

Individual application for membership

Important notes:

- AGS Assure U (Pty) Ltd (hereon forward referred to as AGS Solutions) is not a medical scheme registered under the Medical Schemes Act, 131 of 1998.
- AGSHealth is a registered medical insurance product underwritten by African Unity Life.
- Please do not resign from your current medical scheme/insurer until you have received written notification of acceptance from AGS Health.
- Please ensure that the first name and surname of the principal member, spouse and dependents are completed in accordance with the ID or passport.

Cover may only commence on the first day of a nominated month. Which month would you like cover to commence?

Section 1: Personal details

Principal member:

Title:		Initials:		First name:										
Surname:														
Previous surname:														
ID/Passport number:														
Country in which passport was issued:														
Gender:	Male	Female	Date of birth:	Y	Y	Y	Y	/	M	M	/	D	D	
Country of residence:														
Marital status:	Single	Married	Separated	Divorced	Widowed									
Home address:											Postal code:			
Postal address: (if different)											Postal code:			

Contact Details:

Home:		-	Cellular:									
Email address:												

Please note that the email address you provide will be used when AGSHealth communicates with you.

Occupational Details of Principal Member:

Occupation:	
Agriculture, Food and Natural Resources	Hospitality and Tourism
Architecture and Construction	Human Services
Arts, Audio/Video Technology and Communications	Information Technology
Business Management and Administration	Law, Public Safety, Corrections and Security
Education and Training	Manufacturing
Finance	Marketing, Sales and Service
Government and Public Administration	Science, Technology, Engineering and Mathematics
Health Science	Transportation, Distribution and Logistics

Income Level:

R4 000 to R12 000	
R12 000 to R20 000	
R20 000 to R28 000	
R28 000 to R36 000	
R36 000 above	

Spouse or partner (If spouse or partner is also applying for membership)

Title:		Initials:		First name:									
Surname:													
Previous surname:													
ID/Passport number:													
Gender:	Male	Female	Date of birth:	Y	Y	Y	Y	/	M	M	/	D	D

Dependents:

	Full Names	Surname	Relationship to member	ID number / Date of birth
Dependent 1				
Dependent 2				
Dependent 3				
Dependent 4				

Section 2: Medical Questions					
Failure to disclose a medical illness or injury that you or your dependents have before taking this policy, could limit and or exclude certain benefits or result in termination of your membership.					
Have you or your dependents had any of the following:					
2.1.1 Cancer, tumors, and abnormal growths e.g., cancerous tumor; non-cancerous tumor; blood cancer				YES	NO
Name	Condition	Year of diagnosis	Treating Doctor		
2.1.2 Blood conditions				YES	NO
Name	Condition	Year of diagnosis	Treating Doctor		
2.1.3 Metabolic and endocrine conditions e.g., diabetes; thyroid issues; osteoporosis				YES	NO
Name	Condition	Year of diagnosis	Treating Doctor		
2.1.4 Brain and nerve conditions e.g., epilepsy; headaches, Parkinson Disease question?				YES	NO
Name	Condition	Year of diagnosis	Treating Doctor		
2.1.5 Eye and eyelid conditions e.g., Cataracts; glasses; corneal ulcer				YES	NO
Name	Condition	Year of diagnosis	Treating Doctor		
2.1.6 Ear, nose, and throat conditions e.g., hearing problems; chronic tonsillitis; sinus problems				YES	NO
Name	Condition	Year of diagnosis	Treating Doctor		
2.1.7 Heart and circulation problems e.g., high blood pressure; chest pain; high cholesterol				YES	NO
Name	Condition	Year of diagnosis	Treating Doctor		
2.1.8 Breathing and lung conditions e.g., Asthma; emphysema, clot (s) in the lung				YES	NO
Name	Condition	Year of diagnosis	Treating Doctor		
2.1.9 Stomach and digestive conditions e.g., Gall stones; heartburn; hernia				YES	NO
Name	Condition	Year of diagnosis	Treating Doctor		
2.1.10 Back, bone and muscle conditions e.g., Arthritis; back pain; lupus				YES	NO
Name	Condition	Year of diagnosis	Treating Doctor		
2.1.11 Kidney and bladder conditions e.g., Kidney Stones; urine retention; bladder infection				YES	NO
Name	Condition	Year of diagnosis	Treating Doctor		
2.1.12 Did you or any of your dependents have a historical abnormal PSA test or prostate infections?				YES	NO
Name	Condition	Year of diagnosis	Treating Doctor		

