Maximum age limit entry is 64

Day1 Health (Pty) Ltd is an authorised Financial Services Provider (FSP 11319), underwritten by African Unity Life Limited (2003/016142/06), a licensed life insurer and an authorised Financial Services Provider - FSP 8447. The Day1 Health Plan is demarcated by CMS. This product is a Medical Insurance Product and not a Medical Aid registered by the Council for Medical Schemes DM1053A. For more information regarding this demarcated product please visit https://www.medicalschemes.co.za/insurers/

DAY1 HEALTH APPLICATION FORM
Value Plus Hospital Plan

Personal details (Principal Member) (ID Copy Required)

Surname:		ID Number:	
Title	Dr/Mr/Mrs/Miss	Full Names:	
Occupation:		Date of Birth:	
Employer:			
Residential Address: Code:			
Postal Address: Code:			
Work:	Cell:	Fax:	Home:
Email Address:			
Preferred Method of Communication:			

Dependants to be covered

Spouse:		ID No:
Child 1:		ID No:
Child 2:		ID No:
Child 3:		ID No:
Child 4:		ID No:

Beneficiary

Name		ID No:

COVERED MEMBER	MONTHLY PREMIUM	
Single Policy	**R 390.00**	
Single + 1 Child	R 546.00	
Single + 2 Child	R 702.00	
Single + 3 Child	R 858.00	
Single + 4 Child	R1 014.00	
Couple	**R 702.00**	
Couple + 1 Child	R 858.00	
Couple + 2 Child	R1 014.00	
Couple + 3 Child	R1 170.00	
Couple + 4 Child	R1 326.00	

Additional Information		
Are you or any of your dependants on any form of chronic medication? Person: Condition: Medication:	Yes	No
Are you or any of your dependants receiving treatment for any other medical condition other than a chronic condition? Person: Condition: Medication:	Yes	No
Are you or any of your dependants receiving treatment for any dental condition? Person: Condition: Medication:	Yes	No
Are you of any of your dependants concerned about any other current condition which may require medical or dental attention in the future? Person: Condition: Medication:	Yes	No
Are you pregnant?	Yes	No
If not, is there a possibility that you may be pregnant?	Yes	No
Have you or any of your dependants undergone any major operations in the past 5 years? Person: Procedure: Date of procedure:	Yes	No
Have you or any of your dependants been admitted into hospital in the past 5 years? Person: Reason for admission: Date of admission:	Yes	No
Are you or your spouse a member of a Medical Aid scheme or hospital plan? Person: Name of scheme / plan: Date of inception of policy:	Yes	No

Acknowledgement

- I warrant that I have been provided with all the intermediary, insurer's and benefit details as well as any additional information as I may have requested.
- I warrant that all details and facts provided herein are accurate and properly disclosed.
- I understand that there are no surrender values attached to this policy.
- Failure to pay monthly premiums will result in benefits lapsing.
- In the event of any query regarding this policy or any claim in terms of this policy, I consent to the disclosure of any relevant information to the intermediary, Insurer or any Day1 Health (Pty) Ltd official for the purposes of resolving the query.
- In the event of no nominated beneficiary, I agree that the necessary burial costs will be paid directly or to the person who paid for such costs. Thereafter, any remaining benefit will be payable to the first claimant with reasonable title to claim any benefits.
- I acknowledge that the Day1 Health (Pty) Ltd Value Plus Hospital Plan is not a Medical Aid.

Name of Account Holder		Name of Bank	
Branch		Branch Code	
Account Number		Account Type	
Inception Date		Debit Order Date	

I authorise the Payroll Administrator / Day1 Health (Pty) Ltd to deduct the above mentioned premium from my salary / account each month.

_____ _____

Signature of Principal Member Date

_____ _____

Signature of Accountholder Date
(*If not principal member)*

Day1 Health (Pty) Ltd may use your information or obtain information about you for the following purposes:

- Assessment of your needs and underwriting your policy
- Managing and servicing your policy
- Assessment and processing of claims
- Credit searches, claims checks, and the verification of personal information
- Fraud prevention and detection in conjunction with the insurer
- Market research and statistical analysis
- Offering other related products and services to you
- Audit and record keeping purposes
- Compliance with legal and regulatory requirements
- Sharing information with service providers.

Storage of your information may be abroad, but we will not share your information with a third party unless we are satisfied that they have adequate security measures in place to protect your personal information.

You may access your personal information that we hold and also request us to correct or update this information. In certain cases you have the right to object to the processing of your personal information.
Our privacy policy can be accessed via (www.day1health.co.za).

POLICY HOLDER DECLARATION

Client Name:	
Rep Name:	
Chosen Plan:	

Please choose option A, B or C

I, _____, hereby declare that I have opted for the Day1 Health Value Plus Hospital Plan as **A.** a replacement of my current Medical Aid: _____
I, _____, hereby declare that I have opted for the Day1 Health Value Plus Hospital Plan as **B**. an addition to my current Medical Aid: _____
I, _____, hereby declare that I have opted for the Day1 Health Value Plus Hospital Plan as **C**. I am presently not covered by any Medical Aid.

By choosing option A, I have decided to do the replacement for the following reasons:

☐ Due to circumstances beyond my control, the Medical Aid premium is no longer affordable.
☐ I enjoy good health and I am satisfied with the benefits that the Day 1 Health Value Plus Hospital Plan offers.

Other reasons: _____

_____

_____

The Medical Insurance benefits have been explained to my satisfaction and I am aware of the difference in benefits between a Medical Insurance Plan and a Medical Aid.

Signed at: _____

Date: _____

Signature of Principal Member: _____

Witness: _____