

Plan	Optima Accidental & Trauma		Optima Enhance 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						
Child 6						
Medical Questionnaire (for any additional member names on this application form)						
Are you currently receiving treatment or 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			
Preferred	Optima Enhance		Optima Accidental & Trauma			
Principal	R520		R263			
Spouse	R520		R263			
Child 1	R272		R263			
Child 2	R272		R263			
Child 3	R272		R263			
Child 4	R272		R263			
Total Cost						
Bank Details						
Account Holder			Bank Name			
Account Number			Branch Code			
Deduction Dates	1 <sup>st</sup>	5 <sup>th</sup>	15 <sup>th</sup>	25 <sup>th</sup>	Last day of the month	
First Deduction Date						
Additional Cards (R45 each)			First Debit Total			
<p>Registration fee includes a once off charge of R105 for Welcome Pack delivery.</p> <p>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 Mediacall 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 Mediacall Insured Health Plan is not Medical Aid and that the benefits are not equivalent to that of a medical aid. MediWallet Insurance Plans are powered by Mediacall Healthcare which is a product of Xperia Financial Services (Pty) Ltd, a Licensed Financial Services Provider (FSP 45551), registered with FSCA (Financial Sector Conduct Authority) and CMS (Counsel of Medical Schemes) demarcation exemption (DM1051). Stated Hospital Benefits are underwritten by Lion of Africa Life Assurance Company Ltd, a licensed life insurer in terms of the Insurance Act (FSP 15283). MediWallet is operated by FeverTree Finance (Pty) Ltd, an Authorised Financial Services (FSP 44281) and Registered Credit Provider (NCRCP 6072).</p>						

Signature of Principal Member: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Account Holder: \_\_\_\_\_ Date: \_\_\_\_\_

For Office use only:

Broker Name: \_\_\_\_\_ Advisor Code: \_\_\_\_\_

Entity Name: \_\_\_\_\_ Date: \_\_\_\_\_