2.1.12 Did you or any of your dependents have a historical abnormal PSA test or prostate infections? YES NO

Name	Condition	Year of diagnosis	Treating Doctor

2.1.13 Are you or any of your dependents currently pregnant? YES NO

Name	How many weeks	Treating Doctor

Section 3: Plan Option choice

Combination Plans

Green Combo	Blue Combo	Red Combo
Compact Plan		

Day 2 Day Only

Green Day 2 Day	Blue Day 2 Day	Red Day 2 Day
Hospital Plan Only	Emergency Plan Only	Hospital & Emergency

Doctors Details Primary Doctor: Practice name:

Practice contact:

Doctors Details Secondary Doctor: Practice name:

Practice contact:

Funeral Plans

10 000 Single Plan	20 000 Single Plan	30 000 Single Plan
10 000 Family Plan	20 000 Family Plan	30 000 Family Plan

Dental Plans

Bronze Dental Plan	Gold Dental Plan
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Section 4: Banking details for Debit Order

Tick here if we may use the same bank account details provided for your AGSHealth Claim refunds

If not, please complete the bank details below.
(Please do not provide credit card details. AGSHealth is not allowed to record your credit card details)

Name of account holder:																									
Name of bank:																									
Account number:																									
Account type:	Current/Cheque:												Savings:												
Branch code:																									
Debit order Date:																									

Please note that you, as the principal member, need to sign this section, if somebody else's bank account details have been provided.

Signature of principal Member

Date

Signature of account holder

Date

Section 5: Consent for AGSHealth to process personal information

- 5.1 I declare to the best of my knowledge and believe that the given particulars are true and correct.
- 5.2 I am satisfied that the plan chosen by me suite my needs.
- 5.3 I can afford the monthly premium of the plan chosen by me.
- 5.4 I have chosen this plan purely out of free will and on my own account without the request for a financial need's analysis or financial advice from any person.

AGSHealth and the Administrator are committed to maintaining the confidentiality of your personal information and complying with the Protection of Personal Information Act, 2013 when processing your personal information. We request your consent to process your personal information and obtain your personal information from any other person for the purposes set out in this section. While your consent is voluntary, it is a requirement for your membership.

1. The personal information we require relates not only to you but also to your child and adult dependents, and you confirm that you are authorised to provide consent in this section on behalf of your dependents on AGSHealth.
2. You authorise, and give consent to, AGSHealth and the Administrator to collect, store, collate, process, share and further process your personal information, including health information, and that of your dependents, for purposes of your membership of AGSHealth, risk profiling and management and as set out in this section.
3. If you have consented to the disclosure of your personal information to any other entity or person (person means any natural or juristic person, firm, company, corporation, state, agency or organ of a state, association, trust or partnership, whether or not having legal personality) or if a contractual relationship exists between AGSHealth or the Administrator which requires AGSHealth or the Administrator to provide your personal information to any other person AGSHealth or the Administrator may do so.
4. You must give AGSHealth and the Administrator all information and evidence they may require from time to time for the purposes of assessing this application, your membership of AGSHealth, risk profiling or management. You authorise AGSHealth and the Administrator to obtain, from any person, including any medical doctor or other healthcare provider who has attended you or your dependents in the past or who will attend to you or your dependents in the future, any information we may require concerning you or any of your dependents in assessing any risk or claim in relation to this application, your membership of AGSHealth, risk profiling or management and you consent to that person providing, and instruct that person to provide, AGSHealth and the Administrator with this information on request. You waive the provisions of any law or regulation that restricts the disclosure of this information. You must also submit to any examination by AGS Health's medical assessor as and when AGSHealth requires this.
5. You understand that your personal information will be shared between AGSHealth, the Administrator and contracted third parties both locally and outside the Republic of South Africa who require this information, for purposes related to your membership of AGSHealth and:
 - to grant you access to interact with AGSHealth on its website; and
 - to provide any credit bureau or registered credit provider with your credit information as defined in the National Credit Act, 2005 (credit information includes, for example, my credit history, financial history, pattern of payment or default under any credit agreements, debt re-arrangement arrangements or judgments obtained for outstanding debts).

