

## 2024 CORPORATE HEALTH INSURANCE CLIENT APPLICATION FORM

### 1. CREATE YOUR PROFILE

Speak with your HR representative or the financial advisor appointed by your employer about the **Corporate Health Insurance** option available to you and the terms and conditions of cover.

Based on the discussion, please select the type of application which will form the basis of your contract with us.

- New or existing employee who isn't already covered by a **Health Insurance** policy (Complete Sections 3, 4, 6, and 11 - 14. Complete **Section 10** if you're applying for the **EMERGENCY & ACCIDENT BENEFIT OPTION** and **HOSPITAL CASH PLAN**. **Section 2** is for your HR representative to complete, and **Sections 5 and 7** are for your appointed financial advisor to complete.)
- Employee switching cover from another **Health Insurance** provider or medical aid (Complete Sections 3, 4, 6, and 11 - 14 and submit a recent copy of your policy document or medical aid membership certificate dated not older than **31 days** for underwriting purposes. Complete **Section 10** if you're applying for the **EMERGENCY & ACCIDENT BENEFIT OPTION** and **HOSPITAL CASH PLAN**. **Section 2** is for your HR representative to complete, and **Sections 5, 7 and 9** are for your appointed financial advisor to complete.)

### 2. EMPLOYER GROUP DETAILS

Employer Group	<input type="text"/>	Employer Group Branch (if applicable)	<input type="text"/>
HR Representative	<input type="text"/>	HR Representative Email Address	<input type="text"/>
Employer Group Stamp / Authorised Signatory	<input type="text"/>	Employee Number	<input type="text"/>
		Employee Appointment Date	<input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> - <input type="text" value="M"/> <input type="text" value="M"/> - <input type="text" value="D"/> <input type="text" value="D"/>

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

### 3. MAIN APPLICANT DETAILS

Title	<input type="text"/>	Name	<input type="text"/>	Surname	<input type="text"/>
ID/Passport No.	<input type="text"/>	Date of Birth	<input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> - <input type="text" value="M"/> <input type="text" value="M"/> - <input type="text" value="D"/> <input type="text" value="D"/>		
Cellphone No.	<input type="text"/>	Alternative Contact No.	<input type="text"/>		
Physical/Postal Address	<input type="text"/>			Postal Code	<input type="text"/>
Email Address	<input type="text"/>				

### 4. DEPENDANT DETAILS

Joining as a family? We'll cover you and your spouse on one **Health Insurance** policy, including children of whom you're the parent or legal guardian. Submit a legal document from the South African Court of Law as proof of guardianship, where applicable. **Extended family members don't qualify for cover.**

Speak with your HR representative or the group's appointed financial advisor about adding your dependants.

Title	<input type="text"/>	Name	<input type="text"/>	Surname	<input type="text"/>
ID/Passport No.	<input type="text"/>	Date of Birth	<input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> - <input type="text" value="M"/> <input type="text" value="M"/> - <input type="text" value="D"/> <input type="text" value="D"/>		
Gender	<input type="text"/>	Relationship	<input type="text"/>		

---

Title	<input type="text"/>	Name	<input type="text"/>	Surname	<input type="text"/>
ID/Passport No.	<input type="text"/>	Date of Birth	<input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> - <input type="text" value="M"/> <input type="text" value="M"/> - <input type="text" value="D"/> <input type="text" value="D"/>		
Gender	<input type="text"/>	Relationship	<input type="text"/>		

---

Title	<input type="text"/>	Name	<input type="text"/>	Surname	<input type="text"/>
ID/Passport No.	<input type="text"/>	Date of Birth	<input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> - <input type="text" value="M"/> <input type="text" value="M"/> - <input type="text" value="D"/> <input type="text" value="D"/>		
Gender	<input type="text"/>	Relationship	<input type="text"/>		

---

Title	<input type="text"/>	Name	<input type="text"/>	Surname	<input type="text"/>
ID/Passport No.	<input type="text"/>	Date of Birth	<input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> - <input type="text" value="M"/> <input type="text" value="M"/> - <input type="text" value="D"/> <input type="text" value="D"/>		
Gender	<input type="text"/>	Relationship	<input type="text"/>		

### 5. BROKERAGE & FINANCIAL ADVISOR DETAILS

Brokerage	<input type="text"/>	Financial Advisor	<input type="text"/>
Brokerage Code	<input type="text"/>	Advisor Code	<input type="text"/>
		Advisor Signature	<input type="text"/>

**Health Insurance is not a medical aid, does not provide similar cover as medical aid and cannot be substituted for a medical aid membership.**

## 6. CORPORATE HEALTH INSURANCE BENEFIT OPTIONS

Your monthly premium is stated in the quote your employer accepted. Your HR representative or the group's appointed financial advisor can provide premium details.

