SIRAGO UNDERWRITING MANAGERS (PTY) LTD
REG NO: 1993/001387/07 | VAT NO: 4950188724 | FSP NO: 4710

PHYSICAL ADDRESS: Midrand Business Park, Building 3,
563 Old Pretoria Main Road, Midrand, 1685
POSTAL ADDRESS: PO Box 1115, Bromhof, 2154
TEL NO: 010 599 1163 | EMAIL: applications@sirago.co.za

Compliance Officer: Moonstone Compliance (Pty) Ltd

APPLICATION FORM 2020

Please complete this form in black ink and CAPITAL letters

Medical Scheme membership no.:
Name of Medical Scheme:
Medical Scheme Option:
Is this application part of a group? (Place a clear X inside the box) yes ☐ no ☐ If YES, group name:
Previous Gap Cover:
Date Joined:
Date Terminated:
Required Inception Date:

PRINCIPAL INSURED DETAILS

Name and Surname:
ID number \ Passport: Mr ☐ Mrs ☐ Miss ☐ Dr ☐ Other
Date of birth:
Email Address:
Contact details: Home no.: Work no.:
Fax no.: Cell no.:
Postal address:
Code:
Residential address:
Code:

SPOUSE DETAILS

Name and Surname:
ID number \ Passport: Mr ☐ Mrs ☐ Miss ☐ Dr ☐ Other
Date of birth :
Email Address:
Contact details: Home no.: Work no.:
Fax no.: Cell no.:
Medical Scheme membership no.:
Name of Medical Scheme:
Medical Scheme Option:

DEPENDANTS

Dependants are:
- Spouse and/or dependant children up to the age of 21 years
- Adopted/foster child (please attach documentary proof)
- Students up to the age of 27 (please prove full time enrolment)
- Provide studency proof or medical certificate if you are on the same medical aid

Name and Surname:
ID number \ Passport: Male ☐ Female ☐
Date of birth : Relationship to applicant:

Name and Surname:
ID number \ Passport: Male ☐ Female ☐
Date of birth : Relationship to applicant:

Name and Surname:
ID number \ Passport: Male ☐ Female ☐
Date of birth : Relationship to applicant:

Name and Surname:
ID number \ Passport: Male ☐ Female ☐
Date of birth : Relationship to applicant:

SPECIFIC HEALTH QUESTIONS

The following questions are related to the policyholder and or any beneficiaries or dependents on the policy.

		YES	NO
1	Have you been admitted to hospital in the last 4 months?		
2	Are 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 taken or are currently taking chronic medication in the past 24 months?		
5	Have you been on gap cover before and / or have had a gap claim? If yes, who was the provider?		

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

Question no.	Applicant/dependents	Disorder	Medication	Date Diagnosed

DECLARATION BY APPLICANT

I, the undersigned, hereby declare:

1. 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 Sirago Underwriting Managers (Pty) Ltd. If you are in any doubt as to whether a fact is material or not, you should disclose it.)
2. That I understand that any relevant material fact omitted in this proposal form may lead to Sirago Underwriting Managers (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.
3. 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.
4. 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. You hereby waive any right to privacy of any insurance information provided by you or on your behalf, in respect of any insurance policy or claims you lodge. You also consent to this information being disclosed to any other insurance company and/or verified against other legitimate source or a database.
5. I specifically consent to Sirago Underwriting Managers (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 Sirago Underwriting Managers (Pty) Ltd for purpose of verifying the disclose as provided on my application form.
6. That I will advise Sirago Underwriting Managers (Pty) Ltd of any changes to my health state between the point of application and actual inception of my policy.
7. As part of our claims validation process we used the services of a contracted 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.
8. We reserve the right to call for additional information of a clinical nature. In the event that Sirago requests a PMA (Post Medical Assessment) from your doctor as part of the claims assessing and authentication process
9. I authorise Sirago Underwriting Managers to negotiate with service providers on my behalf for my medical claims and or bill and pay the provider direct.
10. 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 Sirago Underwriting Managers (Pty) Ltd.

Signature of policy holder _____ Date: _____

Spouse (If married in community of property) _____ Date: _____

OPTION SELECTION

☐ ULTIMATE GAP COVER	☐ INDIVIDUAL	☐ 0 - 54	☐ 55 - 64	☐ 65+	☐ FAMILY	
☐ PLUS GAP COVER	☐ INDIVIDUAL	☐ 0 - 54	☐ 55 - 64	☐ 65+	☐ FAMILY	
☐ GAP ASSIST COVER	☐ INDIVIDUAL	☐ 0 - 54	☐ 55 - 64	☐ 65+	☐ FAMILY	
☐ GAP-LITE COVER	☐ INDIVIDUAL	☐ 0 - 54	☐ 55 - 64	☐ 65+	☐ FAMILY	
☐ GOV-GAP COVER	☐ INDIVIDUAL	☐ FAMILY				
☐ EXACT COVER	☐ INDIVIDUAL	☐ 0 - 54	☐ 55 - 64	☐ 65+	☐ FAMILY	
☐ EXACT WITH GAP AND CO-PAY COVER	☐ INDIVIDUAL	☐ 0 - 54	☐ 55 - 64	☐ 65+	☐ FAMILY	

