kaelogap

INSURED BY CENTRIQ INSURANCE
A LICENSED NON-LIFE INSURER

Continuation Form

IMPORTANT NOTE: Continuation requests received after the 15th of the current month will only come into effect on the first of the following month. Please complete, sign and return this form to your broker. Kaelo Gap email address: kaelogap@kaelo.co.za.

Policy Number: _____ Effective Date: _____

A Policyholder Details:

First Name: _____

Surname: _____

ID Number: _____ Cellphone: _____

Gender: _____ Date of Birth: _____

Email: _____

Address: _____

_____

B Select Plan:

I want to change my Kaelo Gap Plan to:

◯ Kaelo Gap Optima ◯ Kaelo Gap Core

C Policy Type:

Please select which Policy type and Premium you would like to continue on.
Should you wish to add Lifestyle Benefits please select the check box below in addition to the Policy type.

Policy Type	Description
◯ Single Policy	If you are continuing as a single Policyholder, you accept that cover will only apply to yourself and that should any changes be required, you will notify Kaelo within 90 days. This includes the addition of dependants. Premiums are payable monthly.
◯ Family Policy	If you are continuing as a family, you accept that cover will apply to you, your spouse and your children. Cover for children only applies until they reach the age of 25 years. Should any changes be required, you will notify Kaelo within 90 days. This includes the addition or removal of dependants. Premiums are payable monthly.
◯ Lifestyle Benefits	Kaelo Lifestyle and **extraRewards** by Dis-Chem

D Debit Order Details:

Account Name: _____ Account Number: _____

Branch Name: _____ Bank Name: _____

Account Type: _____ Bank Code: _____

Debit Order Date: Last working day of the month Premium: _____

Name and Surname of Premium Payer: _____

Please note Premiums are due in arrears.

You will see the following reference on your bank statement: KAELO +KGPpolicynumber

I, the Premium payer, 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 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: _____

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E Broker Details:

Broker House Name: _____ Broker Consultant Name: _____

F Mandatory Documents:

Please ensure that the following documents are submitted with your amendment/s:

- A clear copy of either the ID or birth certificate of all Insured Parties being registered.
- A clear copy of the Medical Scheme membership certificate is required.

G Declaration:

I, _____ (full name) declare that this continuation form, whether in my handwriting or not, is accurate and complete and forms the basis of the contract of insurance between the Insurer and myself. I apply for the insurance product/s and agree to abide by its Policy rules and/or those of its Insurer and any amendments which may be made from time to time. I confirm that all the information provided is complete and true and that I have not concealed any relevant 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, 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 provide irrevocable authority for Kaelo and its Insurer to obtain any of my or my dependant's medical history from any healthcare provider, Medical Scheme, insurance company or healthcare broker to assess 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. If any Policy Benefit becomes payable after or as a result of my death, I 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 my employer deducts the Premium from my salary. I provide authority for my employer to deduct such Premiums and pay this across to Centriq. I accept that any notice given to my employer is deemed to have been given to me.

◯ I consent to Centriq and its operators processing and further processing my personal information in accordance with the Protection of Personal Information Act to conclude and perform in terms of this insurance contract.

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

Signature: _____ Date: _____

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