FBC Insurance Company Limited

Photo

FBC HEALTH MEMBERSHIP APPLICATION/AMENDMENT FORM

1. ***Please use block letters***
2. ***. Please tick applicable box***

New member application *Complete All Sections* ☐ **Change of personal details** *Complete Section 1,2,3,4,5,6* ☐ **Change of banking details** *Complete Section 1,2,3,5,* ☐ **Dependent registration** *Complete Section 1,2,3,4,5,8* ☐

Dependent termination Complete Section 1,2,3,4,5 ☐ **Change of Package** Complete Section 1,2,3,4,5,8 ☐ **Change of marital status** Complete Section1,2,3,6 ☐

SECTION 1: OPTION SELECTION - please indicate the option you wish to join

Lite ☐ Standard ☐ Private ☐ Executive ☐ International ☐

Flexi Standard ☐ Private Lite ☐ Flexi Private ☐ Flexi Executive ☐ Flexi International ☐

SECTION 2: EMPLOYER INFORMATION - this section must be completed by employer or account holder

Name of Employer/Account Holder _____

Employer/Group Code_____ Payroll/Employee Number

Registration Start Date D D M M Y Y Y Y

No of Dependents Adult Child Other Total

COMPANY STAMP

No of Dependants	Adult	Child	Other	Total
Plan Contributions				

We confirm that the applicant is employed by us and contributions are being deducted according to the FBC Health policy conditions and option chosen. All sections of the application form have been completed.

Name of Salary Administrator_____

Signature ---------- Date signed ----------

SECTION 3 : DETAILS OF PRINCIPAL MEMBER - this section is mandatory

Surname: _____ **First Name:**_____**Title** _____

Date of Birth D D M M Y Y Y Y Gender : M F

ID Number _____ Membership Number _____

Telephone (H) _____ Cell Number: _____
Telephone (W) _____ Email Add: _____
Physical Address _____ Postal Address _____

SECTION 4: REGISTRATION OR ADDITION OF DEPENDANTS – spouse/child/new-born/adult dependant

Adult rates apply to any dependent who is 18 years and older. Child rates apply to full time students aged between 18-25years provided proof is attached to the application form for the current academic studies. Acceptance of the dependents will be in accordance with the rules of FBC Health.

FIRST NAME	SURNAME	DATE OF BIRTH	RELATIONSHIP	GENDER	ID NUMBER

PASSPORT SIZE PHOTOS

DEPEDENDANT 1

DEPENDANT 2

DEPENDANT 3

DEPENDANT 4

DEPENDANT 5

DEPENDANT 6

SECTION 5: BANK DETAILS OF PRINCIPAL MEMBER – refund of claims

I hereby instruct FBC Health to deposit claim refunds using the information provided below and authorize the Society to reverse any erroneous transactions and/or rectify any electronic fund transfer errors without prior notice.

USE THIS ACCOUNT FOR CLAIMS REFUNDS

Accountholder Name _____

Bank Name _____

Bank Account Number _____

Branch Name _____ **Branch Code**_____

SECTION 6: AMENDMENT OF DEPENDANTS – change of details or termination of dependants

Please attach certified copies of Marriage Certificate/ ID for change of surname or DOB. Attach a copy of death certificate if termination is due to death.

FULL NAMES	DATE OF BIRTH	AMEND OR TERMINATE	TERMINATION/AMMENDMENT REASON	DELETION/ADDITION DATE

SECTION 7: DETAILS OF PREVIOUS MEDICAL AID – Please attach certificate of last medical funder

Have condition specific waiting period, exclusions or late joiner penalties ever been imposed on the member or dependent on application for membership of any other medical aid scheme?

SECTION 8: MEDICAL HISTORY

Please note: It is compulsory to answer each question. Failure to disclose medical conditions could limit and/or exclude you or your dependents from receiving certain benefits or result in termination of your membership.

1.Any Chronic illnesses. Cardio and Vascular conditions, Obstructive lung diseases, Diabetes, High or Low blood pressure, RaisedCholesterol Asthma, Depression, Anxiety, Systematic lupus erythematous, Epilepsy, Thyroid disorders? If yes, please provide details.

					Y	N
Name of Beneficiary	**Name of Condition & date diagnosed**	**Are you currently receiving treatment?**	**Date of last treatment**	**Name of Medication**	**Attending GP/Specialist**	

2.Digestive system or Stomach disorders? Liver failure, Gall bladder or pancreas, Stomach or duodenal ulcer, Hiatus hernia, Crohn's disease, Irritable bowel syndrome, Rectal bleeding, Hepatitis. If yes, please provide details.

					Y	N
Name of Beneficiary	**Name of Condition & date diagnosed**	**Are you currently receiving treatment?**	**Date of last treatment**	**Name of Medication**	**Attending GP/Specialist**	

3. Muscle, Bone, Dental, Orthodontic condition, Skin or nerve illness or disorders. Acne, Eczema or psoriasis, Multiple sclerosis, Back injury/neck or joint problems or replacements, Arthritis, Prosthetic limbs, Gout, Stroke, Blackouts, Migraine, Alzheimer's etc. If yes, please provide details

		Y	N

Name of Beneficiary	Name of Condition & date diagnosed	Are you currently receiving treatment?	Date of last treatment	Name of Medication	Attending GP/Specialist

4. Urinary tract, genital /Gynecological disorders? e.g. UTI, Kidney stones, Kidney Failure, Prostatitis, Ovarian cysts, Fibroids, etc., If yes please provide details

		Y	N

Name of Beneficiary	Name of Condition & date diagnosed	Are you currently receiving treatment?	Date of last treatment	Name of Medication	Attending GP/Specialist

5. Blood disorders, Cancer, etc.? If yes, please provide details

		Y	N

Name of Beneficiary	Name of Condition & date diagnosed	Are you currently receiving treatment?	Date of last treatment	Name of Medication	Attending GP/Specialist

6. Ear, Nose, Throat or Eye disorders? Defective vision, Cataracts, Glaucoma, Blindness, Retinitis, wear spectacles or contact lenses, Hearing loss, Ear discharge, Allergies, recurrent Tonsillitis, etc. If yes, please provide details.

