Policy Number | | | | | | | | |

DEPENDANT ADDITION FORM 2014

Submit to : admin@turnberry.co.za or fax to 086 649 0417

Principle Insured Person : _____ **ID Number :** _____

Address:

Telephone Number :

E-mail address :

DEPENDANT'S DETAILS

Name of dependant	Identity number	Date of birth	Gender M/F	Relationship to policyholder	Is child a full time student? Y	N

EXTENDED FAMILY COVER

A "Family" means the Principal insured person and an Eligible spouse (listed under Section A) and Eligible children (listed under Section A), who have not attained the age of 21 years or if an unmarried full time student who have not attained the age of 25, unless mentally or physically disabled and unable to earn any form of income. Any dependant falling under this definition are included at **no additional costs.**

If you have extended family or an additional dependant registered on your medical aid and they do not qualify in terms of our definition of a family as per the definition above, you may add them onto your policy. The cost per additional dependant is detailed below.

Rates quoted below are per person. To calculate the additional cost for extended family you wish to cover, multiply the number of people by the rate for the applicable age category.

Product	Ages 0-21 (incl)		Ages 22-64 (incl)		Ages 65 – 79 (incl)		Total
	Rate	Number	Rate	Number	Rate	Number	
Pro-Care (all options)	R16		R29		R81		
Execu-Care	R30		R67		n/a		
Maxi-Care (all options)	R15		R25		n/a		
Elect-A-Care	R17		R28		R76		

MEDICAL QUESTIONS

		Yes	No
1.	Are you aware of any reason why the dependant to be added may require hospitalisation in the next 12 months? (If yes, please complete Section 1)		
2.	Has the dependant to be added been hospitalised in the last 5 years? (If yes, please complete Section 2)		
3.	Is the dependant currently being treated for any condition? (If yes, please complete Section 3)		
4.	Has the proposed dependant ever been diagnosed with and/or treated for cancer?		

Section 1

Please provide full details of scheduled or potential hospitalisation in the next 12 months. Should the space provided below be insufficient please attach a supporting schedule.

Insured's name	Diagnosis and treatment	Expected date of hospitalisation

Section 2

Please provide full details of all procedures which required hospitalisation in the last 5 years. Should the space provided below be insufficient please attach a supporting schedule.

Insured's name	Diagnosis and treatment	Date of hospitalisation	Date of Last symptoms

Section 3

Please provide full details of all conditions for which the dependant is currently being treated, as well as the current status of the condition (e.g. under observation, medicated, in remission, etc.). Should the space provided below be insufficient please attach a supporting schedule.

Insured's name	Diagnosis and treatment	Current status of condition

DECLARATION

I have been informed of my rights in terms of the Policyholder Protection Rules to have the following information disclosed to me before entering into any insurance contract: 1) The Statutory Notice; 2) Intermediary accreditation and mandate confirmation; 3) Mandatory disclosures. I hereby apply for the benefits stipulated in this document, subject to the terms and conditions of the policy contract and I agree that this application and declaration shall be the basis of the contract between me and Constantia Insurance Company Limited ("Insurer"). I hereby warrant that the answers and statements provided in the application form are true and correct in every particular and that I have withheld no information whatsoever, which is material to or is likely to affect the assessment of the risk under the proposed insurance. I undertake to advise Turnberry in writing if a change takes place in the health of the insured person/persons between the date of signing the declaration of health and the date of acceptance of the risk whichever occurs last. I understand that any inaccurate and untrue statements or failure to notify Turnberry of a change in health prior to the acceptance of the policy may render my policy null and void and all premiums paid forfeited to the Insurer. I acknowledge that no representation made to me by any agent or employee of the Insurer shall in any way bind the Insurer unless it is thereafter confirmed in writing by the Insurer. I hereby irrevocably authorise: a) the Insurer to obtain from any person any information the Insurer needs to which this application relates; b) the person concerned to give the Insurer the information it requests under the authorisation in (a); the Insurer to share with other insurers and the LOA any information to assess risks or claims. Any information may, under this authorisation, be obtained or given at any time, even after death. I agree that a photocopy or fax of this application form is as effective and valid as the original. If I have an email address for correspondence with Turnberry, I accept the risks of email correspondence and shall not hold Turnberry liable for any loss or damage arising through any unauthorised access to the email correspondence or any interception of any communication between Turnberry and me.

I acknowledge that should any of my personal and/or banking details change it is my responsibility to ensure that Turnberry are notified of the changes.

I acknowledge that the premium is due monthly in advance on the 1st day of each calendar month and if not received by Turnberry by the 15th day of the following calendar month, then this policy shall be deemed to have been cancelled at midnight on the due date.

Has any insurer ever declined a proposal of yours or cancelled any policy or any section thereof?	**Yes**	**No**

Signature: _____ Date: Y Y Y Y M M D D