Signature of principal member

Date

Section 6: General Terms and Conditions

DISCLOSURES:

I warrant that I have taken note and understand the cover limits, waiting periods and the limitations of this policy. Should there be any dispute as to the information provided, the policy wording that that forms part of the Welcome Pack will be deemed to be correct and will be the basis of this agreement. In no way do I expect that the policy will provide unlimited cover in the event of medical occurrences unless expressly indicated as such. This is an application for a binding insurance contract on the intermediary and myself and no further acceptance of terms and conditions or any other documents will be necessary for this contract to become binding. I fully understand that the AGS Health Policy is based on insurance cover and is not a medical aid and that the policy is a month-to-month contract. The cover in this policy has no surrender/cancellation/maturity values and in the event that my premium is unpaid, the cover applicable to the policy will lapse, subject to the grace period offered by the Administrator being AGSHealth. I further declare that all the information entered by me on this application is true and correct and should any further information be required I will make this available to the Administrator or Insurer as necessary for my policy or any query related to the policy. The disclosure of medical conditions is true and correct, and I am in no way entering this agreement with the knowledge of undisclosed conditions or expected future conditions. The policy wording necessary for this policy to be binding on the parties will be made available to me through communication by the Administrator. **PAYMENT OF COVER:** I accept that the payment of any cover due to a valid claim will first be paid to the Administrator trust account held in my name, for distribution to the service providers who have presented valid invoices for services rendered to a beneficiary of this policy. I understand and accept that after these payments have been made only the remaining portion of the claim will be paid to me, the principle insured of this insurance product. I hereby issue power of attorney and a mandate to AGSHealth to act on my behalf for each and every claim. I understand that no additional charge will be levied against me for the services offered in assisting me with my claim.

ACCEPTANCE: The Administrator will advise me of the acceptance of the terms of the above policy and if there are any terms and conditions that require additional disclosure for my individual policy.

ITC RATING CHECK:

I authorise the Administrator to submit my details to ITC to properly rate my account and credit record. The Administrator warrants that all information received from ITC in this regard will be treated as confidential and will not be disclosed to any third parties.

PREMIUM INCREASES/POLICY AMENDMENTS:

The Administrators reserve the right to increase premiums or amend the policy cover at their discretion. Notice of any premium increases or cover amendments will be given in writing 30 days (one calendar month) before any such changes come into effect.

POLICY INITIATION FEE:

I consent to my account being debited with the once-off policy initiation fee of R 150.00 (One Hundred and Fifty Rand) on the same date as my first policy debit order.

PREMIUM REFUNDS:

Should a policy be cancelled in writing within the first 30 days of the date of application (cooling off period), the premium and initiation fee will be refundable if it has been deducted from my nominated bank account. If the policy is cancelled after the 30 days cooling-off period, a one calendar month written notification period will apply and the policy will only be cancelled 30 days after the first day of the following month. I understand that my premium will only be refunded 30 days after it has been deducted and I may need to submit supporting documentation before any refunds are granted.

