Stratum Benefits

2022 HEALTH INSURANCE | MEMBER APPLICATION FORM

Brokerage

Broker Name

Broker Email Address

Broker Code

Broker Contact Number

Broker Signature

1. CREATE YOUR PROFILE

If you're an individual wanting to switch cover from another health insurance provider or from medical aid cover, please complete our Transfer Application Form.

Please select the type of application relevant to your profile, which will form the basis of your contract with us.

Attach a clear copy of your identity document.

◯ Brand new applicant *(For a **first-time joiner** who isn't already covered on a Health Insurance policy.)*

◯ Existing dependant applying for continuation of cover as the principal insured on your own policy *(Also complete **Section 2 - Current Principal Insured Details**.)*

2. CURRENT PRINCIPAL INSURED DETAILS

*Complete this section if you're a dependant covered on an existing **Stratum Benefits Health Insurance** policy applying for cover on your own policy. Let us know who the principal insured person is on the policy you're currently covered on.*

Name

Surname

ID/Passport

and/or

Policy Number

3. MAIN APPLICANT DETAILS

Title

Name

Surname

ID/Passport

Date of Birth – –

Gender

Cellphone

Alternative Contact No.

Email Address

Physical/Postal Address

Postal Code

Attach proof of your address not older than 3 months.

Country of Residence

Country of Nationality

Where would you like us to send your member card to? Please provide an address where mail can be received.
Allow **+/- 21 working days** for delivery depending on postal services.

Physical/Postal Address

Postal Code

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. Please 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 who are **20 years** or **younger** pay **child dependant premiums**. Children who are **21 years** or **older** pay **adult dependant premiums** if they're **full-time students** or proof of **financial dependency** is submitted every year. 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**.

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

- Marriage certificate for a spouse
- ID/Passport documents for adult dependants
- Birth certificates for child dependants
- Medical report to confirm disability of a special needs dependant

Name

Surname

ID/Passport

DoB – –

Relation

DEPENDANT DETAILS [CONTINUED]

Name

Surname

ID/Passport DoB – – Relation

Name

Surname

ID/Passport DoB – – Relation

Name

Surname

ID/Passport DoB – – Relation

4. 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

5. HEALTH INSURANCE BENEFIT OPTIONS

*If you're **56** or **older** and apply for cover on the **Day-to-Day Benefit Option**, or if you're **61** or **older** applying for cover on the **Emergency & Accident Benefit Option**, you'll pay a higher premium as indicated. If you can prove that you've been on medical aid or primary healthcare insurance cover for **15** or **more consecutive years** from the age of **35** onward, the lower premium category will apply.*

DAY-TO-DAY BENEFIT OPTION

Ages	Monthly Premium							
55 or younger	Principal Insured..... ◯	R 349	Spouse..... ◯	R 281	Adult Dependant..... ◯ *Financially dependent 21+*	R 281	Child Dependant..... ◯ *20 or younger*	R 107
56 or older	Principal Insured..... ◯	R 530	Spouse..... ◯	R 462				

EMERGENCY AND ACCIDENT BENEFIT OPTION

Ages	Monthly Premium							
60 or younger	Principal Insured..... ◯	R 175	Spouse..... ◯	R 95	Adult Dependant..... ◯ *Financially dependent 21+*	R 95	Child Dependant..... ◯ *20 or younger*	R 39
61 or older	Principal Insured..... ◯	R 220	Spouse..... ◯	R 140				

COVER START DATE – –

6. RECOMMENDATION

If you appoint a broker, a recommendation will be made and advice will be given based on the information you provide. If you don't agree with the recommendation or advice and want more information, you should bring this to your broker's attention.

FOR YOUR BROKER TO COMPLETE

The purpose of this section is to make sure your client's health coverage requirements have been reviewed to help determine which Health Insurance option will best suit their needs.

Your recommendation based on these discussions are as follows:

Option

Reason for your recommendation

7. WAITING PERIODS

*Waiting periods apply from the start date of your policy and from each person's cover start date. The **Certificate of Membership** you'll receive when your policy is activated will confirm the waiting periods that apply to each insured person.*

2 MONTH GENERAL WAITING PERIOD

You don't have cover during this period for the **Day-to-Day**, **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 and Accident Benefits** and **Essential Assistance Programme (EAP)**.

By signing this application form, you acknowledge and accept that your policy will be subject to waiting periods for specific medical events.

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.

The benefit will be paid out to your and your registered spouse's nominated beneficiary. If you don't nominate beneficiaries, the benefit will be paid out to your respective estates.

The **Accidental Death Benefit** also covers a child dependant if death is due to a motor vehicle accident. The benefit for a child dependant will be paid out to the principal insured person 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 – –

9. YOUR HEALTHCARE PROVIDER(S)

*Let us know who your doctor is so that we can contact them about joining **Unity Health's** provider network.*

Doctor | Contact Number

Doctor | Contact Number

10. YOUR PAYMENT PROFILE

Attach a copy of the premium payer's latest bank statement or proof of account from their bank.

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.

10. 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

11. 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.

12. 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.

13. 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 – –

Email **yourapplication@stratumbenefits.co.za**. Please enquire if you've not received your policy documentation within **7 working days** from submitting your **Member Application Form**.