

OPTION CHANGE FORM

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Compliance Office: Moonstone Compliance (Pty) Ltd

Please ensure that the following documents are included as part of the request to add or amend any products:

- Copy of ID Document / Passport (Including all Dependants)
- Proof of Bank Account (letter on Company letterhead confirming deduction - for payroll deductions) No Internet statements will be accepted.
- Medical Scheme Certificate of Membership (COM).

POLICY HOLDER DETAILS

Cura Policy Number	Current Option			
Surname	Initials		Title	
Full Name				
ID/Passport Number	Date of birth	Gender	Male	Female
Telephone (H)	Cell Phone			
Telephone (W)	Email Address			

OPTION SELECTION

I wish to change my existing Cura Administrators Product (specify product and option):

I wish to add the following Cura Administrators Product:

(If changing and adding options, please tick both boxes)

Top-Up (Gap) Cover

Ultimate Plus Cover	Individual	Family	0-64	65+	Premium per month
Ultimate Cover	Individual	Family	0-64	65+	*Intermediary Fee (Optional) * The Intermediary Fee will only be collected subject to us receiving a signed contract between the intermediary and policyholder. This Intermediary fee is optional and is paid to the intermediary on top of the statutory commission on your approval.
Advanced Plus Cover	Individual	Family	0-64	65+	
Advanced Cover	Individual	Family	0-64	65+	
Standard Cover	Individual	Family	0-64	65+	
Basic Cover	Individual	Family	0-64	65+	
Student Cover	Individual between the age of 21 and 27 only				Inception Date of new Option/Product

Additional Covers Products (Contact your Cura broker for information and application forms for these additional products)

- **Cancer Cover (Principle insured only)** Additional Form to be Completed
- **Funeral Cover** Additional Form to be Completed
- **Non-PMB Support** Additional Form to be Completed
- **Health insurance** Additional Form to be Completed
- **Incident Assist** Additional Form to be Completed

NOMINATED BENEFICIARY DETAILS (For Accidental death benefit on the Advanced Plus, Ultimate and Ultimate Plus)

Beneficiary 1:

Name of Beneficiary	Title	
ID/Passport Number	Date of birth	Relationship to Policyholder
Contact Number	Email Address	

Beneficiary 2:

Name of Beneficiary	Title	
ID/Passport Number	Date of birth	Relationship to Policyholder
Contact Number	Email Address	



Signature of Policyholder /
Authorised Signature

Date

MEDICAL SCHEME DETAILS

Medical Scheme

Medical Scheme Option

Medical Scheme No.

Date Joined

Copy of Medical Scheme Membership Certificate attached (mandatory except for application for Incident Assist or Health Insurance)

Is this application part of a group?

Yes

No

If YES, group name:

HEALTH DECLARATION

The following questions relate to you and your dependants covered under this policy.

Yes

No

1.	Have you been admitted to hospital in the last 4 months?		
2.	Are you expecting a hospital admission or aware of any conditions or illness that would require treatment in the next 12 months?		
3.	Are you or any of your dependents currently pregnant?		
4.	Have you or anyone named in this application ever experienced, been treated for, investigated for, or are currently suffering from any medical condition, undiagnosed illness, planned medical procedure, or any other disorder?		

I agree to the above section of the form

If you answered "Yes" to any of the questions, please provide details below.

Question No.

Name of Insured

Condition

Date of Last Treatment

DECLARATION BY POLICYHOLDER

I, the undersigned, hereby declare:

- That I understand that this is an Accident and Health policy with stated benefits in terms of the Short-term Insurance Act 53 of 1998 and not a Medical Scheme product.
- The sharing of claims information and underwriting information by Insurers is essential to enable the insurance industry to underwrite policies, assess risks fairly, reduce the incidence of fraudulent claims and protect the public interest in terms of limiting excessive premium increases.
- I specifically consent to Cura Administrators (Pty) Ltd contacting my current Medical Scheme and/or medical practitioner to verify any medical details as provided in my claim form. I further consent to such information being disclosed to Cura Administrators(Pty) Ltd for purpose of verifying the disclosed information as provided on my application form.
- As part of the claims validation process we may use the services of a third party in order to authenticate medical scheme membership, plan option type, relevant beneficiaries and agreed medical scheme option tariffs amongst other relevant information to validate the claim.
- Cura Administrators(Pty) Ltd reserve the right to call for additional information of a clinical nature. In the event that Cura Administrators requests a PMA (Post Medical Assessment) from my doctor as part of the claims assessing and authentication process.
- I authorise Cura Administrators to negotiate with service providers on my behalf for my medical claims and/or bill and pay the provider direct.
- In the event of a bereavement related claim the Insurer will pay the benefit into the policyholder or nominated beneficiaries account. The beneficiary must be noted on the policy prior to any loss. Cura Administrators will require the full name, surname and ID to note the beneficiary. At the time of a claim Cura Administrators will require the beneficiary's ID and proof of bank. Should there be no beneficiary noted on the policy prior to the loss, or should Cura Administrators be unable to confirm the identity of the beneficiary, payment will always be made into the policyholder's account.

Signed at

on this

date of

20

Signature of Policyholder /
Authorised Signature

