Stratum Benefits

2022 CORPORATE GAP COVER | CLIENT APPLICATION FORM

1. CREATE YOUR PROFILE

*Speak with your HR Representative or Broker about the **Corporate Gap Cover** option available to you as an Employee, as well as the waiting periods and terms and conditions of cover before submitting your application form.*

Based on the discussion you've had with your HR Representative or Broker, please select the type of application relevant to your profile which will form the basis of your contract with us.

○ Employee applying for cover *(A brand-new employee or an existing employee who isn't already covered on a Gap Cover policy with another provider, or as a dependant on an existing Stratum Benefits policy.)*

○ Employee switching cover from another Gap Cover provider *(Please also complete **Section 8 - Replacement Policy Disclosure** and submit your current policy document not older than **30 days** for underwriting purposes.)*

2. EMPLOYER GROUP DETAILS

Employer Group

Employer Group Stamp / Authorised Signatory

Employer Group Branch (*if applicable*)

Employee Appointment Date

Employee Number

*(Attach written confirmation from your HR Representative that confirms your employment date if you're applying for cover **within 90 days** from your permanent employment date for underwriting purposes.)*

HR Representative Name

HR Representative Email Address

3. MAIN APPLICANT DETAILS

Title

Name

Surname

ID/Passport

Date of Birth

Cellphone

Alternative Contact No.

Physical/Postal Address

Postal Code

Email Address

Medical Aid

M/A No.

Medical Aid Plan

4. DEPENDANT DETAILS

Joining as a family? We'll cover you, your spouse and all the dependants registered on both your and your spouse's medical aid plans on one Gap Cover policy, even if you belong to different medical aids or medical aid plans subject to approval from your Employer. Speak with your HR Representative or Broker for more information about adding your dependant(s).

Provide your dependants' medical aid details if it differs from your or your spouse's. Child dependants who move to their own medical aid plan must apply for their own Gap Cover policy.

ID/Passport	Date of Birth *yyyymmdd*	Relation	Title	Name	Surname

5. BROKERAGE DETAILS

Brokerage: ATFIN CONSULTING (PTY)

Broker

Broker Signature

Brokerage Code

Broker Code

3737483465

6. CORPORATE GAP COVER OPTIONS

Your monthly premium is subject to the Employer Group Quote accepted by your Employer. Speak with your HR Representative or Broker about premium details.

*Select the **Corporate Gap Cover** option available to you as part of a registered Employer Group.*

CORPORATE COMPACT 300 ○
CORPORATE ELITE ○
CORPORATE ELITE PLUS ○
CORPORATE ACCESS ○
CORPORATE ACCESS PLUS 500 ○
CORPORATE ACCESS CO-PAY PLUS 300 ○

If the **Gap Cover** option your Employer offers doesn't reflect here, please provide the option name:

COVER START DATE ____ - __ - __

7. WAITING PERIODS

Waiting periods are determined by the demographic profile of the Employer Group and the Employer Group Quote accepted by your Employer.

*Your applicable waiting periods will be confirmed in the **Cover Letter** that you'll receive when your policy is activated.*

3 MONTH GENERAL WAITING PERIOD

We don't cover you during this period unless you claim for accidental events that occur after your cover start date.

EXCEPTION TO THE RULE

Out-Patient Specialist Consultation Cover offered on the CORPORATE ELITE PLUS option always receives a **3 Month General Waiting Period.**

12 MONTH PRE-EXISTING CONDITION WAITING PERIOD

We don't cover you during this period for investigations, medical procedures, surgeries or treatments related to any illness or medical condition that was diagnosed, or that you received advice or treatment for within **12 months** before your policy's start date.

10 MONTH LIMITED PAYOUT BENEFIT

If you claim from our GAP COVER, CO-PAYMENT COVER, ROBOTIC SURGERY CO-PAYMENT, PENALTY CO-PAYMENT, SUB-LIMIT COVER or ACCESS COVER in the first **10 months** of cover for specific medical events, we'll pay between **20%** and **100%** of the **approved claim amount** as quoted and accepted by your Employer, subject to benefit limits where applicable.

If, however, your medical event is due to a medical condition that you received advice or treatment for within **12 months** before the start date of your policy, your claim will be subject to a **Pre-Existing Condition Waiting Period** if this waiting period applies to the Employer Group.

Accidental events don't form part of the **10 Month Limited Payout Benefit**.

By signing this application form, you acknowledge and accept that your policy may be subject to waiting periods and/or the 10 Month Limited Payout Benefit if you claim in the first 10 months of cover for specific medical events.

Speak with your HR Representative, Broker or refer to our product brochure for more information about the listed medical events.

8. REPLACEMENT POLICY DISCLOSURE

*This section is applicable to you and your appointed Broker if you're an applicant switching cover as indicated in **Section 1**.*

*As the main applicant completing this section, or having it completed by your Broker, you understand that your current Gap Cover policy will be replaced with a **Stratum Benefits** policy and that certain aspects of the new policy will be different from the old policy.*

REPLACEMENT POLICY DISCLOSURE

- A change in terms and conditions, monthly premium and benefits will apply because benefit and fee structures of products are different.
- If there's a break in cover of **30 days** or **more** between the end date of cover with the previous insurer and the cover start date with us, you may receive full waiting periods.
- The **Policy Schedule** that you'll receive when your cover is activated explains the general exclusions, terms and conditions of cover in more detail.

TRANSFER WAITING PERIODS

Your policy may be subject to underwriting, regardless of whether you're switching cover between the same insurer or from a different insurer. Waiting periods applicable to our **Corporate Product Ranges** are determined by the demographic profile of the Employer Group.

PRE-EXISTING CONDITION WAITING PERIOD APPLICABLE TO LIKE-FOR-LIKE BENEFITS AND/OR ENHANCED BENEFITS

If the current Gap Cover policy with another provider has been active for **less** than **12 months** and a **Pre-Existing Condition Waiting Period** applies, the balance of the waiting period will be carried over but won't exceed the waiting period stipulated in the Employer Group Quote.

If our Gap Cover policy provides enhanced benefits, a **6 Month Pre-Existing Condition Waiting Period** will apply but won't exceed the waiting period stipulated in the Employer Group Quote.

If the current Gap Cover policy with another provider has been active for **12 months** or **longer**, a **6 Month Pre-Existing Condition Waiting Period** may apply to any enhanced benefits our Gap Cover policy provides.

Please submit a copy of your current policy document not **older** than **30 days** for underwriting purposes**.**

By signing this application, you acknowledge and accept that your policy may be subject to waiting periods.

FOR YOUR BROKER TO COMPLETE

Please provide details of the policy replacement in the table below:

POLICY REPLACEMENT RECORD	CURRENT PRODUCT	REPLACEMENT PRODUCT
Name of Insurer		Constantia Insurance Company Limited
Product Name		
Cancellation and Cover Start Date		
Premium		
Differences in Products		
Reason(s) for Transferring Cover		

9. MEDICAL HISTORY DISCLOSURE

*The question below pertains to you and your dependants applying for cover, where applicable, and must be answered regardless of whether or not a **Pre-Existing Condition Waiting Period** will apply to you and/or your dependants.*

1. Have you, or any of your dependants, been diagnosed with any illness, seen or been advised to see a healthcare provider, or visit a medical facility for an investigation, test, medical procedure or surgery in the past **12 months**, except for the common cold, routine dental work and routine check-up? ◯ Yes ◯ No

If Yes, please provide more details about the diagnosis, referral and/or treatment.

NAME	ILLNESS / MEDICAL CONDITION	DIAGNOSIS / REFERRAL / TREATMENT DATE
		Date ____ - __ - __
		Date ____ - __ - __
		Date ____ - __ - __

10. YOUR PAYMENT PROFILE *(Please complete this section if you're paying your policy premium yourself)*

By signing this section and upon acceptance of your application, you:

1. understand that cover will commence after the first premium is received.
2. authorise Stratum Benefits to debit your account for the policy premium that's payable in advance on the debit order date as selected.
3. authorise Stratum Benefits to accept this debit order authority as a payment instruction issued by the account holder.
4. accept that depending on the selected debit order date, a double, or triple debit may be incurred.
5. agree that this debit order authority will remain in force until cancelled in writing by the principal insured person, by Stratum Benefits if premiums aren't received for two consecutive months, if the account being debited is closed, the account holder is deceased or if authority to debit isn't granted.
6. understand that this debit order authority may only be assigned to a third party if this contract is also assigned to a third party.
7. understand that if your payment date falls on a Sunday, or recognised South African public holiday, the debit order date will default to the next working day.
8. accept that if the premium from a previous debit order deduction is returned, a **R 25** admin fee will be added to the next premium deduction.
9. accept that your premium may be adjusted during an annual renewal, or due to benefit restructuring necessitated by legislation, with one month's written notice and subject to your right of cancellation of cover, the debit order authority will extend to the adjusted premium.
10. understand that your debit order deductions will be processed through a computerised system provided by the South African Banks. Details of each debit order deduction will be displayed on your bank statement with the reference prefix "STRATUM", followed by an 8 digit number ending with "NETCASH".
11. accept that given the debit order authority granted by you, it's your responsibility to ensure that premiums are collected in order to remain covered.
12. accept that you'll not be entitled to any refund of amounts that have been deducted while this debit order authority is in force, if such amounts were legally due.
13. understand that the product premium is inclusive of VAT.

Account Type ◯ Cheque ◯ Savings Bank _____ Account Number _____

Account Holder _____

Debit Order Date ◯ 1st ◯ 4th ◯ 7th ◯ 15th ◯ 20th ◯ 25th ◯ 28th ◯ Last day of the month | Term ◯ Monthly ◯ Annual

Optional Professional Fee (Increments of R10) _____ Product Premium R _____ Total Monthly Premium R _____

Account Holder Signature _____

11. PROSPECTIVE CLIENT CONSENT *(Applicable to all applicants)*

As the main applicant applying for insurance cover, I understand and acknowledge that the Gap Cover policy I'm applying for is not a medical aid, doesn't provide similar cover as that of a medical aid, and can't be substituted for medical aid membership.

I hereby declare and accept that:

1. I'm applying for insurance cover subject to the waiting periods, benefit and general exclusions, and terms and conditions of the policy contract, and confirm that these have been communicated and explained to me prior to the policy start date.
2. all the details provided are true and correct, and that no information has been withheld that may be material to, or is likely to affect the assessment or acceptance of my risk.
3. in the event of any material non-disclosure or misrepresentation, my policy may be rendered null and void. I accept that I'll forfeit any and all premiums, and that Stratum Benefits may decline to indemnify or compensate me and/or my dependants, where applicable, for any claims under any item or section of cover.
4. should this application form be incomplete, it may not be processed by Stratum Benefits.
5. my, and my dependants' eligibility for cover is dependent on us remaining active members of a registered medical aid. I undertake to advise Stratum Benefits if I terminate my, and/or my dependants' medical aid membership at any time.
6. in terms of the Financial Advisory and Intermediary Services Act, 2002 (FAIS), my broker must be mandated by a licensed Financial Services Provider (FSP) as a representative with the necessary (FAIS) sub-categories to act on my behalf, and that it's my responsibility to determine whether my broker has the necessary authorisation.
7. where a broker's been appointed by me, I authorise payment of their monthly commission.
8. Stratum Benefits is irrevocably authorised to process and store my, and/or my dependants' personal information required for the purpose of administrating cover under this policy. I undertake to notify Stratum Benefits of any change in my personal details within a reasonable time period. This authorisation will be terminated upon the cancellation of my policy wherein my data will then be stored for the prescribed years, and thereafter destroyed in a responsible manner.

Main Applicant Signature _____ Date ____ - __ - __

12. PROTECTION OF PERSONAL INFORMATION

USE OF PERSONAL INFORMATION DECLARATION

Information is processed as set out in our **Privacy Policy**. By accepting these terms and conditions, or by providing personal information to us, you agree and give permission to us to use your personal information as set out in our **Privacy Policy**. This can be viewed in the **Policy Schedule** that you'll receive when your policy is activated, or by visiting our website at:
https://www.stratumbenefits.co.za/files/POPI-Privacy-Policy.pdf

Do we have your permission to contact you for marketing purposes, like when we run competitions or launch new products? ◯ Yes ◯ No

How may we contact you? ◯ Email, SMS and Telephone ◯ Email only ◯ SMS only ◯ Telephone only