness / Surgery

Hospital/Service Provider Name: _____

Reason for Hospitalisation/Treatment: _____

Admission/event date: D D M M Y Y Y Y Discharge date: D D M M Y Y Y Y

If this event was related to Oncology Treatment, please confirm the date you were first diagnosed: D D M M Y Y Y Y

E. Benefit Claimed | Medical Scheme Shortfalls and Co-Payments:

Service Date	Service Provider	Charged Amount	Medical Scheme Paid	Shortfall you are Claiming	Have you paid the Service Provider	
					Yes ☐	No ☐
					Yes ☐	No ☐
					Yes ☐	No ☐
					Yes ☐	No ☐
					Yes ☐	No ☐

F. Event Details | Medical Scheme Contribution Waiver and Family Protector:

Select the benefit you are claiming for: ☐ Medical Scheme Contribution ☐ Waiver Family Protector

Was the Death or Disability due to an accident? ☐ Yes ☐ No *Only accidents are covered*

Date of Death/Accident: D D M M Y Y Y Y *Please attach a copy of the Medical Scheme Membership Certificate*

Details leading to disability: _____

Medical Scheme Premium: _____ **(Amount in Rands)** *Please attach a copy of the Death Certificate and Police Report*

G. Event Details | Hospital Booster:

Admission Date	Discharge Date	Service Provider

H. Event Details | Family Booster:

Due Date	Birth Date

I. Event Details | Mediclinic Extender Cancer Lump Sum Benefit:

Diagnosis Date	Type of Cancer	Is this a first time diagnosis	
		Yes ☐	No ☐
		Yes ☐	No ☐

J. Declaration

I declare that the information, including all supporting documentation, provided to Kaelo in support of my claim is true and correct. I understand that any non-disclosure or false information my result in my claim not being paid or the cancellation of my cover. In order to ensure we are doing all we can to help you, we are able to source certain claims information through our SwitchAssist process in partnership with Med Claim Assist. By signing this declaration you are giving Kaelo permission to access any outstanding documentation or information relating to this claim via Med Claim Assist.

Kaelo Risk (Pty) Ltd reserves the right to negotiate a discounted rate with the relevant service providers on your behalf, if a discount is granted, payment will be made directly into the respective service provider's/Doctor's bank account thus rendering the Payment Instruction on the Claim Form null and void.

I consent to Centriq, and its operators, processing, and further processing, my personal information in accordance with the Protection of Personal Information Act, for the purposes of concluding, and performing in terms of, this insurance contract.

Full Name: Signature:

Date: D D M M Y Y Y Y

Please return the completed claim form to:

E-mail address: sanlamclaims@kaelo.co.za

T 0861 111 167
E **sanlamclaims@kaelo.co.za**