APPLICATION FORM

Cura Administrators
Cura Administrators (Pty) Ltd, an authorised Financial Service Provider (FSP 26848)

829 Rubenstein Drive, Moreleta Park, Pretoria, 0044
Telephone: 010 021 0260 I **Email:** newbus2@curaadmin.co.za

Compliance Office: Moonstone Compliance (Pty) Ltd

Please ensure that the following documents are included as part of the application form:
- **Copy of ID Document / Passport (Including all Dependants)**
- **Proof of Bank Account (letter on Company letterhead confirming deduction - for payroll deductions) No Internet statements will be accepted.**
- **Medical Scheme Certificate of Membership (COM).**
- **Proof of previous Gap Cover with start and end date (If applicable).**

Gap Cover is not a medical scheme, and the cover is not the same as that of a medical scheme. This policy is not a substitute for medical scheme membership.

POLICY HOLDER DETAILS

Surname | **Initials** | **Title**

Full Name

ID/Passport Number | **Date of birth** | **Gender** **Male** ☐ **Female** ☐

Marital Status **Single** ☐ **Married** ☐ **Seperated** ☐ **Divorced** ☐ **Widowed** ☐

Telephone (H) | **Cell Phone**

Telephone (W) | **Spouse Cell Phone**

Email Address | **Spouse Email Address**

Physical Address

Postal Code

To protect your information and ensure speedy delivery, we will communicate with you using the above email address. Please complete your Postal Address (if different to your Residential Address):

Postal Address

Postal Code

DEPENDANTS DETAILS

Dependants are:
- **Spouse and/or dependent children up to the age of 21 years.**
- Adopted/foster child (please attach documentary proof).
- Please provide us with your Medical Scheme Certificate of Membership (COM).
- All newborns must be registered within 30 days after birth.
- Proof of full time "Student Registration" must be attached for all children between 21 and 26 years, if a dependant.

Relationship		Male	Female	ID/Passport Number
Spouse		☐	☐	
Dependant 1		☐	☐	
Dependant 2		☐	☐	
Dependant 3		☐	☐	
Dependant 4		☐	☐	
Dependant 5		☐	☐	
Dependant 6		☐	☐	
Dependant 7		☐	☐	
Dependant 8		☐	☐	

- **I hereby declare that the above insured persons, with different surnames, are related to me as:**

Biological Child ☐ **Adopted Child** ☐ **Step Child** ☐ **Foster Child** ☐ **Married to Policyholder** ☐ **Common law Husband/Wife** ☐

I agree to the above section of the form

HEALTH DECLARATION

The following questions relate to you and your dependants covered under this policy.

		Yes	No
1	Have you been admitted to hospital in the last 4 months?	☐	☐
2	Are you expecting a hospital admission or aware of any conditions or Illness that would require treatment in the next 12 months?	☐	☐
3	Are you or any of your dependents currently pregnant?	☐	☐
4	Have you or anyone named in this application ever experienced, been treated for, investigated for, or are currently suffering from any medical condition, undiagnosed illness, planned medical procedure, or any other disorder?	☐	☐

If you answered "Yes" to any of the questions, please provide details below.

Name of Dependant	Condition	Date of Last Treatment

INTERMEDIARY DETAILS

Intermediary House: Rob Mitchell Brokers t/a Cover the Gap **Intermediary Code**

Representative: Tyrone Raman **FSP Number** 31569

Telephone (O) 0311002330 **Cell No** 0769444542

Signed at _____ **on this** _____ **date of** _____ **20** _____

Signature of Adviser _____

DEBIT ORDER DETAILS AND DEBIT AUTHORITY CONSENT

Payment Method: **Monthly Debit Order** ☐ **Payroll Deduction** ☐ **Debt Order Day** _____ **day of every month**

Name of Account Holder _____

Name of Bank _____ **Account Number** _____

Branch Name _____ **Branch Code** _____

Type of Account **Current Account** ☐ **Transmission Account** ☐ **Savings Account** ☐ **Other** _____

I hereby instruct and authorise you to draw against my bank account the amount necessary for payment of my monthly premium due in respect of the above mentioned insurance, without prejudice to the rights of Cura Administrators (Pty) Ltd. I further authorise you to increase the amount in the terms of the policy from time to time and authorise my bank to effect payment.

