UNITYHEALTH

Cycle-Med
Xtreme sports health cover

CYCLE-MED & MOTO-X
INDIVIDUAL DEBIT ORDER APPLICATION FORM

Underwritten by Constantia Insurance Company Limited (CICL), Reg. No. 1952/001514/06, FSP No: 31111 (The Insurer)

FOR OFFICE USE ONLY	
POLICY NUMBER	

BROKER DETAILS

BROKER / CONSULTANT NAME	Wayne McKenzie		
NAME OF BROKERAGE	McKenzie Life CC		
FSP NUMBER	FSP 1702	VAT NUMBER	442 019 3890
BROKER CODE	MCK001	UNIQUE IDENTIFIER (IF NECESSARY)	
BROKER E-MAIL ADDRESS	wayne@mckenzielife.co.za	BROKER CONTACT NUMBER	021 797 7724

PRODUCT SUMMARY AND SELECTION (select one only)

CYCLE-MED	
☐	
PRINCIPAL	**R255.00**
ADULT	**R255.00**
CHILD	**R210.00**

MOTO-X	
☐	
PRINCIPAL	**R280.00**
ADULT	**R280.00**
CHILD	**R235.00**

INCEPTION DATE (date cover is to commence)	D	D	M	M	Y	Y	Y	Y

PERSONAL PARTICULARS

APPLICANT *Attach clear copies of identity documents

TITLE			SURNAME												
ID NUMBER														FIRST NAMES	
GENDER	MALE	☐		FEMALE	☐										

DEPENDANTS *Attach clear copies of identity documents for all dependants, copy of the marriage certificate for a spouse dependant.

Where applicable a physician report must be included to confirm disability of handicapped dependants.
*If applicable attach proof of full time studies

FIRST NAME (AND SURNAME IF DIFFERENT)	RELATIONSHIP	I.D. NUMBER												

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CONTACT DETAILS

POSTAL ADDRESS	PHYSICAL ADDRESS (IF DIFFERENT TO POSTAL)
POSTAL CODE	POSTAL CODE

*Attach proof of address (not older than 3 months)

HOME NUMBER	AREA CODE		WORK NUMBER	AREA CODE	
CELL NUMBER	AREA CODE		E-MAIL		

CURRENT MEDICAL PRACTITIONER DETAILS

Note: please ensure that the below details are correct and completed in full.

DOCTOR NAME		
TELEPHONE NUMBER	AREA CODE	

PREMIUM PAYMENT

DEBIT ORDER DETAILS

ACCOUNT HOLDERS NAME		BANK / BUILDING SOCIETY	
ACCOUNT NUMBER		BRANCH	
BRANCH CODE		ACCOUNT TYPE	☐ CURRENT
			☐ TRANSMISSION
			☐ SAVINGS

PLEASE SELECT PREFERRED DEBIT ORDER COLLECTION DATE

25TH	☐	LAST WORKING DAY OF THE MONTH	☐

Please note that premiums are collected in advance on your selected debit order date indicated above.

***Attach copies of your latest bank statement**

Having applied for the above mentioned Unity Health Policy and on acceptance of my application by the Insurer, I hereby authorise the Insurer or its representative to debit my account, the premiums payable under the above plan on the chosen day of each month in accordance with the Debit Order System. Such authorisation shall remain in force and effect until cancelled by myself, in writing with one calendar months' notice. I further authorise the Insurer to increase the amount due in terms of the policy from time to time and authorise my bank to effect payment on relevant increases. Notwithstanding the fact that I grant the Insurer permission to collect premiums, I acknowledge that I need to ensure that premiums are collected for cover to remain in force.

SIGNATURE OF ACCOUNT HOLDER

DATE D D M M Y Y Y Y

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DISCLOSURES

Unity Health hereby confirms

a) That the applicant and his/her dependants personal and medical information, (obtained from healthcare providers) will be kept confidential.

b) That both personal and medical information obtained by Unity Health will not be used or sold commercially.

c) That data security measures are in place at Unity Health.

d) That staff of Unity Health as well as its contracted third parties are bound by confidentiality agreements.

e) That the insurer's contractual agreements ensure the confidentiality of data management and administration.

DECLARATION

I declare that I have not withheld any information and I accept that this application and declaration shall be the basis of the contract of insurance between me and the insurer, which will become effective on the first day of the month for which premiums are received. I also acknowledge that I have requested and instructed the broker not to complete a financial needs analysis. Furthermore, I understand and accept that this instruction not to proceed with a full financial needs analysis could have the effect that all my financial needs may not be properly addressed.

I further confirm that the following notable conditions have been explained to me:

a) No benefits will be payable during a general 2-month waiting period for all treatment received except for in-patient hospital treatment or out-patient casualty treatment.

b) No benefits will be payable during a 12-month waiting period for all chronic medication and optometry benefits.

c) No benefits will be payable during a 9-month waiting period for all pre-birth maternity benefits.

d) Not all my dependants are automatically covered under this policy, only my adult dependents and eligible children are covered as per the policy definitions.

I, the undersigned applicant:

a) Acknowledge that it is my responsibility to ensure that claims are submitted within the 4 month submission period.

b) Acknowledge that it is my responsibility to ensure that the monthly premium is received by the insurer.

c) Acknowledge and accept that Unity Health reserves the right to cancel the policy if any premium is not paid on the due date.

d) Undertake to inform the insurer within one (1) calendar month should the situation regarding the dependency of any of my dependants change.

e) Hereby consent to all conversations between myself, the insurer or any party as being recorded;

f) I further authorise and instruct the insurer and any medical provider (including emergency and hospital providers) concerned to give any information relating to myself and my dependants to the staff appointed by the insurer, for the purposes of ensuring that the members of the policy receive appropriate and necessary medical services while reducing inappropriate care and wastage of medical resources.

g) I understand that should I request to terminate my policy with Unity Health, I will be required to place one (1) calendar month notice with the insurer.

I confirm that although I have completed this application form, it does not constitute an insurance contract until a policy number is assigned, policy issued and premium is successfully paid.

SIGNATURE OF APPLICANT	PRINTED NAME OF APPLICANT	DATE	D	D	M	M	Y	Y	Y	Y

Please return to your broker (cyclemed@mckenzielife.co.za) or alternatively:

Unity Health
PO Box 1862, Cramerview, 2060
Tel Number 0861366006, Fax Number (011) 706 5568
E-mail Address: membership@unityhealth.co.za

Unity Health is a division of Ambledown Financial Services (Pty) Ltd, Reg No: 2004/006271/07, Authorised FSP 10287

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