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service@iwyzegap.co.za

APPLICATION FORM GAP COVER

IMPORTANT NOTE

Please note that any non-disclosure or misrepresentation below may result in your claim being rejected or your policy being cancelled or voided from inception.

Please complete the form in writing and print, sign, scan and email the completed form to sales@iwyze.co.za.

1. DETAILS OF PRINCIPAL MEMBER & DEPENDANTS:

(Note: Cover for dependants only applies to your spouse and/or children up to age 26. Other dependants are not covered.)

	First Name/s	Surname	ID Number is compulsory for the Principal Member
Principal Member:			
Spouse:			Date of Birth: Y Y Y Y M M D D
Child 1:			Date of Birth: Y Y Y Y M M D D
Child 2:			Date of Birth: Y Y Y Y M M D D
Child 3:			Date of Birth: Y Y Y Y M M D D
Child 4:			Date of Birth: Y Y Y Y M M D D
Child 5:			Date of Birth: Y Y Y Y M M D D

Tel No: Cell No:

Email:

2. COVER DETAILS:

Medical Scheme: Option:

Start Date: Y Y Y Y M M D D

Previous Scheme:

Start Date: Y Y Y Y M M D D End Date: Y Y Y Y M M D D

Please indicate your desired date of commencement of iWYZE Gap Cover (month/year): M M Y Y Y Y

(Note: Applications received after the 11th of the current month will only activate in the following month).

3. HEALTH QUESTION

In answering the question below, consider any dental treatment, family planning consultations with medical specialists, existing ailments and/or prescribed chronic medicine.

Are you or any of your dependants currently aware of any reason that you or any of your dependants may require hospitalisation or cancer treatment within the next 12 months? Y N

If you have answered "yes" to the previous health question, please provide full details in the space provided below (if the space is insufficient, please attach a signed addendum to this application form):

Dependant Name	Details of Condition / Treatment / Disorder	Last Date of Treatment	Provide details of Future Treatment incl. date/s

4. APPLICATION STATUS:

Please indicate the status of your application by ticking one of the relevant boxes below:

1. I do not currently have iWYZE Gap Cover, but wish to join in my private capacity.
2. I currently have Gap Cover with another provider, but I wish to transfer my cover to iWYZE Gap Cover.

Notes:

- Waiting periods may apply to your cover, depending on the option chosen above.
- For option 2 proof of cover with the other provider must be provided.
- All applications remain subject to our standard underwriting terms and conditions.

5. DEBIT ORDER DETAILS:

Bank Name:		Branch Name:	
Branch Code:		Account Type:	
Account No:		Account Name:	

6. DECLARATION BY PRINCIPAL MEMBER:

I, (full name) _____ with ID number _____ hereby declare that this application form, whether in my handwriting or not, is accurate and complete and forms the basis of the contract of insurance between the Insurer and myself. I hereby apply for the iWYZE insurance product/s and agree to abide by its policy rules and/or those of its Insurer and any amendments thereto which may be made from time to time. I confirm that all the information provided herein is complete and true and that I have not concealed any relevant or pertinent information that may affect the evaluation of risk considered under this policy of cover. I understand that the provision of any false, misleading or missing information could result in my application being rejected or my membership being cancelled or claims being rejected. Should this occur, I agree to refund all benefit payments that I have received in relation to this policy of insurance. I hereby provide irrevocable authority for iWYZE or its Underwriter to obtain any of my or my beneficiaries' medical history from any Medical Service Provider, Medical Scheme, insurance company or healthcare intermediary for the purposes of assessing this application for insurance, as well as the underwriting of any future risk or the assessment of any claim that relates to this insurance cover. Premiums due to iWYZE are payable monthly. Premiums that are in arrears will result in my membership being suspended or possibly terminated. In the event that any policy benefit becomes payable subsequent to or as a result of my death, I hereby provide an irrevocable authority for such benefits to be paid directly to my surviving spouse or failing such circumstance to the nominated guardians or trustees responsible for the future care of my minor children or failing either of the preceding events to my estate. Where applicable, I hereby authorise iWYZE to draw against the above bank account all amounts due to iWYZE in terms of this insurance cover. Should the relevant premiums be adjusted by the Insurer, I hereby confirm that the adjusted amount may be drawn from the above account subject to the notice period outlined in the policy document. This request is to remain in force unless cancelled within 30 days' written notice.

Full Name: _____ Signature: _____

Date: Y Y Y Y M M D D