APPLICATION FORM

Please select one of the following Plans

Basic	☐	**Standard**	☐
Prestige	☐	**Comprehensive**	☐

PRINCIPLE INSURED DETAILS

Title: Dr / Prof / Adv / Mr / Mrs / Miss / Ms	First Name:		
Surname:	Gender:	M	F
ID or passport no:	Date of birth: DD / MM / YYYY		
Postal Address:			
City:	Postal Code:		
Tel Home:	Tel Work:		
Fax no:	Cell no:		
E-mail:			

DEPENDANTS DETAILS

No	Relationship	Surname	First Name	Date of birth	Age	Gender	
1				DD / MM / YYYY		M	F
2				DD / MM / YYYY		M	F
3				DD / MM / YYYY		M	F
4				DD / MM / YYYY		M	F
5				DD / MM / YYYY		M	F

PREMIUM PAYER DETAILS

Only complete this section if the Premium payer details differ from those of the Principle Member.

First Name:	Surname:
ID or passport no:	Tel Home:
Tel Work:	Fax no:
Cell no:	E-mail:

DEBIT ORDER DETAILS

Available deduction dates: 25th to 05th of the month. The premium is due monthly in advance.
The Commencement Date of the policy will be the first of the month after which the first premium is deducted and received.

Bank:	Account Number:
Account Holder Name:	Branch Code:
Branch Name:	Type of account:
Preferred Deduction Date: DD / MM / YYYY *Any date between 25th and 5th of a month*	Commencement Date: 0 1 / MM / YYYY

I hereby instruct and authorize you to draw against my account with the abovementioned bank (or any other bank or branch to which I my transfer my account) the amount necessary for the payment of my monthly premium due in respect of the abovementioned insurance. All such withdrawals from my bank account by you shall be treated as though they had been signed by me personally. I agree to pay any bank charges relating to this debit order instruction. This authority may be cancelled by me by giving you thirty days notice in writing, sent by prepaid registered post. I understand that I shall not be entitled to any refund of amounts which you have withdrawn while this authority was in force, if such amounts were legally owing to you. Receipt of this instruction by you shall be regarded as receipt thereof by my bank (whichever it is or will be). I acknowledge that the party hereby authorized to affect the drawing(s) against my account may not cede or assign any of its rights to any third party without my prior written consent. I further authorize you to increase the amount due in terms of the policy in accordance with any annual escalation and to authorize my bank to affect payment accordingly.

_____ _____

Signature of Account Holder **Date**

CLAIMS PAYMENTS

Only complete this section if the claim settlement must be paid into a bank account other than indicated above.

Bank:	Account Number:
Account Holder Name:	Branch Code:
Branch Name:	Type of account:

DECLARATON BY APPLICANT

I, the undersigned, hereby declare that:

1. All information supplied on this form, whether in my handwriting or not, is true and complete and will form the basis of this policy.
2. I understand that this is a dental insurance policy with stated benefits in terms of the Short Term Insurance Act 53 of 1998, and does not constitute a Medical Scheme product.
3. I understand that I may cancel this policy within 30 days with no loss.

_____ _____

Signature of Applicant **Date**

INTERMEDIARY DETAILS

Name and Surname of Intermediary:	Wynand Louw
Name of Brokerage:	Aquilla Financial Solutions cc
FSP Number:	38139
Broker code:	BR1077