Children **20 years or younger** pay child dependant premiums until age **21**. Children between **21 and 25 years of age** pay adult dependant premiums. From **26 years of age**, child dependants must apply for cover on their own policies.

Add the **GP PRE-AUTH WAIVER** when applying for the **DAY-TO-DAY BENEFIT OPTION** to see any network GP without prior approval. A monthly policy premium applies to the **GP PRE-AUTH WAIVER** regardless of the number of individuals on the policy.

Take the **HOSPITAL CASH PLAN** when applying for the **EMERGENCY & ACCIDENT BENEFIT OPTION**. Applicants must be insured on both options when selecting the **EMERGENCY & ACCIDENT BENEFIT OPTION** with the **HOSPITAL CASH PLAN**. Cover can't be chosen for only specific individuals.

If the **GP PRE-AUTH WAIVER** isn't selected with the **DAY-TO-DAY BENEFIT OPTION**, or the **HOSPITAL CASH PLAN** with the **EMERGENCY & ACCIDENT BENEFIT OPTION** when applying, you can do so for the new benefit year beginning **1 January 2025**.

Go to [www.stratumbenefits.co.za/health-insurance-options/](http://www.stratumbenefits.co.za/health-insurance-options/) or scan the **QR code** to read more about the benefits our **Health Insurance** options provide.



### DAY-TO-DAY BENEFIT OPTION

Principal Insured  Spouse  Adult Dependant (Child dependant between 21 and 25 years of age)  Child Dependant (20 years or younger)

### GP PRE-AUTH WAIVER (Can only be taken when applying for the DAY-TO-DAY BENEFIT OPTION)

Monthly Policy Premium

### EMERGENCY & ACCIDENT BENEFIT OPTION

Principal Insured  Spouse  Adult Dependant (Child dependant between 21 and 25 years of age)  Child Dependant (20 years or younger)

### HOSPITAL CASH PLAN (Can only be taken when applying for the EMERGENCY & ACCIDENT BENEFIT OPTION)

Principal Insured  Spouse  Adult Dependant (Child dependant between 21 and 25 years of age)  Child Dependant (20 years or younger)

Cover Start Date  -  -

## 7. RECOMMENDATION

Your financial advisor, as indicated in **Section 5 - Brokerage & Financial Advisor Details**, will give advice and recommend a **Health Insurance** option based on the information you provide.

If you don't agree with the advice or recommendation, you should bring this to your financial advisor's attention.

#### FOR YOUR FINANCIAL ADVISOR TO COMPLETE

This section aims to ensure the applicant's healthcare insurance needs have been reviewed to determine which **Health Insurance** option best suits their needs.

Your recommendation based on these discussions is as follows:

Option	
--------	--

Reason for your recommendation	
--------------------------------	--

#### FINANCIAL NEEDS ANALYSIS

Please indicate if a needs analysis was done.

- A full needs analysis was done. The Insurer may request a copy of the signed document for auditing purposes at any time.
- A full needs analysis wasn't done. The applicant understands and agrees with the recommendation.

## 8. WAITING PERIODS

Waiting periods may apply to you depending on the quote your employer accepted. If you join **within 90 days** of your permanent employment date, you'll receive the waiting periods the employer group received when joining. Full waiting periods will apply if you join **after 90 days** of your permanent employment date.

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 will apply.

The **Certificate of Membership** you'll receive when your policy is activated will confirm the waiting periods for each insured person.

#### 1 MONTH GENERAL WAITING PERIOD

There's no cover during this period for the **DAY-TO-DAY BENEFITS**, **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

#### 12 MONTH CHILDBIRTH WAITING PERIOD

There's no cover during this period for the **CHILDBIRTH PAYOUT BENEFIT** under the **HOSPITAL CASH PLAN**.

#### 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 may be subject to waiting periods for specific medical events.

## 9. REPLACEMENT POLICY DISCLOSURE

This section applies to you and your dependants applying to switch cover from another **Health Insurance** provider or medical aid as indicated in **Section 1 - Create Your Profile**.

### REPLACEMENT POLICY DISCLOSURE

- A change in terms and conditions, monthly premiums and benefits will apply as benefits and fee structures between the products offered by **Health Insurance** providers and medical aids are different.
- If there's a break between the last day of cover with your current provider and the first day of cover with us, full waiting periods may apply.
- The **Certificate of Membership** you'll receive when your policy is activated will confirm the waiting periods for each insured person.

### TRANSFER PROCESS & UNDERWRITING

Your policy may be subject to transfer underwriting when switching cover between **Health Insurance** providers or medical aids.

If you transfer as part of a voluntary group or a group where **20 or less** employees join, transfer underwriting may apply.

