Dr. Pikkie Kok
FINANCIAL & HEALTHCARE ADVISOR

2020

CORPORATE ESSENTIAL
CORPORATE CLIENT APPLICATION FORM

Stratum Benefits

Brokerage

Broker

Signature

1. CREATE YOUR PROFILE

As an employee applying for cover as part of an Employer Group Scheme, please complete the below section.

EMPLOYER GROUP SCHEME DETAILS

Employer Group Scheme

Employer Group Scheme Stamp / Authorised Signatory

Employee Appointment Date

Employee Number

HR Representative Name

HR Representative Email Address

MAIN APPLICANT DETAILS

Title

Name

Surname

ID/Passport

Cellphone

Alternative Contact No.

Email Address

Physical/Postal Address

Postal Code

DEPENDANT DETAILS

We cover you, your spouse and any child dependant of whom you are the parent or legal guardian, unless otherwise specified in the proposal provided and accepted by your employer on behalf of the Employer Group. Speak to your HR Representative or Broker for more information about adding your dependant(s).

Children aged **20 years** or **younger** pay **child dependant premiums**. Children aged **21** years or **older** pay **adult dependant premiums** if they are **full-time students** and **proof** of **financial dependency** is submitted **every year**. We accept proof from the educational facility or stamped copies of your child's bank account statements of the past **3 months**.

Title | Name | ID/Passport

Surname | Relationship

Title | Name | ID/Passport

Surname | Relationship

Title | Name | ID/Passport

Surname | Relationship

Title | Name | ID/Passport

Surname | Relationship

2. CORPORATE HEALTH INSURANCE BENEFIT OPTIONS

Please select the appropriate Corporate Health Insurance benefit option that your Employer Group offers.

The monthly premium that each employee pays as part of the employer group is determined by a number of factors, such as the number of employees joining and whether cover is compulsory or voluntary for employees.

Your monthly premium is subject to the Employer Group Scheme Proposal accepted by your employer. Speak to your HR Representative or Broker for premium details.

DAY-TO-DAY BENEFIT OPTION

Principal Insured ◯ Spouse ◯ Adult Dependant *Financially dependent 21+* ◯ Child Dependant *20 or younger* ◯

EMERGENCY AND ACCIDENT BENEFIT OPTION

Principal Insured ◯ Spouse ◯ Adult Dependant *Financially dependent 21+* ◯ Child Dependant *20 or younger* ◯

DAY-TO-DAY, EMERGENCY & ACCIDENT BENEFIT OPTION

Principal Insured ◯ Spouse ◯ Adult Dependant *Financially dependent 21+* ◯ Child Dependant *20 or younger* ◯

COVER START DATE

3. WAITING PERIODS

Waiting periods apply from the start date of the policy and from each insured person's cover start date unless otherwise specified in your **Cover Letter**, which you will receive when your cover is activated. Speak to your HR Representative, Broker or get in touch with us directly for more information about the waiting periods applicable to the Employer Group Scheme you will form a part of.

Waiting periods do not apply to Employer Groups if **20** or **more** employees join on a **compulsory** basis.

The below waiting periods apply when **20** or **less** employees join or when cover is **voluntary** for employees to join.

1 MONTH GENERAL WAITING PERIOD
Cover does not apply to our **Day-to-Day**, **Employee Wellness Assessment** and **Preventative Care Benefits** during the **first month** of cover.

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 do not apply to our **Emergency and Accident Benefit** 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.

4. NOMINATION OF BENEFICIARY

Please nominate **1 beneficiary** to whom the benefit amount under our **Accidental Death Benefit** will be paid to in the event of your accidental death. If a beneficiary is not nominated the benefit amount will be paid to your estate.

In the event of your spouse's accidental death, the benefit amount will be paid to the principal insured person on the policy.

Please refer to your policy documentation for full terms and conditions.

Title | Name | Surname

ID/Passport Number | Relationship

Address

As the main applicant, you understand that the beneficiary nominated will receive proceeds from the benefit payable under our **Accidental Death 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 your nominated beneficiary cannot be located or passes away prior to your claimable event, the benefit amount(s) payable to them will be paid to your estate;
- If at the time of payment your nominated beneficiary is a minor, the benefit amount(s) will be paid to the minor's legal guardian or a trust for the benefit of the minor, or to any person we are authorised to pay under the relevant law;
- you may amend your nomination at any stage, however, nominations are not effective until confirmed in writing by the Insurer; and
- the benefit amount(s) payable to your nominated beneficiary will be based on the latest valid beneficiary nomination received as accepted by the Insurer.

Main Applicant Signature

Date

5. YOUR PAYMENT PROFILE

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 to debit your account for the policy premium that is payable in advance, on the debit order date as selected.
3. authorise Stratum Benefits 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, or by Stratum Benefits if premiums are not received for two consecutive months.
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 if the premium from a previous debit order deduction is returned, a **R 25** admin fee will be added to the next premium deduction.
9. 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.
10. 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 prefix "STRATUM" followed by an 8-digit number ending with "SAGEPAY".
11. accept that given the debit order authority granted by you, it is your responsibility to ensure that premiums are collected in order to remain covered.
12. accept that you shall 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.
13. understand that the product premium is inclusive of VAT.

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) R

Total Monthly Premium R

Account Holder Signature

6. YOUR HEALTHCARE PROVIDER(S)

Please provide details of your doctor(s), whom we will contact with an offer to join Unity Health's national provider network.

Doctor | Contact Number

Doctor | Contact Number

7. PROSPECTIVE CLIENT CONSENT *(Applicable to all applicants)*

As the main applicant applying for insurance cover, I hereby declare and accept that:

1. I am 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 my cover start date.
2. all the information provided is true and correct and that I have not withheld any information which 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 will forfeit any and all premiums and that Stratum Benefits may decline to indemnify or compensate me and/or my dependant(s) where applicable, for any claims under any item or section of cover.
4. should this application form be incomplete, it may not be processed by Stratum Benefits.
5. I understand that this insurance cover is not a medical aid membership nor does it provide benefits similar to that of a medical aid.
6. 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 is my responsibility to determine whether my broker has the necessary authorisation.
7. I have appointed the above-mentioned broker and authorise payment of their monthly commission.
8. Stratum Benefits is irrevocably authorised to process and store my and/or my dependant's personal information required for the purpose of administrating cover under this policy, and I undertake to notify Stratum Benefits of any change in my personal details within a reasonable time period.
9. I further authorise and instruct the Insurer and any medical provider (including emergency and hospital providers) concerned 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 **yourportfolio@stratumbenefits.co.za**. Please enquire if you have not received your policy documentation within **7 days** from submitting your Corporate Client Application