Application Form 2018



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Personal Details (Policyholder) Surname: ID Number:										
Title:	12 1121112									
Employer:	Full Names: Where did you hear about us?									
Physical Address:			vviiele u	iiu you iieai	l about us:					
Physical Address: Postal Address:										
Postal Address: Preferred Delivery Address:										
Alternative Numbe	Cell: Work: Home: Fax: Alternative Number: Email Address:									
Emergency Contac				Home Lan						
Do you smoke? Y		ow many per day?		Trome Lan	Baase.					
What is your heigh		у рег шау		What is yo	our weight?					
Wildt is your ficigit			Members t							
Spouse:			Wichibers	o be covere	ID Number:					
Child 1:					ID Number:					
Child 2:					ID Number:					
Child 3:					ID Number:					
Child 4:					ID Number:					
Does your spouse s	smoke? Yes No	If YES, how many pe	er day?							
What is your Spous				What is yo	our Spouse's weigh	nt?				
, ,			Bene	eficiary	, 5					
Name:		IC	Number:				Rel	ation:		
Cell:	W	/ork:		Home:		Fax:				
Alternative Number	er:			Email Add	dress:					
Additional Information (All members to be covered)										
		Additional	Information (All member	rs to be covered)					
Are you currently r	eceiving treatment for a				rs to be covered)		Yes		No	
	eceiving treatment for a about and/or aware of	ny medical and/or de	ntal condition	?			Yes Yes		No No	
	about and/or aware of	ny medical and/or de	ntal condition	?						
Are you concerned	about and/or aware of m of medication?	ny medical and/or de	ntal condition	?			Yes		No	
Are you concerned Are you on any for Are you pregnant? Have you undergo	about and/or aware of m of medication? ne any major operations	ny medical and/or de any condition which r ?	ental condition may require m	?			Yes Yes		No No	
Are you concerned Are you on any for Are you pregnant? Have you undergon Are you or your spe	about and/or aware of m of medication? ne any major operations ouse a member of a medication.	ny medical and/or de any condition which r ? dical scheme or hospi	ntal condition may require m tal plan?	? edical or de	ental attention?		Yes Yes Yes		No No	
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Single Accident Booster					
Booster Cover			~		
Level 1	R76	R250 000			
Level 2	R152	R350 000			
Level 3	R228	R450 000			
Level 4	R304	R550 000			
Level 5	R380	R650 000			
Level 6	R456	R750 000			
Level 7	R532	R850 000			
Level 8	R608	R950 000			
Level 9	R684	R1050 000			
Total Premium	R				

Family Accident Booster					
Premium	Benefit	✓			
R148	R400 000				
R296	R550 000				
R444	R700 000				
R592	R850 000				
R740	R1 000 000				
Total Premium R					
	Premium R148 R296 R444 R592 R740	Premium Benefit R148 R400 000 R296 R550 000 R444 R700 000 R592 R850 000 R740 R1 000 000			

ICU Illness Benefit Booster						
Booster Cover Premium 🗸						
Single	R73					
Family R146						
Total Premium	R					

Chronic Essential				
Booster Cover		✓		
Per Condition	R65			

Total Premium R

Plan	Premium
Plan	R
Accident Booster	R
ICU Booster	R
Chronic Booster	R
Chronic Essential	R
Total Premium	R

Chronic Booster							
Condition	Level 1	Level 2	Level 3				
Depression	R181	R375	R516				
Bipolar	R375	R696	R1469				
Menopause	R246	R310	R387				
Diabetes	R438	R696	R1469				
Total Premium R							

Bank Details						
Name of Account Holder:		Name of Bank:				
Branch Name:	Branch Code:					
Account Number:		Account Type:				
Monthly Debit Date:	1 st 7 th 15 th 20 th 25 th	Commencement Date:	0 1 M M 2 0 Y Y			
ayment Reference: Abbreviated name as registered with the bank is AffinityHe + Policy Number						

I hereby authorise you to issue and deliver payment instructions to the bank (or any other bank or branch to which I may transfer my account) on condition that the sum of such payment instructions will never exceed my obligations as agreed to in this Agreement, and commencing on the Commencement date and continuing until this Authority and Mandate is terminated by me by giving you notice in writing of no less than 1 month, emailed to info@affinityhealth.co.za.

The individual payment instructions so authorised to be issued must be issued and delivered monthly.

In the event that the payment day falls on a Saturday, Sunday or recognised South African public holiday, the payment day will automatically be the very next ordinary business day. Further, if there are insufficient funds in the nominated account to meet the obligation, you are entitled to track my account and re-present the instruction for payment as soon as sufficient funds are available in my account.

I understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African Banks and I also understand that details of each withdrawal will be printed on my bank statement. Each transaction will contain a reference, which must be included in the said payment instruction and if provided to you should enable you to identify the Agreement. A payment reference is added to this form before the issuing of any payment instruction.

Mandate - I acknowledge that all payment instructions issued by you shall be treated by my abovementioned bank as if the instructions had been issued by me personally.

Cancellation - I agree that although this Authority and Mandate may be cancelled by me, such cancellation will not cancel the agreement. I shall not be entitled to any refund of amounts which you have withdrawn while this authority was in force, if such amounts were legally owing to you.

Assignment - This Authority and Mandate cannot be assigned to any third party.

For Office Use Agent: Iracema Fonseca/ IFC Agent Code: 5089 Kindly indicate the most convenient day and time to be contacted by a consultant in order to verify the information provided on this application form Day: Time:	Signature of Policyholder		Signat	ure of Account Holder			
times, maistre the most convenient adjuna time to be contracted by a constitution of the	For Office Use	Agent: Ir	acema F	onseca/ IFC	Agent Code: 50	89	
		t in order to ver	fy the	Day:		Time:	