Waiting periods that apply won't exceed the waiting periods confirmed in the quote the employer group accepted.

Please submit a copy of your current policy document or medical aid membership certificate dated not older than **31 days** for underwriting purposes.

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

### FOR YOUR FINANCIAL ADVISOR TO COMPLETE

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

POLICY REPLACEMENT RECORD	CURRENT PRODUCT	REPLACEMENT PRODUCT
Name of Insurer or Medical Aid		Bryte Insurance Company Limited
Product Name		
Cancellation and Cover Start Dates		
Premium		
Differences in Products		
Reasons for Transferring Cover		

## 10. NOMINATION OF BENEFICIARIES

The **EMERGENCY & ACCIDENT BENEFIT OPTION** offers an **ACCIDENTAL DEATH BENEFIT** that pays out in the event of your and/or your spouse's accidental death.

If beneficiaries aren't nominated, the benefit amounts will be paid to your respective estates.

The payout benefit applicable to child dependants, if death is due to a motor vehicle accident will be paid out to the principal insured or the principal insured's estate if there's no surviving principal insured.

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

### NOMINATION BY THE MAIN APPLICANT

Title	<input type="text"/>	Name	<input type="text"/>	Surname	<input type="text"/>
ID/Passport No.	<input type="text"/>	Relationship	<input type="text"/>		
Email Address	<input type="text"/>	Contact No.	<input type="text"/>		

### NOMINATION BY THE SPOUSE

Title	<input type="text"/>	Name	<input type="text"/>	Surname	<input type="text"/>
ID/Passport No.	<input type="text"/>	Relationship	<input type="text"/>		
Email Address	<input type="text"/>	Contact No.	<input type="text"/>		

The **HOSPITAL CASH PLAN** offers a **DAILY HOSPITAL PAYOUT BENEFIT** that pays out in the event of your and/or your registered dependants' accidental death. If a beneficiary isn't nominated, the benefit amounts will be paid to the principal insured's estate.

### NOMINATION BY THE MAIN APPLICANT

Title	<input type="text"/>	Name	<input type="text"/>	Surname	<input type="text"/>
ID/Passport No.	<input type="text"/>	Relationship	<input type="text"/>		
Email Address	<input type="text"/>	Contact No.	<input type="text"/>		

As the main applicant, you understand that the beneficiary nominated will receive proceeds from the benefits payable under the **ACCIDENTAL DEATH BENEFIT** and/or **DAILY HOSPITAL PAYOUT BENEFIT**, subject to the terms and conditions of your policy and/or limitations imposed by law at the time of your claimable event.

You also understand that:

- you may nominate a beneficiary of your choice;
- if the nominated beneficiary can't be located or passes away before your claimable event, the benefit amount payable to them will be paid to your estate;
- if at the time of payment the nominated beneficiary is a minor, the benefit amount will be paid to the minor's legal guardian or a trust for the benefit of the minor, or to any person **Unity Health** is authorised to pay under the relevant law;
- you may amend a nomination at any time. However, nominations aren't effective until confirmed in writing by the Insurer; and
- the benefit amount payable to the nominated beneficiary will be based on the latest valid beneficiary nomination received and accepted by the Insurer.

Main Applicant Signature

Date     -   -

## 11. YOUR HEALTHCARE PROVIDERS

Let us know who your or your family's general practitioners are, and we'll contact them about joining **Unity Health's** provider network if they're not already part of the network.

Doctor	<input type="text"/>	Contact No.	<input type="text"/>
Doctor	<input type="text"/>	Contact No.	<input type="text"/>

## 12. YOUR PAYMENT PROFILE

Please complete this section if you're the policy premium payer.

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

1. authorise **Stratum Benefits** to accept this debit order authority as confirmed payment instruction issued by the account holder.
2. authorise **Stratum Benefits** to debit your account for monthly policy premiums payable in advance on the selected debit order date.
3. understand that the debit order deductions will be processed through a computerised system provided by the South African Banks. Details of each deduction will be referenced on your bank statement with the prefix "**Stratum**" and an **8-digit number** ending with "**Netcash**".
4. understand that selecting an annual premium won't result in a premium discount.
5. accept that depending on the selected debit order date, a double or triple debit may be incurred.
6. understand that cover will commence after the first premium is received.
7. agree that this debit order authority will remain in force until cancelled in writing by the principal insured person.
8. accept that **Stratum Benefits** may cancel your policy if premiums aren't received for two consecutive months, the bank account being debited is closed, the account holder is deceased, or if authority to debit is no longer granted.
9. understand that this debit order authority may only be assigned to a third party if this contract is assigned accordingly.
10. understand that the debit order date will default to the following working day if the payment date falls on a Sunday or recognised South African public holiday.
11. accept that if a debit order deduction is returned, an administration fee of **R 25.00** will be added to the following premium deduction.
12. accept that you're not entitled to any refund of amounts deducted while this debit order authority is in force if such payments are legally due.
13. understand that policy premiums include VAT but aren't tax deductible, as medical aid contributions. An IT3 tax certificate can't be issued for this purpose.
14. accept that the policy premium may be adjusted during an annual renewal or due to benefit restructuring necessitated by legislation with **31 days** written notice. Subject to your right of cancellation of cover, the debit order authority will extend to the adjusted premium.
15. accept that your responsibility is to ensure premiums are collected and paid to remain covered.

