EMPLOYEE HEALTH INSURANCE APPLICATION FORM (TO BE COMPLETED BY THE EMPLOYEE)

PRINCIPAL INSURED (MAIN INSURED PERSON)

Title: Mr Mrs Ms Other Initials

First name(s)

Surname

ID/Passport number Date of birth D D M M Y Y Y Y

Contact number

Email address

Postal address

Postal code

Residential address

Postal code

DEPENDENTS

Cover is limited to the Policyholder and maximum of 4 Dependants in total.

Dependants can include:

Either an Adult or Child who is dependent upon the Policyholder for access to the benefits available within this policy.

Adult: A person over the age of **21** (twenty-one), except for a full-time student over the age of **21** (twenty-one) who is dependent on the Policyholder and approved by Us as eligible for membership of this policy.

Child: A Child is a person under the age of 21 (twenty-one), who is considered to be the Immediate Family of the Policyholder eligible for membership in terms of this policy. Cover as a Child can be extended to the age of **27** (twenty-seven) if they are full-time students. Documented proof of full-time studies is required annually.

Immediate Family: The Immediate Family is a defined group of relations, whether over or under the age of **21** (twenty-one) and determines which members of a Policyholder's family may join this policy. The definition extends to those connected to the Policyholder in the following manner:

- By birth, adoption, stepchildren or grandchildren or any other child who has been placed in the custody of the Policyholder and in respect of whom the Policyholder is liable for care and support;
- A Spouse of a Policyholder as defined in this policy;
- Any other relative, who at the Insurers discretion, qualifies for membership under this polic;.

Spouse: A person who is a significant other, partner or non-marital partner of that the principal insured person:

- In a marriage or customary union recognised in terms of the laws of the Republic; or
- In a union recognised as a marriage in accordance with the tenets of any religion; or
- In a same sex or heterosexual union which the Underwriter is satisfied is intended to be permanent.

Please refer to the terms and conditions in Policy Wording.

First name(s)

Surname

ID/Passport number Date of birth D D M M Y Y Y Y

Gender: Male Female Relationship to applicant (Compulsory)

First name(s)

Surname

ID/Passport number Date of birth D D M M Y Y Y Y

Gender: Male Female Relationship to applicant (Compulsory)

First name(s)

Surname

ID/Passport number Date of birth D D M M Y Y Y Y

Gender: Male Female Relationship to applicant (Compulsory)

First name(s)

Surname

ID/Passport number | | | | | | | | | | | | | Date of birth D D M M Y Y Y Y

Gender: Male ☐ Female ☐ Relationship to applicant (Compulsory)

HEALTH DECLARATION

Specific health questions

The following questions relate to you, your beneficiaries and dependents covered under this policy.

1. Have you been admitted to hospital in the last 4 months? YES ☐ NO ☐
2. Are you expecting a hospital admission or are you aware of any conditions or illness that would require treatment in the next 12 months? YES ☐ NO ☐
3. Are you or any of your dependents currently pregnant? YES ☐ NO ☐
4. Have you taken chronic medication in the past 24 months, or are currently taking chronic medication? YES ☐ NO ☐

If you answered "YES" to any of the questions, please provide details below:

QUESTION NO.	APPLICANT/DEPENDENT NAME	CONDITION	MEDICATION	DIAGNOSIS DATE

I, the undersigned, hereby declare:

1. That there has been no change in my state of health nor has any illness been suffered by me, or any of my dependents, from the date of my application and the signing of this statement.
2. Agree that my cover is subject to the rules of the product with special reference to the policy wording.
3. I acknowledge and understand the content of the above statement. I have no objection to taking the prescribed oath. I consider the prescribed oath to be binding on my conscience.

Policyholder's signature Date D D M M Y Y Y Y

OPTION SELECTION

Please return the completed form to your HR department

Option: Golden Hour Plus Hospital Plan ☐ Primary Standard ☐ Primary Standard With Hospital Plan ☐ Comprehensive Plus ☐

Premium per month R Primary Standard ☐

Employee's signature Date D D M M Y Y Y Y

Please Note: Premiums for any dependents will be deducted from the Employee's salary and paid by the Employer on the Employees behalf to GENRIC.

NOMINATED BENEFICIARY (RELATED TO ACCIDENTAL DEATH BENEFITS)

First name(s)

Surname

ID/Passport number | | | | | | | | | | | | | Relationship to employee

CONTACT DETAILS

Telephone number Cellphone number

Email address

EMPLOYER DETAILS

Employer name | Employer group number

Employee name | Employee number

Date of employment D D M M Y Y Y Y

Policy start date D D M M Y Y Y Y

We warrant that the employee is an employee of our organisation and that we will deduct the amount of the monthly premium as invoiced by GENRIC Insurance Company as per the employee's instruction.

Employer signature | Date D D M M Y Y Y Y

DECLARATION AND INFORMED CONSENT IN TERMS OF THE PROTECTION OF PERSONAL INFORMATION ACT 4, OF 2013 (POPIA)

We at GENRIC respect our client's right to privacy. We need to collect and process personal information in terms of various Privacy and Data Management laws and are bound by the terms and provisions of the Protection of Personal Information Act, regarding the acquisition, usage, retention, transmission, and deletion of such personal information.

Our Client's personal information is collected for the primary purpose of providing the client with insurance cover and for all other activities and processes incidental to and relevant to this purpose. As this information forms the basis of the assessment and terms we offer our clients, it must be correct, complete, and up-to-date.

We will always comply with all relevant regulations in dealing with such information and keep it secure and confidential at all times. The information shall be kept confidential; however, we shall disclose it to certain third parties as required and other insurers for the specific purpose of insurance and to reduce and prevent any form of fraudulent activity.

Should you decide to cancel this insurance contract, further consent is given to GENRIC to retain the information for the legally permitted retention period, for statistical and reporting purposes only.

Should you decide not to accept the proposal, the information collected will be de-identified and only used for statistical and research purposes.

You hereby voluntary consent to GENRIC and its third party service providers processing such personal information.

You understand the purposes for which such personal information is required and for which it will be used.

You give GENRIC permission to process such personal information as provided above.

Our Privacy Notice and POPIA Policy provides the details of how we deal with the personal information of our clients, and it is available at www.genric.co.za.

EMPLOYEE DECLARATION

I, the undersigned, do hereby declare and state as follows that:

1. The information contained in this application form is true and correct.
2. I acknowledge that the sharing and accessing of information (including credit information held by other institutions) for underwriting and claim purposes is in the public interest, as it will enable insurers to underwrite policies, assess and re-assess risks fairly and to reduce the incidence of fraudulent claim with a view to limiting premiums.
3. I further consent to any underwriting information and credit information held by other institution being accessed and verified on databases.
4. I also consent to the underwriting, claims or credit information referred to above being retained on any shared database and shared with insurers and/or other institutions for underwriting purposes and/or to reduce the incidence of fraud, notwithstanding the cancellation of this policy by myself or by GENRIC Insurance Company Limited.

Employee's signature | Date D D M M Y Y Y Y

INTERMEDIARY DETAILS , WHERE APPLICABLE

Intermediary Group/ Full name

Intermediary code | Salesperson

Sales Code | Contact number

PLEASE RETURN THE COMPLETED FORM TO YOUR INTERMEDIARY