		Y	N

Name of Beneficiary	Name of Condition & date diagnosed	Are you currently receiving treatment?	Date of last treatment	Name of Medication	Attending GP/Specialist

7. Are you or any of your dependents pregnant? If yes, please provide details

		Y	N

Name of Beneficiary	Name of Condition & date diagnosed	Are you currently receiving treatment?	Date of last treatment	Name of Medication	Attending GP/Specialist

8. Have you or any of your dependents had surgery in the past 12 months, or are you planning to have surgical procedure in the next 12 months? Or any other condition not stated above? If yes, please provide details

		Y	N

Name of Beneficiary	Name of Condition & date diagnosed	Are you currently receiving treatment?	Date of last treatment	Name of Medication	Attending GP/Specialist

DECLARATION BY PRINCIPAL MEMBER

I. the principal member, hereby apply to have my nominated dependants sign up for FBC Health Cover.

2. I understand that this application, together with any supporting documents and the FBC Health Cover Policy Conditions, form the basis of my contract with the Insurer.

3. Declaration in respect of my living-in partner (if applicable): I confirm that my partner and I are in a committed relationship akin to a marriage based on mutual dependency and a shared household.

4. FBC Health Cover Policy Conditions and benefits

a. I agree that I, and my dependants, will be bound by the FBC Health Cover Policy Conditions and will abide by them.

b. The Insurer shall not be bound in any way by any representations or undertakings made or given by any person save as contained in the FBC Health Cover Policy Conditions.

5. Exclusions

a. I understand that the Insurer may impose exclusions in respect of myself and / or any of my nominated dependants.

b. I accept any such exclusion that may be imposed in terms of the FBC Health Policy Conditions.

6. Banking Details

a. I agree to advise the Insurer in writing of any changes to my banking details.

b. I understand that failure to do so will result in me being liable for any subsequent banking charges or other costs / losses incurred due to the use of the incorrect banking details.

c. I agree that I am liable for any loss that may arise as a result of me providing the wrong bank account details in the FBC Health Cover Bank Details section of this form.

7. Premiums and any other amounts owed to the Insurer

a. I acknowledge that it remains my responsibility to ensure that any amounts due by me to the Insurer are paid to the Insurer.

b. I agree that any amounts owing by me as a result of claims debt must be paid to the Insurer.

c. I also accept that I will be responsible for any costs associated with the recovery of any debts.

8. Disclosure of information

a. I confirm that I have the necessary authorisations to disclose the information that the Insurer may require and provide the necessary authorisations in respect of my nominated dependant(s).

b. I confirm that the information provided in this application, and in any other documents submitted in support of this application, is true, correct and complete and that I have not withheld, concealed or misstated any information, including any information that the Insurer should know to assess my eligibility to receive health insurance.

c. I furthermore confirm that I understand that my membership will become null and void should the above statement be found to be incorrect and that in such an event, all monies paid in respect of my membership shall be forfeited and that the Insurer shall furthermore be entitled to recover any amounts paid for services rendered from the provider and/or myself.

d. I undertake to promptly advise the Insurer of any change in status of health of myself and any of my nominated dependants that occurs prior to the date of registration with the Insurer and acknowledge that the additional information may be subject to underwriting. I acknowledge that not doing so may lead to the Insurer reconsidering the basis of my membership application.

e. I indemnify the agents and administrator of FBC Health Cover against any claim, of whatever nature, which may be made against them as a result of, or arising out of the disclosure of any medical information in fulfilling this agreement.

f. I irrevocably authorise any medical practitioner, hospital, medical institution or other person to disclose information about my own, or my nominated dependants' health status to the Insurer or any entity contracted by the Insurer in order to fulfil its functions, duties and obligations in terms of this agreement and I agree that this authorisation shall remain in force after my/their death(s).

g. I irrevocably authorise the Insurer to collect, process and share my personal information and that of any nominated dependants(s) with any entity contracted by the Insurer in order to fulfil its functions, duties and obligations in terms of this agreement. I agree that this authorisation shall remain in force after my/their death(s) and understand that this may partially limit my/their right to privacy.

9. Cancellation

a. I acknowledge that upon cancellation of my policy, any amounts owing to the Insurer will be deducted from any amounts due to me.

b. I confirm that I, and all my dependants, will cancel any existing health insurance cover prior to commencement on FBC Health Cover.

10. Personal contact

a. I consent to the use of any of the contact details given in this application to send me information pertaining to my policy (confidential or other).

b. I undertake to inform the Insurer of any change of address and contact details. The Insurer shall not be held liable as a result of my neglecting to inform the Insurer of any changes to the aforementioned.

c. I consent to my telephone conversations with the Insurer being recorded and forming part of the Insurer's records. I also agree that such records shall remain the sole property of the Insurer.

11. Marketing

In order to keep you updated on activities about FBC Health Cover (FBCHC), we would like to communicate, where necessary, via email or SMS.

Signed at .....

Signature..... Date signed .....