Stratum Benefits

2022 CORPORATE HEALTH INSURANCE | EMPLOYEE APPLICATION FORM

*Speak with your HR Representative or the Broker appointed by your Employer about the **Corporate Health Insurance** 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'll complete this application form as either a brand-new employee or as an existing employee who isn't already covered on a Health Insurance policy with another provider, or as a dependant on an existing Stratum Benefits policy.

1. BROKERAGE DETAILS

Brokerage

Broker Name

Broker Email Address

Broker Code

Broker Contact Number

Broker Signature

2. EMPLOYER GROUP DETAILS

Employer Group

HR Representative Name

HR Representative Email Address

Employer Group Stamp / Authorised Signatory

3. MAIN APPLICANT DETAILS

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.*

Title

Name

Surname

ID/Passport

Date of Birth – –

Gender M F

Attach a clear copy of your identity document.

Cellphone

Alternative Contact No.

Email Address

Physical/Postal Address

Postal Code

Attach proof of your residential address not older than 3 months if you're not responsible for the payment of your policy's premiums.

Country of Residence

Country of Nationality

4. DEPENDANT DETAILS

*This **Health Insurance** policy covers you, your spouse and all your child dependants as long as you're their parent or legal guardian, subject to approval from your Employer. Speak with your HR Representative or the group's appointed Broker for more information about adding your dependant(s). Submit a legal document from the South African Court of Law that confirms legal guardianship, where applicable. **Extended family members don't qualify for cover**.*

CHILDREN 20 YEARS OR YOUNGER

Corporate Essential: Child dependant premiums apply.
Corporate Essential Plan D: Child dependant premiums are included in the policy premium.

CHILDREN 21 YEARS OR OLDER

*Children who are **21 years** or **older** may be added to your policy if they're **full-time students** or if proof of **financial dependency** is submitted **every year**.*

Corporate Essential: Adult dependant premiums apply.
Corporate Essential Plan D: Premiums are included in the policy premium.

We accept proof from the educational facility confirming **full-time studies** (distance learning won't be considered), or stamped copies of your child's **bank account statements** of the past **3 months** with an **affidavit**.

4. DEPENDANT DETAILS [CONTINUED]

Attach a clear copy of the required document for each dependant as indicated.

- ID/Passport document for a spouse and every adult dependant (***21 years*** *or* ***older***)
- Birth certificates for child dependants *(**20 years** or **younger**)*
- Medical report to confirm disability of a special needs dependant

Name

Surname

ID/Passport DOB – – Relationship

Name

Surname

ID/Passport DOB – – Relationship

Name

Surname

ID/Passport DOB – – Relationship

Name

Surname

ID/Passport DOB – – Relationship

5. FICA QUESTIONNAIRE

Is any applicant a Domestic Prominent Influential Person (DPIP), Foreign Public Official (FPPO), or a client, associate or family member of a DPIP / FPPO?

◯ Yes ◯ No

If "YES", provide details below:

Name and Surname of DPIP/FPPO

Position of DPIP/FPPO Relationship to DPIP/FPPO

6. CORPORATE HEALTH INSURANCE BENEFIT 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 Health Insurance** benefit option available to you as part of a registered Employer Group.*

CORPORATE ESSENTIAL | DAY-TO-DAY BENEFIT OPTION

Principal Insured..... ◯
Spouse..... ◯
Adult Dependant..... ◯
Financially dependent 21+
Child Dependant..... ◯
20 or younger

CORPORATE ESSENTIAL | EMERGENCY & ACCIDENT BENEFIT OPTION

Principal Insured..... ◯
Spouse..... ◯
Adult Dependant..... ◯
Financially dependent 21+
Child Dependant..... ◯
20 or younger

CORPORATE ESSENTIAL PLAN D | DAY-TO-DAY BENEFIT OPTION

Principal Insured..... ◯
Spouse..... ◯
Adult Dependant..... ◯
Financially dependent 21+
Child Dependant..... ◯
20 or younger

CORPORATE ESSENTIAL PLAN D | ACCIDENT BENEFIT OPTION

STANDARD COVER ◯ R 260 000 | **HIGH COVER** ◯ R 1 250 000

Principal Insured..... ◯
Spouse..... ◯
Adult Dependant..... ◯
Financially dependent 21+
Child Dependant..... ◯
20 or younger

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 **Certificate of Membership** that you'll receive when your policy is activated.*

*Waiting periods don't apply to Employer Groups when it's compulsory for **20** or **more** employees to join.*

*When **20** or **less** employees join or when it's voluntary for employees to join, the below waiting periods may apply:*

1 MONTH GENERAL WAITING PERIOD
You don't have cover during this period for the **Day-to-Day**, **Employee Wellness Assessment** and **Preventative Care** Benefits.

9 MONTH PRE-BIRTH CONSULTATION WAITING PERIOD
12 MONTH CHRONIC MEDICATION WAITING PERIOD
12 MONTH EYE CARE WAITING PERIOD

EXCEPTION TO THE RULE
Waiting periods don't apply to the **Emergency & Accident Benefit Option** and **Essential Assistance Programme (EAP)**.