CANCELLATION:

Cancellations requested after the inception date are subject to a full calendar month notice period and must be submitted in writing and a cancellation fee of R150.00 (One Hundred and Fifty Rand) may be levied.

TERMS AND CONDITIONS:

By accepting this product, you are confirming that is appropriate and in accordance with your needs. Please note it's your responsibility to take care as to the appropriateness of the advice given. You were not provided with full comprehensive advice. Please note that there was no one that compared our product with any other competing product. You have been presented with a product of AGS Health only. Should this product replace a current policy fulfilling the same need, you will need to cancel that policy timeously to avoid paying fees and charges twice.

Please be informed that there are waiting periods and exclusions that apply. Please refer to the policy document which you will receive within 2 business days. It is your responsibility as a client of AGS Health to read the policy and understand the policy.

We receive 3.25% commission from African Unity Life which equates to 100% of total commission received.

Should you miss your monthly payment due, your policy will be suspended, and you will have no benefit. Should you miss two payments, your policy will lapse.

PAYMENT INSTRUCTIONS:

I hereby authorise AGSHealth Ltd or appointed collection agent namely Insure Group Managers LTD t/a Epic, to deduct premiums, excess amounts or any amounts are per the policy wording or terms and conditions of the parties. I acknowledge that failure / rejection of said debits may result in my policy being suspended or cancelled. I agree that all payment instructions issued by the underwriter will be treated by my nominated bank as specified in Section 9 of the application, as if the instruction has been issued by me personally.

PAYMENT:

I hereby agree and authorise the account specified in Section 9 of the application to be debited every month with the premium amount starting on the inception date or the next business day. The inception date is deemed to mean the next occurrence of the date chosen. Should this date have passed, the policy inception date will fall into the next calendar month. I acknowledge that premiums are collected in advance and not in arrears.

DECLINED / FAILED PAYMENTS:

Will be debited on the next debit order date, or alternatively through a special debit that may be run at any time from the date of notification by our collection agent of the failed / returned payment as mentioned above. This will carry an administration charge of R50.00 (fifty rand), which will be levied to my account and collected with my premium. I acknowledge that in the event of declined / failed debits, I may incur additional bank charges as levied by my bank. Should the payment be returned once, the policy cover will be suspended, and the policy may be re-dated to begin on the first of the following month. No claim will be entertained until such time as the premium has been paid to the

Administrator within the grace period. I hereby grant permission to the Administrator to double debit my account in the event of a rejected payment. If this double payment is returned, no further attempts will be made to collect premiums and cover will be cancelled with immediate effect. The Administrator reserves its right to collect cancellation fees with whatever means in law necessary to offset the costs of marketing collateral issued and charges as contained herein.

EXCESSIVE CLAIMS:

I understand that should my claims history be deemed excessive; a policy increase may be levied on my premium. This increase is at the discretion of the Administrators and subject to a 30 day (one calendar month) written notice period.

HEALTH LOADING:

I accept and understand that pre-existing conditions (known or unknown) may be excluded and/or may increase my monthly contribution. **EACTIVATION FEE:** Should the policy status become cancelled or suspended for whatever reason, a reactivation charge of R 150.00 (One Hundred and Fifty Rand) will be charged.

TRANSACTIONAL CARDS:

Cards are issued per individual policyholder. Dependent cards are available at an extra charge of R50.00 (Fifty Rand) per card. This fee, upon request, will be deducted from my account upon a signed request received for new cards.

POLICY DELIVERY:

The policy documents, Membership cards, policy guides and associated documents will be sent out within thirty days after the receipt of the initiation fee and successful collection of my first premium collection. The information in the policy wording as well as in all declarations made will form the basis of the contract, and it is warranted by AGS Health that such information is accurate. This policy, however, shall not be invalidated on account of any incorrect statement made in good faith, unless the incorrectness of such statement is of such a nature as to be likely to have materially affected the assessment of the risk under the Policy at the time the policy was issued

Signature of principal member

Date