AFFINITY HEALTH

# Application Form

## Principal Member Personal Information

| | | | |
|---|---|---|---|
| Surname: | | Full Name: | |
| ID/Passport Number: | | Date of Birth: | |
| Gender: | ☐ Female ☐ Male | Marital Status: | ☐ Single ☐ Married ☐ Divorced ☐ Widowed |
| Company Address: | | Employee Number: | |
| Physical Address: | | Home Language: | |
| Preferred Delivery Address: | | | |
| Contact Number: | Cell: | Work: | Emergency: |
| Email Address: | | Weekly/Monthly Wages: | |
| Ethnic Group: | ☐ White ☐ Black ☐ Coloured ☐ Indian ☐ Other | **Note:** Ethnicity reporting is required by the Council for Medical Schemes. | |
| Do you Smoke? | ☐ Yes ☐ No | If yes, how many a day? | Weight? Height? |

## Members to be covered

| | | | |
|---|---|---|---|
| Spouse: | | ID/Passport Number: | |
| Ethnic Group: | ☐ White ☐ Black ☐ Coloured ☐ Indian ☐ Other | Gender: ☐ Female ☐ Male | |
| Smoker? | | Weight? | |
| Dependant 1: | | ID/Passport Number: | |
| Ethnic Group: | | Gender: ☐ Female ☐ Male | Relationship: |
| Dependant 2: | | ID/Passport Number: | |
| Ethnic Group: | | Gender: ☐ Female ☐ Male | Relationship: |
| Dependant 3: | | ID/Passport Number: | |
| Ethnic Group: | | Gender: ☐ Female ☐ Male | Relationship: |
| Dependant 4: | | ID/Passport Number: | |
| Ethnic Group: | | Gender: ☐ Female ☐ Male | Relationship: |
| Dependant 5: | | ID/Passport Number: | |
| Ethnic Group: | | Gender: ☐ Female ☐ Male | Relationship: |

## Package Options: Policy Options and Rates

(Indicate the amount of dependants in the allocated space) (Not more than 1 (one) Spouse shall be covered)

| Healthcare Packages: | ☐ Affinity Reef | ☐ Chrome | ☐ Bronze | ☐ Delta Max |
|---|---|---|---|---|
| Principal Member: | R399 ☐ | R509 ☐ | R659 ☐ | R739 ☐ |
| Spouse: | R369 ☐ | R469 ☐ | R609 ☐ | R669 ☐ |
| Adult Dependant: | R369 ☐ | R469 ☐ | R609 ☐ | R669 ☐ |
| Child Dependant: | R219 ☐ | R309 ☐ | R389 ☐ | R439 ☐ |
| Insurance Packages: | ☐ | ☐ | ☐ | ☐ |
| Principal Member: | R45 ☐ | R62 ☐ | R91 ☐ | R130 ☐ |
| Spouse: | | | | R51 ☐ |
| Healthcare Packages: | ☐ Silver Max | ☐ Gold Max | ☐ Platinum Max | ☐ Titanium Max |
| Principal Member: | R929 ☐ | R1 019 ☐ | R1 259 ☐ | R1 449 ☐ |
| Spouse: | R839 ☐ | R939 ☐ | R1 159 ☐ | R1 329 ☐ |
| Adult Dependant: | R839 ☐ | R939 ☐ | R1 159 ☐ | R1 329 ☐ |
| Child Dependant: | R499 ☐ | R589 ☐ | R719 ☐ | R829 ☐ |
| Insurance Packages: | ☐ | ☐ | ☐ | ☐ |
| Principal Member: | R113 ☐ | R164 ☐ | R170 ☐ | R175 ☐ |
| Spouse: | | R51 ☐ | R56 ☐ | R63 ☐ |
| **Total Premium:** | R | **Inception Date:** | | |

Affinity Life Limited

Affinity Health is a product of the Insurer, and Underwriting Managing Agency, Affinity Life Limited (Registration Number 1952/001635/06), a registered Life Assurer and authorised Financial Services Provider (FSP 49986). This policy shall be voidable in the event of misrepresentation, misdescription or non-disclosure of any particular material fact to this insurance by or on behalf of an insured person. Terms and conditions as contained in the policy document apply.

AFFINITY HEALTH GROUP SCHEMES

# Application Form

## Declaration

I hereby request and authorise you to deduct from my salary the above mentioned amount or any other variable amount pertaining to this agreement. These deductions from my salary shall be treated as though they have been authorised by me personally.

Principal Member Signature: ______________________

Date: DD | MM | YYYY

## Termination of Medical Aid Letter

To whom it may concern, I ______________________ (ID Number) ______________________ employed by ______________________ (Company Name) hereby confirm that I want to cancel my current medical aid with ______________________ (Name of medical aid provider) and will be joining Affinity Health from the ____________ (Inception date).

Please note that the cancellation notice will be applicable from the ____________ (Cancellation date of Medical Aid).

I hereby confirm the statement provided above is true and accurate.

## FOR OFFICE USE ONLY

Agent (Union Official): ______________________

Brokerage: ______________________ Brokerage Code: ____________

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