OPTION BY APPLICANT:

Premium per month	R
TOTAL PREMIUM PAYABLE	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

Please return the completed form to applications@sirago.co.za or by fax to 086 508 2292

NOMINATED BENEFICIARY (related to death benefits and/or premium waivers)

Name and Surname: _____

ID number / Passport: _____ Mr ☐ Mrs ☐ Miss ☐ Dr ☐ Other _____

Date of birth : _____ Email Address: _____

Contact details: Home no.: _____ Work no.: _____

Fax no.: _____ Cell no.: _____

Relationship to Main member: _____

The Premium waiver benefit consists of two sub-benefit categories and is only applicable to active dependents who on the Sirago policy at the time of death or Total Permanent Disability

DEBIT ORDER AUTHORITY - PRINCIPAL INSURED DETAILS

Please complete this form in black ink and CAPITAL letters

Policy Number:

Name and Surname:

ID number / Passport.: Mr Mrs Miss Dr Other

Date of birth: Email Address:

Contact details: Home no.: Work no.:

Fax no.: Cell no.:

Postal address:

Code:

Residential address:

Code:

I/We hereby confirm acceptance of the below mentioned insurance policy, and authorise Sirago Underwriting Managers (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 Sirago Underwriting Managers (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 Sirago Underwriting Managers (Pty) Ltd.

All such withdrawals from my/our bank account by Sirago Underwriting Managers (Pty) Ltd shall be treated as though they had been signed by me/us personally.

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 Sirago and your policy number as confirmed in the policy documents.

This authority may be cancelled by me/us by giving Sirago Underwriting Managers (Pty) Ltd thirty days' notice in writing, however I/we understand that I/we shall not be entitled to any refund of amounts which Sirago Underwriting Managers (Pty) Ltd has withdrawn while this authority was in force, if such amounts were legally owing to Sirago Underwriting Managers (Pty) Ltd.

DEBIT ORDER DETAILS

Name of account holder:

Account no.:

Bank: Standard Bank, ABSA, FNB, Nedbank, Capitec, Other

Account type: Cheque, Savings, Transmission, Other

Debit order day: 1st 7th 15th 25th 31st 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 Sirago Underwriting Managers (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.

Signature of account holder Date:

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.
Premiums are payable on a monthly basis by debit order. If two or more debit orders are returned, Sirago Underwriting Managers (Pty) Ltd will not be held liable should the policy be automatically terminated, or should claims incurred during this period of suspension not be paid. 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.

*If the facility is in the name of a Company, Close Corporation, Trust or Association the full names of such entity and the capacity of the signatory must be reflected.
In the event that the payment day falls on a Sunday, or recognised South African public holiday, the payment day will automatically be the very next ordinary business day.
Payment instructions due in December may be debited against my account on

I/We acknowledge that all payment instructions issued by you shall be treated by my/our above-mentioned Bank as if the instructions have been issued by me/us personally.

I/WE acknowledge that this Authority may be ceded or assigned to a third party if the Agreement is also ceded or assigned to that third party, but in the absence of such assignment of the Agreement this Authority and Mandate cannot be assigned to any third party.

IMPORTANT INFORMATION

- Please make sure FULL details are given for questions answered YES.
- Application forms could be underwritten and conditions may be excluded for longer than 10 months.
- The onus lies on the insured to make sure that premiums are paid on a monthly basis. Reference on bank statements read: MD SIRAGO_MED
- Effective from 1 January 2020.
- In the event of a bereavement related claim the Insurer will pay the benefit into the principal 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 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 principal policyholders account.

BANKING DETAILS FOR REFUNDS

SHOULD YOU NOT COMPLETE THIS SECTION IT WILL RESULT IN US USING YOUR DEBIT ORDER DETAILS

Name of account holder:

Account no.:

Bank: ☐ Standard Bank ☐ ABSA ☐ FNB ☐ Nedbank

Other

Account type: Cheque ☐ Savings ☐ Transmission ☐ Other

Signature of account holder Date:

INTERMEDIARY DETAILS

Intermediary Group:	Atfin Consulting(Pty)Ltd	Intermediary Code:	1844
Sales Person:		Sales Code:	
Tel no.:	0210071623	Cell no.:	

STATISTICS

Race: ☐ Indian/Asian ☐ Black ☐ Coloured ☐ White ☐ Other

Gender: ☐ Male ☐ Female

Income Bracket: ☐ 0 - 2 500 ☐ 2 501 - 5 000 ☐ 5 001 - 7 500 ☐ 10 001 - 12 500 ☐ 12 501 - 15 000 ☐ 15 001 +

We believe in protecting your privacy and will not share, rent or sell any personal information or any statistical data received to third parties outside of Sirgo Underwriting Managers, except as described in this policy.

BROKER FEE AGREEMENT

I (Full Name) _____ with ID number _____

acknowledge that my broker / advisor is (Company Name) _____

with FSP number _____ is authorised to request Sirago Underwriting Managers with FSP number 4710 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.

Signature

Signature

Brokerage

Client

Date

Date