I/We hereby confirm acceptance of the below mentioned insurance policy, and authorise Cura Administrators (Pty) Ltd to issue and deliver payment instructions to their Banker, to draw on my/our account at the under mentioned institution in any manner agreed on between Cura Administrators (Pty) Ltd and such institution, the amount of the premium payable on condition that the sum of such payment instructions will never exceed my/our obligations as agreed to in the Agreement and commencing on _____ and request the aforesaid institution to debit my/our account with all debits drawn against it by Cura Administrators (Pty) Ltd.

All such withdrawals from my/our bank account by Cura Administrators (Pty) Ltd shall be treated as though they had been signed by me/us personally. I/we certify that the above bank details are correct. If these banking details have not been provided accurately, or if the details change at any time in the future and I/we fail to notify such changes or if payments are not made in accordance with the Debit Order Instruction, the responsibility of payment will rest with me/us.

I acknowledge that any fees and charges levied by the bank on account of the debit order or any debit order payments which may be rejected for any reason whatsoever will be for my account.

I/We understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African Banks. I also understand the details of each withdrawal will be printed on my Bank statement bearing a specific reference number which will reflect Cura and your policy number as confirmed in the policy documents. This authority may be cancelled by me/us by giving Cura Administrators (Pty) Ltd 30 days' notice in writing, however I/we understand that I/we shall not be entitled to any refund of amounts which Cura Administrators (Pty) Ltd has withdrawn while this authority was in force, if such amounts were legally owing to Cura Administrators (Pty) Ltd.

Signature as used for operating on the account _____ **Date** _____

GAP COVER NEEDS ANALYSIS (Not required for an Incident Assist or Health Insurance Application)

Medical Scheme | **Medical Scheme Option**

Medical Scheme No. | **Date Joined**

Is this application part of a group? Yes ☐ No ☐ **If YES, Group name**

Have you had Gap cover previously? Yes ☐ No ☐ **If YES, Insurer name**

Previous gap cover product | **Previous Monthly Premium R**

Date Started | **Date Terminated**

I, the undersigned, hereby declare:

- 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. (A material fact is likely to influence the assessment of this application by Cura Administrators (Pty) Ltd. If you are in any doubt as to whether a fact is material or not, you should disclose it.)
- That I understand that any relevant material fact omitted in this proposal form may lead to Cura Administrators (Pty) Ltd 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 the cancellation of this policy or rejection of claims without refund of premiums.
- That I understand that this is an Accident and Health policy with stated benefits in terms of the Short-term Insurance Act 53 of 1998 and not a Medical Scheme product. This is not a medical scheme and the cover is not the same as that of a medical scheme. This policy is not a substitute for medical scheme membership.
- The sharing of claims information and underwriting information by Insurers is essential to enable the insurance industry to underwrite policies, assess risks fairly, reduce the incidence of fraudulent claims and protect the public interest in terms of limiting excessive premium increases.
- I specifically consent to Cura Administrators (Pty) Ltd contacting my current Medical Scheme and/or medical practitioner to verify any medical details as provided in my application form. I further consent to such information being disclosed to Cura Administrators (Pty) Ltd for purpose of verifying the disclose as provided on my application form.
- That I will advise Cura Administrators (Pty) Ltd. of any changes to my health state between the point of application and actual inception of my policy.
- As part of the claims validation process Cura Administrators (Pty) Ltd may use the services of a third party in order to authenticate medical scheme membership, plan option type, relevant beneficiaries and agreed medical scheme option tariffs amongst other relevant information to validate the claim.
- Cura Administrators (Pty) Ltd reserves the right to call for additional information of a clinical nature. In the event that Cura Administrators requests a PMA (Post Medical Assessment) from my doctor as part of the claims assessing and authentication process.
- I authorise Cura Administrators to negotiate with service providers on my behalf for my medical claims and or bill and pay the provider direct.
- By agreeing to the terms of this consent form, I expressly consent to the processing of my information for marketing purposes and know & understand that by agreeing to same that I may on occasion, receive marketing materials in the form of sms and / or emails and the like from Cura Administrators (Pty) Ltd.

IMPORTANT INFORMATION

- Please make sure FULL details are given for questions answered YES.
- The onus lies on the insured to make sure that premiums are paid on a monthly basis.
- In the event of a bereavement related claim the Insurer will pay the benefit into the policyholder or nominated beneficiaries account. The beneficiary must be noted on the policy prior to any loss. We will require the full name, surname and ID number to note the beneficiary. At the time of a claim we will require the beneficiary's ID and proof of bank. Should there be no beneficiary noted on the policy prior to the loss or should we be unable to confirm the identity of the beneficiary, payment will always be made into the policyholder's account.

☐ **I agree to the above section of the form**

OPTION SELECTION

Top-Up (Gap) Cover

☐ Gap Ultimate Plus Cover	☐ Individual	☐ Family	☐ 0-64	☐ 65+
☐ Gap Ultimate Cover	☐ Individual	☐ Family	☐ 0-64	☐ 65+
☐ Gap Advanced Plus Cover	☐ Individual	☐ Family	☐ 0-64	☐ 65+
☐ Gap Advanced Cover	☐ Individual	☐ Family	☐ 0-64	☐ 65+
☐ Gap Standard Cover	☐ Individual	☐ Family	☐ 0-64	☐ 65+
☐ Gap Basic Cover	☐ Individual	☐ Family	☐ 0-64	☐ 65+
☐ Gap Student Cover	☐ Individual between the age of 21 and 27 only			
☐ Non-PMB Support		☐ Family	☐ 0-64	
☐ Cancer Cover	☐ Individual		☐ 18-64	

Additional application form required for each applicant (18-65)

Premium per month R

***Intermediary Fee (Optional) R**

*** The Intermediary Fee will only be collected subject to us receiving a signed contract between the intermediary and policyholder. This Intermediary fee is optional and is paid to the intermediary on top of the statutory commission on your approval.**

Inception Date

Additional Covers

- **Health insurance (Additional form to be completed)**
- **Funeral Cover (Seperate Electric Process Required)**
- **Incident Assist (Additional form to be completed)**

NOMINATED BENEFICIARY DETAILS (For Accidental death benefit on the Advanced Plus, Ultimate and Ultimate Plus)

Beneficiary 1:

Name of Beneficiary | Title

ID/Passport Number | Date of birth | Relationship to Policyholder

Contact Number | Email Address

Beneficiary 2:

Name of Beneficiary | Title

ID/Passport Number | Date of birth | Relationship to Policyholder

Contact Number | Email Address

Declaration and informed Consent in terms of the Protection of Personal Information Act 4, of 2013 (POPIA)

We at Cura Administrators respect your right to privacy. We need to collect and process some of your personal information in terms of various Privacy and Data Management laws and are bound by the terms and provisions of the Protection of Personal Information Act, regarding the acquisition, usage, retention, transmission and deletion of your personal information. Your personal information collected is for the primary purpose of providing you with insurance cover and for all other activities and processes incidental to and relevant to this purpose. As this information forms the basis of our assessment and terms, we offer you, it must be correct, complete, and up to date.

We will always comply with all relevant regulations in dealing with your information and keep it secure and confidential at all times. Your information shall be kept confidential; however, we shall disclose it to certain 3rd parties as required and other insurers for the specific purpose of insurance and to reduce and prevent any form of fraudulent activity. Should you decide to cancel this insurance contract you further consent to Cura Administrators, in retaining the information in line with the legally permitted retention period, for statistical and reporting purposes only.

Should you decide not to accept the proposal, the information collected, will be identified and only used for statistical and research purposes.

I hereby voluntary consent to Cura Administrators processing my Personal Information.

I understand the purposes for which my Personal Information is required and for which it will be used.

I give Cura Administrators permission to process my Personal Information as provided above.

Our Privacy Notice and POPIA Policy provides the details of how we deal with the personal information of our clients, and it is available on our website at the following address: https://www.curaadmin.co.za/

Signed at | on this | date of | 20

Signature of Policyholder / Authorised Signature

BROKER FEE AGREEMENT

I (Full Name) | with ID Number

acknowledge that my broker / advisor is (Company Name) | with FSP number

is authorised to request Cura Administrators with FSP number 26848 to collect an additional broker fee of R

with my monthly premium on this policy for the services listed below.

List of Services

I agree to the payment of these fees until such time as the policy is cancelled and/or I revoke the above authority.
I am aware that the fees are in addition to any premium payable and commission that the broker earns and are for the provision of the services above.

Signed at | on this | date of | 20

Signature of Client / Authorised Signature

Signature of Adviser

ADDITIONAL NOTES

Submit Form