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

8. NOMINATION OF BENEFICIARY | ACCIDENTAL DEATH BENEFIT

The **Emergency & Accident Benefit Option** offers an **Accidental Death Benefit** that covers you and your registered spouse if either one of you passes away due to an accident.

You and your registered spouse may each nominate a beneficiary who'll receive the payout benefit. If a beneficiary isn't nominated, the benefit will be paid to your respective estates.

Child dependants are also covered if death is due to a motor vehicle accident. A nomination isn't required as the benefit will be paid out to the principal insured noted on the policy.

The **Policy Schedule** that you'll receive when your policy is activated explains the full terms and conditions of this benefit.

NOMINATION BY THE MAIN APPLICANT

Title | Name | Surname

ID/Passport | Relationship

Contact Details | Alternative Contact Details

NOMINATION BY THE SPOUSE

Title | Name | Surname

ID/Passport | Relationship

Contact Details | Alternative Contact Details

Subject to the terms and conditions of your policy or limitations imposed by law at the time of a claim, you understand that:

- the nominated beneficiary will receive proceeds payable under the **Accidental Death Benefit**;
- you may nominate a beneficiary of your choice;
- if the beneficiary is a minor when the benefit amount is payable, the benefit amount will be paid to the minor's legal guardian, trust or any person we're authorised to pay under the relevant law;
- you may amend the nomination at any time, however, nominations aren't effective until it's confirmed in writing by the Insurer; and that
- the benefit amount payable will be based on the latest valid beneficiary nomination that we've received and that the Insurer accepted.

Main Applicant Signature | Date – –

Spouse Applicant Signature | Date – –

10. YOUR HEALTHCARE PROVIDER(S)

*Let us know who your doctor is so that we can contact them with an offer to join **Unity Health's** provider network.*

Doctor | Contact Number

Doctor | Contact Number

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

Attach a copy of your bank statement or proof of account not older than 3 months if you're the premium payer. Proof of address may be required if your address isn't indicated on the proof of banking details or if you aren't the premium payer.

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, through its designated debit order collection agency, to debit your account for the policy premium that is payable in advance on the debit order date as selected.
3. authorise Stratum Benefits, through its designated debit order collection agency, 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 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 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.
9. 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 "CICLSTRATM".
10. 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.
11. accept that you'll not be entitled to any refund of amounts which have been deducted while this debit order authority is in force, if such amounts were legally due.
12. understand that the product premium is inclusive of VAT.

11. YOUR PAYMENT PROFILE [CONTINUED]

Bank

Account Number

Account Holder

Account Type
◯ Cheque ◯ Savings

Term
◯ Monthly ◯ Annual

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

Optional Professional Fee (Increments of R10)

Product Premium R

Total Monthly Premium R

Account Holder Signature

12. DISCLOSURES

We, hereby confirm that:

1. your, and/or your dependants' personal information and medical information obtained from healthcare providers will be kept confidential.
2. neither personal or medical information obtained will be used or sold commercially.
3. data security measures are in place.
4. staff, as well as our contracted third parties are bound by confidentiality agreements.
5. the Insurer's contractual agreements ensure the confidentiality of data management and administration.

13. USE OF PERSONAL INFORMATION DECLARATION

You hereby authorise **Unity Health**, our health insurance administrator, to process your personal information, including but not limited to the administrative functions listed below:

- processing this form;
- processing of future instructions submitted by you; and/or
- communicate with you regarding any matters related to your policy.

You further authorise **Unity Health** to disclose and transfer your personal information to any contracted third party for the purposes of collecting premiums, claim assessments, and statutory reporting regarding this contract.

You acknowledge that you have the right to:

- object to the processing of your personal information on reasonable grounds, unless legislation allows for such processing in line with the POPI Act.
- lodge a complaint with the Information Regulator; and/or
- request from **Unity Health** details of the personal information held about you and how it's processed.

Unity Health will to the best of its ability ensure that it keeps a record of, or has your most up to date personal information, however, it remains your responsibility to inform us of any changes to your personal information in a timely manner. The information that you provide must be complete, correct and up to date.

You understand why your personal information is required and for which purposes. You give **Unity Health** consent to process your personal information as provided in this form.

14. PROSPECTIVE MEMBER CONSENT *(Applicable to all applicants)*

As the main applicant applying for insurance cover, I understand and acknowledge that the Health Insurance 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, 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 I and/or my dependants may not be indemnified or compensated for any claims under any item or section of cover.
4. should this application form be incomplete, it may not be processed.
5. 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.
6. where a broker's been appointed by me, I authorise payment of their monthly commission.
7. 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.
8. I further authorise and instruct the Insurer and any medical provider, including emergency and hospital providers, to give any information relating to myself, and/or my dependants, to the staff appointed by the Insurer for the purposes of ensuring that the insured persons on the policy receive appropriate and necessary medical services, while reducing inappropriate care and wastage of medical resources.

Main Applicant Signature

Date – –