Constantia Life

RONBEL

NAPTOSA
TEACH WITH DIGNITY

Administered by *Ambledown Risk and Underwriting Managers (Pty) Ltd Reg 2004/006271/07 FSP 10287*
Ronbel 198(Pty) Ltd Reg 2007/031620/07 FSP 37365
Underwritten by *Constantia Insurance Company Limited Reg 1952/001514/06*
Constantia Life and Health Assurance Co. Ltd. Reg 99/13922/06

APPLICATION FORM

NAPTOSA Membership No.	
Unique Provincial Code	N A P M E M

DETAILS OF INSURED PERSON (PRINCIPAL MEMBER)

FIRST NAME:			
SURNAME:			
ID NUMBER:			
MEDICAL AID &OPTION:		MEMBERSHIP NO.:	

PHYSICAL ADDRESS		POSTAL ADDRESS	
POSTAL CODE		POSTAL CODE	

CONTACT DETAILS

		FAX:	
TEL NUMBER (HOME)		CELL:	
E-MAIL			

DETAIL OF INSURED PERSONS

RELATIONSHIP	NAME	SEX	AGE	ID NUMBER
SPOUSE				
CHILD DEPENDANT 1				
CHILD DEPENDANT 2				
CHILD DEPENDANT 3				
CHILD DEPENDANT 4				

NOMINATED BENEFICIARY (FUNERAL COVER ONLY)

NAME		ID NUMBER	
CONTACT DETAILS			

GAP COVER	PREMIUM PAYABLE

*__IMPORTANT NOTE:__ Should either the Principal Member or any of their dependants ever been diagnosed or treated for any form of cancer, there will be a permanent exclusion for that person on the Cancer Cover benefit policies. However, the member or dependant still qualifies for the other gap products. .

GAP	GAP PLUS	GAP PLUS EXTEND	GAP SHIELD	GAP SHIELD CO-PAY	
R120.00 pfpm	**R150.00 pfpm**	**R165.00 pfpm**	**R180.00 pfpm**	**R200.00 pfpm**	**R**
*Gap Cover ONLY Maximum age of entry - 70	*Gap Cover Plus *Co-Payment Cover Plus -MRI & CT Scan Co-Payment **Maximum Age of Entry - 70**	*Gap Cover Plus *Co-Payment Cover Plus *MRI & CT scan Co-Payment Plus -Sub-Limitation Cover **Maximum Age of Entry - 65**	*Gap Cover Plus *Cancer Cover **Maximum Age of Entry - 65**	*Gap Cover Plus *Co-Payment Cover Plus *MRI & CT Scan Co-Payment Plus -Cancer Cover **Maximum Age of Entry - 65**	

GAP SELECT	GAP SENIORS	GAP PLUS SENIORS	
R220.00 pfpm	**R185.00 pfpm**	**R225.00 pfpm**	**R**
*Gap Cover Plus *Co-Payment Cover Plus *MRI & CT scan Co-Payment Plus -Sub-Limitation Cover Plus -Cancer Cover **Maximum Age of Entry - 65**	*Gap Cover ONLY **No Maximum Age of Entry**	*Gap Cover Plus *Co-Payment Cover Plus *MRI & CT scan Co-Payment **No Maximum Age of Entry**	

FUNERAL COVER	MAXIMUM AGE AT ENTRY – 65	PREMIUM PAYABLE

FUNERAL COVER OPTION 1		FUNERAL COVER OPTION 2		FUNERAL COVER OPTION 3		
Member/Spouse	R18 000	Member/Spouse	R15 000	Member/Spouse	R10 000	
Children 14 – 21	R10 000	Children 14 – 21	R 8 000	Children 14 – 21	R 7 500	
Children 7 – 13	R5 000	Children 7 – 13	R 4 000	Children 7 – 13	R 3 000	R
Children 0 – 6	R4 000	Children 0 – 6	R 3 000	Children 0 – 6	R 2 500	
Stillborn	R1 000	Stillborn	R1 000	Stillborn	R 1 000	
R45.71 pfpm		**R34.28 pfpm**		**R22.85 pfpm**		

PLUS DEBIT ORDER FEE	**R 3.50**
TOTAL PREMIUM DUE	**R**

Pfpm – Per family per month

DEBIT ORDER AUTHORISATION

(NOTE: THIS SECTION MUST BE COMPLETED)	
GAP COVER PREMIUM	
FUNERAL COVER PREMIUM	
DEBIT ORDER FEE	
TOTAL PREMIUM	

INCEPTION DATE*									**DEBIT ORDER DATE PREFERRED**	**1ST**	**15TH**	**20TH**	**25TH**

(* THE DATE THAT THE DEBIT ORDER PAYMENT IS SUCCESSFULLY RECEIVED)

DEBIT ORDER AUTHORISATION

ACCOUNT HOLDER:			
BANK:			
ACCOUNT NUMBER:		BRANCH:	
BRANCH CODE:		ACCOUNT TYPE:	

Signature of Account Holder

I/we hereby request and authorize you to draw against my/our account with the abovementioned bank (or any other bank or branch to which I/we may transfer my/our account) the sum of _____ **(AMOUNT IN WORDS INCLUDING COMPULSORY DEBIT ORDER FEE**) or any variable amount pertaining to this agreement, on day _____of each month. This being the amount necessary for the settlement of the monthly premium due by you in respect of our contract dated _____. All such withdrawals from my/our account by you shall be treated as though they had been signed by me/us personally. I/we the undersigned "instruct" and authorize your agent to draw against my/our account. I/we also understand that details of each withdrawal will be printed on my/our statement. An administration fee of R 50 will be charged for returned debit orders. I/we agree to pay any banking charges relating to this debit order instruction. This authority may be cancelled by means of giving you thirty days' notice in writing/fax/email to Memp Financial Services (Pty) Ltd, but I/we understand that I/we shall not be entitled to any refund of amounts, which you have withdrawn whilst this authority was in force if such amounts were legally owing to you.

I/we declare that I/we have not withheld any material information and I/we accept that this application and declaration shall be the basis of the contract of insurance between Constantia Life & Health Assurance Co/Constantia Insurance Co. and me/us. I/we declare that I/we understand that this application is subject to waiting periods, pre-existing conditions and exclusions as per the Master Policy Document. I/we further declare that I/we are aware that full details of the relevant FAIS disclosures are available from the NAPTOSA regional office and the website and Memp Financial Services (Pty) Ltd.

Name of Principal Member	**Date**	**Signature**

Completed forms can be emailed to NAPadmin@memp.co.za
Or
Faxed to 086 723 4635

Queries 041 363 7333