AFFINITY HEALTH

Personal Details (Policyholder)

Surname:		ID Number:	
Title:		Full Names:	
Employer:		Where did you hear about us?	
Physical Address:			
Postal Address:			
Preferred Delivery Address:			
Cell:	Work:	Home:	Fax:
Alternative Number:		Email Address:	
Emergency Contact Number:		Home Language:	
Do you smoke? Yes ☐ No ☐	If YES, how many per day?		
What is your height?		What is your weight?	

Members to be Covered

Spouse:		ID Number:	
Child 1:		ID Number:	
Child 2:		ID Number:	
Child 3:		ID Number:	
Child 4:		ID Number:	
Does your spouse smoke? Yes ☐ No ☐	If YES, how many per day?		
What is your Spouse's height?		What is your Spouse's weight?	

Beneficiary

Name:		ID Number:		Relation:	
Cell:	Work:	Home:	Fax:		
Alternative Number:		Email Address:			

Additional Information (All members to be covered)

Are you currently receiving treatment for any medical and/or dental condition?	Yes ☐	No ☐		
Are you concerned about and/or aware of any condition which may require medical or dental attention?	Yes ☐	No ☐		
Are you on any form of medication?	Yes ☐	No ☐		
Are you pregnant?	Yes ☐	No ☐		
Have you undergone any major operations?	Yes ☐	No ☐		
Are you or your spouse a member of a medical scheme or hospital plan?	Yes ☐	No ☐		
Have you or your spouse ever had a medical insurance/aid cancelled by an insurer/medical scheme?	Yes ☐	No ☐		
Are you or your spouse replacing a medical aid with this insurance policy?	Yes ☐	No ☐		
Member:		Member:		
Condition or Event:		Condition or Event:		
Medication:		Medication:		

Indicate the number of members to be covered in the space provided next to the rate amount

Packages	Option 1 Day-to-Day Benefits Only		Option 2 Hospital Plan Benefits Only		Option 3 (Option 1 & 2) Combined	
Main Member	R468		R615		R948	
Spouse	R418		R554		R862	
Child Dependant	R221		R110		R295	
Total Premium		**R**		**R**		**R**

Financial Questions

Source of Income	☐ Salary	☐ Allowance	☐ Grant	☐ Commision	☐ Other	Specify
Net Monthly Household Income		Total Monthly Household Expenses				

LION OF AFRICA LIFE ASSURANCE

Single Accident Booster			
Booster Cover	Premium	Benefit	✓
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			
Booster Cover	Premium	Benefit	✓
Level 1	R148	R400 000	
Level 2	R296	R550 000	
Level 3	R444	R700 000	
Level 4	R592	R850 000	
Level 5	R740	R1 000 000	
Total Premium	R		

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

Chronic Essential		
Booster Cover	Premium	✓
Per Condition	R65	

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:	1st ☐ 7th ☐ 15th ☐ 20th ☐ 25th ☐	Commencement Date:	0 1 M M 2 0 Y Y
Payment 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.

Signature of Policyholder			Signature of Account Holder		

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: