MediWallet

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Plan	**Classic Hospital or Combined Plan**

Main Member											
Title	Dr		Mr		Mrs		Miss		Ms		ID Number
Full Name									Surname		
Cell				Home			Work				
Fax				Email							

Preferred Delivery Address		Postal Address		Residential Address	
Code		Code		Code	

Additional Members to be Covered (Children under 18 years of age, unless in full-time education)			
MEMBER	FULL NAME	GENDER	ID OR DATE OF BIRTH
Spouse			
Child 1			
Child 2			
Child 3			
Child 4			
Child 5			

Medical Questionnaire (for any additional member names on this application form)				
Are you currently receiving treatment of have received treatment for any medical/dental condition?	YES		NO	
Are you concerned about/aware of any condition which may require medical/dental attention?	YES		NO	
Are you currently on any medication?	YES		NO	
Are you pregnant?	YES		NO	
Have you undergone any major operations in the last 10 years?	YES		NO	

If YES was answered to any of the above questions, please provide details:			
Member		Member	
Condition		Condition	
Medication		Medication	

Premium Options	Classic Combined				Classic Hospital			
Age	**18-55**		**56-64**		**18-55**		**56-64**	
Single Member	R1 191		R1 370		R999		R1 220	
Single + 1 Child	R1 574		R1 809		R1 311		R1 509	
Single + 2 Children	R1 950		R2 241		R 1 563		R1 798	
Single + 3 Children	R2 351		R2 703		R1 814		R2 085	
Single + 4 Children	R2 706		R3 112		R2 066		R2 374	
Couple	R2 325		R2 672		R2 120		R2 439	
Couple + 1 Child	R2 700		R3 105		R2 372		R2 729	
Couple + 2 Children	R3 062		R3 521		R2 624		R3 016	
Couple + 3 Children	R3 347		R3 849		R2 874		R3 305	
Couple + 4 Children	R3 625		R4 169		R3 125		R3 594	
5th Child	R363				R140			
Total Cost								

Bank Details							
Account Holder						Bank Name	
Branch Name						Branch Code	
Deduction Dates	1st	5th	15th	25th	Last Day	First Deduction Date	
Additional Cards (R35 each)						First Debit Total	

Registration fee includes a once off charge of R90 for Welcome Pack delivery.
Once your Welcome Pack has been dispatched, any additional membership card(s) ordered will incur a charge for delivery in addition to the cost of the card(s) ordered. I warrant that I have provided with all the intermediary insurers and benefit details, or any additional information as I may have requested. I warrant that all details and facts provided herein are accurate and properly disclosed, even if completed by the intermediary or representative on my behalf. I understand that the benefits offered are risk benefits only and that there are no surrender values. Failure to pay premiums will result in benefits lapsing. In the event of any query regarding this policy or claim in terms of this policy, I consent to the disclosure of any relevant information to the intermediary or any Medicall Healthcare company official for the purposes of resolving this query. In the event of no nominated beneficiary, I agree that 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. Finally, I acknowledge that Medicall Insured Health Plan is not Medical Aid and that the benefits are not equivalent to that of a medical aid.

Signature of Principal Member: _____ Date: _____

Signature of Account Holder: _____ Date: _____

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For Office use only:

Broker Name: _____ Advisor Code: _____

Entity Name: _____ Date: _____