

Document no.  
**10 000**

**ADDITIONAL DEPENDANTS  
APPLICATION FORM**

Please complete this form in black ink and CAPITAL letters

Medical Scheme membership number:	<input type="text"/>	Name of Medical Scheme:	<input type="text"/>
Medical Scheme Option:	<input type="text"/>	If YES, group name:	<input type="text"/>
Is this application part of a group? (Place a clear X inside the box)    Y <input type="checkbox"/> N <input type="checkbox"/>			

**PRINCIPAL INSURED DETAILS**

First name(s) (in full):	<input type="text"/>											
Surname:	<input type="text"/>					Initials:	<input type="text"/>					
ID no.:	<input type="text"/>	Mr	<input type="checkbox"/>	Mrs	<input type="checkbox"/>	Miss	<input type="checkbox"/>	Dr	<input type="checkbox"/>	Other	<input type="text"/>	
Date of birth:	D	D	/	M	M	/	Y	Y	Y	Y	<input type="text"/>	
Contact details:	Home no.:	( <input type="text"/> )	<input type="text"/>	<input type="text"/>	Work no.:	( <input type="text"/> )	<input type="text"/>	<input type="text"/>				
	Fax no.:	( <input type="text"/> )	<input type="text"/>	<input type="text"/>	Cell no.:	( <input type="text"/> )	<input type="text"/>	<input type="text"/>				
Email address:	<input type="text"/>											
Postal address:	<input type="text"/>											
	<input type="text"/>										Code:	<input type="text"/>
Residential address:	<input type="text"/>											
	<input type="text"/>										Code:	<input type="text"/>

**DEPENDANTS**

Dependants are:    - Spouse and/or dependent children up to the age of 21 years    - Students up to the age of 27 (please prove full time enrolment)  
- Adopted/foster child (please attach documentary proof)

Full name and surname:	<input type="text"/>										
ID number:	<input type="text"/>					Male	<input type="checkbox"/>	Female	<input type="checkbox"/>		
Date of Birth:	<input type="text"/>					Relationship to applicant:	<input type="text"/>				
Full name and surname:	<input type="text"/>										
ID number:	<input type="text"/>					Male	<input type="checkbox"/>	Female	<input type="checkbox"/>		
Date of Birth:	<input type="text"/>					Relationship to applicant:	<input type="text"/>				
Full name and surname:	<input type="text"/>										
ID number:	<input type="text"/>					Male	<input type="checkbox"/>	Female	<input type="checkbox"/>		
Date of Birth:	<input type="text"/>					Relationship to applicant:	<input type="text"/>				
Full name and surname:	<input type="text"/>										
ID number:	<input type="text"/>					Male	<input type="checkbox"/>	Female	<input type="checkbox"/>		
Date of Birth:	<input type="text"/>					Relationship to applicant:	<input type="text"/>				

Full name and surname:

ID number:

Male

Female

Date of Birth:

Relationship to applicant:

### SPECIFIC HEALTH QUESTIONS

Have you or any insured under this policy ever received treatment or expect to receive treatment for any of the following:

Y N

1	Do you or any dependant suffer from any health condition, disorder, disease or illness?	<input type="checkbox"/>	<input type="checkbox"/>
2	Have you or any dependant in the past been hospitalised, or had any examinations, testing or diagnostic procedures done?	<input type="checkbox"/>	<input type="checkbox"/>
3	Is any female applicant currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
4	Are you aware of any condition/illness that would require any future treatment?	<input type="checkbox"/>	<input type="checkbox"/>
5	Have you ever been advised to seek medical treatment after an abnormal diagnostic test, or any other reason?	<input type="checkbox"/>	<input type="checkbox"/>
6	Have you or any of your dependant's had a blood relative diagnosed with cancer?	<input type="checkbox"/>	<input type="checkbox"/>
7	Is there any additional information not specifically mentioned in this questionnaire that relates to your health state which may influence our decision on cover?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "Yes" to any of the questions, please provide details below.

Question no.	Applicant/dependents	Full details (including details of disorder, date diagnosed, nature, duration of treatment and details of consulting doctor)
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<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>

Should the above space be insufficient, please attach a separate page.

### Important Information

- Please make sure FULL details are given for questions answered YES.
- Applicants could be underwritten and conditions may be excluded for longer than 10 months, or permanently.
- The onus lies on the insured to make sure that premiums are paid on a monthly basis. Reference on bank statements read: MD SIRAGO\_MED
- Effective from 1 January 2017.

### DECLARATION BY APPLICANT

I, the undersigned, hereby declare, that to the best of my knowledge and belief the information provided in connection with this application whether in my own hand writing or not, is true and I have not withheld any material fact which are known to me. (A material fact is likely to influence the assessment of this application by Sirago Underwriting Managers (Pty) Ltd. If you are in any doubt as to whether a fact is material or not, you should disclose it.)

Full name:

ID no.:

Date:   /   /

Applicant

Spouse (If married in community of property)

### MARKETING CONSENT

By agreeing to the terms of this consent form, I expressly consent to the processing of my information for marketing purposes and know & understand that by agreeing to same that I may on occasion, receive marketing materials in the form of sms and / or emails and the like from Sirago Underwriting Managers (Pty) Ltd.

Please contact me via:

E-mail  SMS  Sirago Underwriting Managers (Pty) Ltd may not contact me.



Sirago Underwriting Managers (Pty) Ltd is an authorised Financial Services Provider (FSP:4710) Underwriting Agency for GENRIC Insurance Company Limited (FSP: 43638). GENRIC is an authorised financial services provider and registered Short-term insurer.

