LIBERTY

Application Form

Medical Gap Cover and Premium Waiver

Please complete and return to:

e info@zestlife.co.za
f 021 673 8911

Postnet Suite 87
Private Bag X1005
Claremont
7735

Product Selection

Medical Gap Cover (Standard Benefit only)	R207 pm
Medical Gap Cover with Cancer Extender	R255 pm
Medical Gap Cover with Dentistry Cover	R445 pm
Medical Gap Cover with Cancer Extender and Dentistry Cover	R493 pm
Medical Premium Waiver - 24 months	R135 pm
Medical Premium Waiver - 60 months	R235 pm

Principal insured details

Title _____ First name/s _____

Last name _____

Date of birth _____ Gender ID number _____

Postal address _____ Postal code _____

Telephone number (w) _____ Cellphone number _____

Email address _____

Medical Scheme _____

Option/Plan _____

Health questions

(Note: The following question only has to be completed if the Cancer Extender option has been selected.)

Have you or any of your dependants on your medical aid ever had any form of cancer, cancerous growths, tumours, lumps or malignant moles?

(Note: The following question only has to be completed if the Medical Premium Waiver option has been selected.)

Have you ever tested positive or been treated for HIV/Aids?

Debit Order details

Full name of account holder _____

Bank name _____ Branch code _____

Account number _____ Account type _____

Date amount to be collected on _____ of every month Date of first debit order collection _____

I hereby authorise Zestlife to issue payment instructions to its bank to collect the monthly premium due by debit order from my bank account on condition that the sum of such payment instruction will never exceed my obligation in terms of this application. The debit order will be collected every month on the debit order collection date selected above. In the event that this collection day falls on a Sunday or recognised South African public holiday, the collection day will automatically be the previous ordinary business day. If there are insufficient funds in the nominated account to meet the debit order, Zestlife will be entitled to track my account and re-present the instruction for payment as soon as sufficient funds are available in my account. I acknowledge that this authority may be ceded or assigned to a third party by Zestlife or Guardrisk, but in the absence of such assignment this debit authority cannot be assigned to any third party. I understand that the payment instruction will be processed through a computerised system provided by the South African Banks. I shall not be entitled to any refund of amounts which Zestlife has collected while this debit order authority was in force, if such amounts were legally owed to Zestlife. This authority may be cancelled by giving Zestlife notice of not less than 30 days.

Zest Life Investments (Pty) Ltd is an authorised Financial Services Provider (FSP).

Signed at _____ on this _____ day of _____ 20_____

_____

Signature of account holder

Needs analysis

The Medical Gap Cover product meets my needs as my medical scheme may not cover the total medical practitioner costs when I am hospitalised. Medical Gap Cover was recommended as a solution because it will cover the difference between the actual medical practitioner charges (subject to a maximum of five times the Medical Scheme Tariff rate) and the medical scheme payment.

The Cancer Extender (if selected) meets my needs because I could experience medical scheme shortfalls on cancer treatment.
The Dentistry Benefit (if selected) meets my need as it covers certain dental procedures that may not be covered by my medical scheme.

The Medical Premium Waiver policy meets my needs as it will continue to pay the medical scheme contributions for me and/or my medical scheme dependant/s in the event of my death or disability. The Medical Premium Waiver product was recommended as a solution because it will cover the medical scheme contributions for me and/or my medical scheme dependant/s for the benefit payment period selected.

I understand that there are other similar products on the market but the intermediary regards this Medical Gap Cover product as the most suitable product for me. Alternatively, the intermediary does not represent any other Medical Gap Cover and Premium Waiver product supplier. I declare that the monthly premium is affordable taking into account my other financial commitments.

Replacement policy

Will any of the following applications replace an existing policy?

Medical Gap Cover Name of current insurer _____

Medical Premium Waiver Name of current insurer _____

If yes, the intermediary will contact you to complete a replacement policy advice record that will provide you with comprehensive information about the consequences of the replacement as the replacement could potentially be prejudicial.

Declarations by applicant

I, the undersigned, hereby declare:

1. That to the best of my knowledge and belief the information provided in connection with this application whether in my own handwriting or not, is true and I have not withheld any material facts which are known to me. NB: A material fact is likely to influence the assessment of this application by Guardrisk. (If you are in any doubt as to whether a fact is material or not, you should disclose it.)
2. That I understand that any relevant material fact omitted in this proposal form may lead to Guardrisk not meeting claims, should the omitted fact have been of such importance that the risk may not have been accepted in the first instance, in terms of the policy. This may lead to cancellation of this policy or rejecting claims, without refund of premiums if applicable.
3. I confirm that I am currently a member or dependant of a medical scheme and that I understand that it is a prerequisite to remain a member or dependant of a medical scheme to qualify for Medical Gap and/or Premium Waiver cover.
4. That I acknowledge that the sharing of claims information and underwriting (including credit information) by Insurers is essential to enable the insurance industry to underwrite policies and assess risk fairly and reduce the incidence of fraudulent claims, in the public interest and a view to limiting premiums. I hereby waive any rights to privacy in any claims information supplied by me or on my behalf in respect of any insurance claim made or lodged by me and I consent to such information being disclosed to any other insurance company or its agent. I also waive any rights of privacy and consent to the disclosure of any information relevant to claims concerning me or any person I represent. I also acknowledge that information provided by me may be verified against other legitimate sources or databases.
5. I specifically consent to Guardrisk 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 Guardrisk for purposes of verifying the disclosure as provided on my claim form.
6. We confirm that by signing this application form you have agreed that we will hold and use your details that you have given us for purposes of providing you with excellent service as a policyholder and that we will also hold your information so that we are able to look after your needs by providing you with appropriate insurance products in the future.

Signed at _____ on this _____ day of _____ 20_____

_____
Signature of policyholder

Financial Adviser / Intermediary details

Full name of Adviser _____

Brokerage name (if applicable) _____

Business telephone number _____

Email _____

Zestlife code _____