Broker House: Aon South Africa (Pty) Ltd - Jacqui Nel

Tel No: 0860 100 404

Broker code: H69X

INSURED BY CENTRIQ INSURANCE
A LICENSED NON-LIFE INSURER

Corporate Policyholder Application Form

Transnet Employer Group - Voluntary

IMPORTANT NOTE: Please complete and sign this form and return it to your broker who will submit it to Kaelo on your behalf. Kaelo will only accept applications received by a broker. Applications received after the 15th of the current month will only activate on the 1st of the following month. Kaelo Gap email address: kaelogap@kaelo.co.za.

A Applicant Details:

- ◯ I do not currently have Gap Cover
- ◯ I am currently a Kaelo Gap Policyholder but wish to transfer my cover through my employer
- ◯ I currently have Gap Cover with another provider but I wish to transfer my cover to Kaelo Gap through my employer

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

Choose Kaelo Gap Plan:

◯ Kaelo Gap Optima ◯ Kaelo Gap Core

Cover Start Date: _____

First Name: _____

Surname: _____

ID Number: _____ Cellphone: _____

Gender: _____ Date of Birth: _____

Email: _____

Address: _____

_____

Employer Details:

Employer Name: Transnet Date of Employment: _____

Branch Name: _____ Employee Number: _____

B 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. Cover for children only applies until they reach the age of 25 years. If any of your dependants are on another Medical Scheme, please provide a copy of their membership certificate.

First Name	Surname	Relationship	Date of birth/ID number	Inception Date

C Waiting Periods:

A three-month General Waiting Period and 12-month Condition-Specific Waiting Period will be applied to voluntary membership within a corporate group. All underwriting will be waived for compulsory corporate groups. If you are transferring your cover from another Gap Cover provider with similar benefits, only the balance of the applicable waiting periods will apply.

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D Debit Order Details:

If you are responsible for the payment of your Premium as part of an employer group, please complete the below section. If your employer is paying the Premium on your behalf, please do not complete this section. The reference you will see on your bank statement is KaeloGap KGP and your Policy number.

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.

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: _____

E Broker Details:

Broker House Name: Aon South Africa Broker Consultant Name: _____

F Mandatory Documents:

Please ensure that the following documents are submitted with your application form:

- 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.
- Proof of cover if you currently have cover with another Gap provider (If applicable)

G Declaration:

I, _____ (full name) 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 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 and 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 applicable, I authorise Centriq to draw against the above bank account all amounts due to Centriq in terms of this insurance cover. Should the Insurers adjust the relevant Premiums, I confirm that the adjusted amount may be drawn from the above account subject to the notice period outlined in the Policy document. This request is to remain in force unless cancelled by one month's written notice. 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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