Account Type	<input type="radio"/> Cheque	<input type="radio"/> Savings	Bank	<input type="text"/>	Account No.	<input type="text"/>					
Account Holder	<input type="text"/>										
Debit Order Date	<input type="radio"/> 1st	<input type="radio"/> 4th	<input type="radio"/> 7th	<input type="radio"/> 15th	<input type="radio"/> 20th	<input type="radio"/> 25th	<input type="radio"/> 28th	<input type="radio"/> Last Day	Term	<input type="radio"/> Monthly	<input type="radio"/> Annual

### FINANCIAL ADVISOR PROFESSIONAL FEES

You may pay your appointed financial advisor a professional fee over and above the monthly commission payable. If you agree to pay a fee, your advisor must explain the additional services you can expect for the fee.

The professional fee will be added to your policy premium and paid to your advisor monthly. You may cancel, reduce, or increase the professional fee anytime.

Professional Fee (Increments of R 10.00)	R	Product Premium	R	Total Monthly Premium	R	Account Holder Signature	<input type="text"/>
---	---	-----------------	---	-----------------------	---	--------------------------	----------------------

### FOR THE FINANCIAL ADVISOR

The Insurer may request a copy of the signed record of advice for auditing purposes at any time.

## 13. PROSPECTIVE POLICYHOLDER CONSENT

As the main applicant applying for insurance cover, you agree and accept that:

1. you're applying for insurance cover subject to the waiting periods, benefit and general exclusions and terms and conditions of the policy contract, which have been communicated and explained to you before the policy's start date.
2. the details provided are true and correct, and no information that may be material to or is likely to affect the assessment or acceptance of your risk has been withheld.
3. if there's any material non-disclosure or misrepresentation, your policy may be rendered null and void. Any premiums will be forfeited, and the Insurer may decline to indemnify or compensate you or your dependants for any claims under any item or section of cover.
4. if you appoint a financial advisor, you're responsible for determining whether a licensed Financial Services Provider mandates the financial advisor with the necessary accreditation and licensing in terms of the Financial Advisory and Intermediary Services Act, 2002, to act on your behalf.
5. when appointing a financial advisor, you authorise **Stratum Benefits** to pay monthly commissions to the advisor.
6. **Stratum Benefits** is authorised to process and store your and your dependants' personal information required to administrate cover under this policy. **Stratum Benefits** will be notified of any change in your details within a reasonable period. This authorisation will be terminated when your policy is cancelled, wherein your data will be stored for the prescribed years and, after that, destroyed responsibly.
7. the Insurer and any medical provider, including emergency and hospital providers, may share information relating to you and your dependants with the staff appointed by the Insurer to ensure you receive appropriate and necessary medical services while reducing inappropriate care and wastage of medical resources.
8. this application form won't be processed if it's incomplete.

Main Applicant Signature	<input type="text"/>	Date	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>
--------------------------	----------------------	------	----------------------	---	----------------------	---	----------------------

## 14. 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 and providing personal information, you agree and permit us to use your data accordingly.

Go to [www.stratumbenefits.co.za/popi-privacy-policy/](http://www.stratumbenefits.co.za/popi-privacy-policy/) or scan the **QR code** to view or download our **POPI Privacy Policy**.



May we contact you for marketing purposes, for example, 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

Send the completed application form to your financial advisor or email us at [yourapplication@stratumbenefits.co.za](mailto:yourapplication@stratumbenefits.co.za).

Please contact us if you haven't received confirmation of cover or your policy documentation within **7 working days** from submitting your application form.



Administered by Unity Health, a division of Ambledown Financial Services (Pty) Ltd, FSP (10287). Underwritten by Bryte Insurance Company Limited, a licensed insurer & authorised FSP (17703). In partnership with Stratum Benefits (Pty) Ltd, FSP (2111). This is not a medical aid and cannot be substituted for a medical aid membership. Terms and conditions apply.



StratumBenefits<sup>+</sup>

011 781 4488 086 633 3761 [yourapplication@stratumbenefits.co.za](mailto:yourapplication@stratumbenefits.co.za) +27 10 448 0861 [www.stratumbenefits.co.za](http://www.stratumbenefits.co.za)