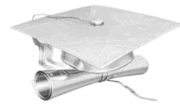
Prime Care
COMPREHENSIVE HEALTH INSURANCE

STUDENT APPLICATION FORM

PRIMECARE PLUS



RENEWAL STUDENT : PLEASE PROVIDE PRIME CARE NO.

PRIME CARE MEMBERSHIP NUMBER: **Student university number:**

** **Copy of student passport and beneficiary full name and I.D. required**

STUDENT

Title: Surname: First Names:

Gender: Male: Female: Nationality: Date of birth: *d d m m y y*

Marital status: Single: Married: Widowed: Divorced: (Place **X** in the applicable box)

RSA Postal Address: Postal code:

RSA Residential Address:

Tel. No: Contact Person (Other than Student)

Student RSA Cell No. Passport No:

GUARDIAN or PARENT

Title: Surname: First Names:

Relationship to Applicant:

Postal address:

Postal code:

Physical address:

Tel. No. Home: Tel. No. Work: Fax:

Cell No: ID/Passport Number:

EDUCATIONAL INSTITUTION

Name: Tel No:

Physical Address

Postal Address: Postal code:

International Office Physical Address:

Faculty: Year of Study: Name of Course:

Tel No: Fax No: Contact Person

NOMINATION OF BENEFICIARY/IES (for death benefit payouts only)

	SURNAME	FIRST NAME(S)	RELATIONSHIP	ID NUMBER	TEL. NUMBER	%
1						
2						
3						
4						

INSURED BENEFITS PLUS RECOMMENDED MEDICAL SAVINGS CONTRIBUTION

The Student Plan insured benefit premium is fixed. You need to choose your Medical Savings contribution.

The insured benefits include Accidental in-hospital benefits, per day in-hospital cover, Emergency Helpline & Evacuation, Death & Disability & Funeral cover.

ANNUAL PREMIUM **DATE OF ENTRY** / / **EXPIRY DATE** / /

ANNUAL INSURED BENEFITS PREMIUM (incl. all Admin fees and brokerage)	**R 2,800.00**
MINIMUM MEDICAL SAVINGS (DAY TO DAY BENEFITS)	**R 900.00**
TOTAL ANNUAL PREMIUM	**R 3,700.00**

NOTE: This Policy must be renewed before the Expiry Date to preserve benefits and validate the Evidence of Insurance for the next year!

HEALTH QUESTIONNAIRE - PLEASE COMPLETE IN FULL, IN RESPECT OF THE APPLICANT

State whether you have ever been treated, or are currently receiving treatment, for any of the following illnesses:

1	Blood disorders, e.g. anaemia, bleeding disorders, haemophilia, leukaemia	YES	NO
2	Eye related disorders, e.g. glaucoma, blindness, eye surgery, retinitis pigmentosa, cataracts	YES	NO
3	Musculo-skeletal disorders, e.g. arthritis, back problems, gout, osteoporosis, joints, e.g. knee, shoulder, etc.	YES	NO
4	Neurological disorders, e.g. epilepsy, muscular weakness, stroke, brain or spinal cord disorders, chronic fatigue	YES	NO
5	Psychological disorders, e.g. anxiety, depression, stress, panic attacks, alcohol or drug dependency, attention deficit	YES	NO
6	Do you expect to receive any treatment, or surgery in the next 12 months and do you expect to be hospitalised?	YES	NO
7	Do you currently receive or expect to receive treatment with medication for longer than 3 months?	YES	NO

If you have answered YES to any of the questions above, please supply full details below. If the space is insufficient, please attach information.

Question	Full details (incl. details of disorder, date diagnosed, nature & duration of treatment and the consulting doctor's contact details)
1	
2	
3	
4	
5	
6	
7	

N.B. Any misrepresentation or non-disclosure of material medical or factual information will render all benefits granted by Complimed and its Insurer null and void. In addition, any payment made due to such actions will be required to be repaid by the insured to Complimed.

Please read the **DECLARATION** and **TERMS** and **CONDITIONS** sections which follow carefully and sign to indicate understanding and acceptance of all terms and conditions.

DECLARATION IN RESPECT OF POLICIES ISSUED BY COMPLIMED ON BEHALF OF SELECTED INSURERS

1. Failure to disclose material information or the provision of incorrect information can result in immediate cancellation of my policy.
2. I declare that any false statement in the above application, or the non-disclosure of any material information will render the policy and the cover afforded thereby null and void.
3. I hereby authorise any hospital, physician, or any other person who has attended or examined me to furnish to Complimed, or their authorised representative, all information with respect to any illness, injury or medical history, consultation, prescription or treatment and medical history, consultation, or medical records.
4. I hereby acknowledge that any benefits paid out on my behalf, not covered by the terms and conditions of the policy cover, will be refunded to Complimed and its Insurer.
5. I hereby apply for the insurance cover and agree that any benefits due will be payable provided all relevant premiums are paid to date.
6. I authorize Complimed and its Insurer. to pay the benefits according to my authorised beneficiaries.
7. I understand that this policy required consent to the disclosure of private underwriting and claims information per the Terms and Conditions.

I certify that the above information is true and correct and accept that the operation of my **Prime Care Card** and my participation in risk products is subject to the terms and conditions as set out above.

SIGNATURE OF APPLICANT: ____

Signed at _________________________________ on this ________ day of _____________________ 20 ______