MediWallet

Powered by: Medicall HEALTHCARE

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 Hospital				Classic Combined			
Age	**18-55**		**56-64**		**18-55**		**56-64**	
Single Member	R1 354		R1 559		R1 521		R1 749	
Single + 1 Child	R1 674		R1 927		R2 011		R2 311	
Single + 2 Children	R1 997		R2 297		R2 491		R2 862	
Single + 3 Children	R2 316		R2 663		R3 003		R3 452	
Single + 4 Children	R2 639		R3 032		R3 456		R3 974	
Couple	R2 708		R3 115		R2 969		R3 412	
Couple + 1 Child	R3 029		R3 486		R3 449		R3 965	
Couple + 2 Children	R3 352		R3 852		R3 911		R4 497	
Couple + 3 Children	R3 671		R4 220		R4 275		R4 916	
Couple + 4 Children	R3 990		R4 590		R4 629		R5 325	
5th Child	R179				R464			
Total Cost								

Bank Details					
Account Holder		Bank Name			
Account number		Branch Code			
Deduction Dates	1st	5th	15th	25th	Last day of the month
First Deduction Date					
Additional Cards (R45 each)		First Debit Total			

Registration fee includes a once off charge of R110 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.

MediWallet Insurance Plans are powered by Medicall Healthcare which is a product of Xperia Financial Services (Pty) Ltd, a Licensed Financial Services Provider (FSP45551), 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 (FSP15283). MediWallet is operated by FeverTree Finance (Pty) Ltd, an Authorised Financial Services (FSP44281) and Registered Credit Provider (NCRCP19967).

Signature of Principal Member:____Date: ____________________

Signature of Account Holder:____Date: ____________________

For Office use only:

Broker Name: ____Advisor Code: ________________

Entity Name:____Date: ____________________