OPTION CHANGE / ADDITIONAL PRODUCT FORM

Administrators (Pty) Ltd

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Insured by the Constantia Life and Health Assurance Company Limited (FSP 49986) and Constantia Insurance Company Limited (FSP 31111) (Managed by Ambledown Financial Services (Pty) Ltd (FSP No. 10287).

Administered by Cura Administrators (Pty) Ltd, an Authorised Financial Services Provider (FSP 26848).

This is not a medical scheme application and the cover is not equivalent to that of a medical scheme. This policy is not a substitute for medical scheme membership and is a Short-Term Health Insurance product. This section only applies to the health insurance cover, not funeral and other life products.

Cura Policy No: Cura Product:

1 DETAILS OF PRINCIPAL MEMBER: Please fill in your details below. Ensure that all fields are marked clearly and can be read easily.

Name(s): Initials:

Surname: ID Number:

Telephone (H): Telephone (W): Cell No:

E-mail:

Medical Scheme: Option: Member No:

Name of Main Member:

I wish to change my Cura option: I wish to add the following Cura product

Please select an option below by inserting an "X" in the appropriate block

Cura Gap Ultimate + Cura Gap Advanced + Gap Standard Cura Gap Student (Individuals between the age of 18 and 27)

Cura Gap Ultimate Cura Gap Advanced Cura Gap Basic

Cura Funeral Cover - R18 000 Cura Funeral Cover - R30 000 Cura Cancer Cover Cura Life & Health

Did you receive any advice from your broker, regarding this option change? Yes No

2. ADDITIONAL BROKER FEE:

herewith authorise that an additional Broker Fee with intervals of R10.00 (minimum R20.00) can be debited from my bank account R

Member Signature: _____ Date:

3. HEALTH DECLARATION: Please fill in your details below. Ensure that all fields are marked clearly and can be read easily.

Do you or any of the eligible persons on this application suffer from any existing medical conditions, or have you received treatment for any illness or injury in the past. (Including pregnancy) Yes No

If yes, please provide details below

Name of insured	Details of known existing medical conditions	Date of last treatment

Member Signature _____ Date: