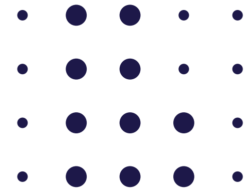
DEPENDANT ADDITION FORM

(FSP no. 36571)



(FSP no.1596)

Policy Number:

Telephone: 0861 000 509
Fax: 0861 000 508
Physical Address: 4 Osborne Lane, Bedforview, 2007
Postal Address: Private Bag X2, Gardenview, 2047

Please complete and return by fax to: 086 649 0417 | Email to: admin@turnberry.co.za

Principal Insured Person: ID Number:

Address:

Telephone Number:

Email Address:

A. DEPENDANT DETAILS

Name of Dependant		Identity Number (Date of Birth if no ID No)	Gender M/F	Relationship to Policyholder
Surname	First Name			

B. 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 26 years unless mentally or physically disabled and unable to earn any form of income. Any dependants falling under this definition are included at no additional cost. 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 26-64 (incl)		Ages 65-79 (incl)		Ages 80+		Total
	Rate	Number	Rate	Number	Rate	Number	
PREMIER	R86		R264		R343		
ENHANCE	R65		R198		R257		
OPTIMAL	R75		R211		R274		
SYNERGY	R72		R196		R255		
VITAL	R36		R105		R137		

C.	DECLARATION OF HEALTH				
1.	Are you aware of any reason why the dependant to be added may require hospitalisation and/or medical treatment in the next 12 months from the date of application , including admission for any diagnostic procedures e.g. Colonoscopies, Gastroscopies, MRI and CT scans or as a result of Pregnancy? (If yes, provide details below.)				YES ◯ NO ◯
	Name	Symptoms/Diagnosis	Treatment	Date of first Diagnosis/ Symptoms	Date of last Treatment
2.	Has the dependant to be added been diagnosed, treated, hospitalised and/or sought medical advice for any condition within the last 12 months, from date of application? (If yes, provide details below.)				YES ◯ NO ◯
	Name	Symptoms/Diagnosis	Treatment	Date of first Diagnosis/ Symptoms	Date of last Treatment
3.	Has the proposed dependant ever been diagnosed with and/or treated for cancer? (If yes, provide details below.)				YES ◯ NO ◯
	Name	Symptoms/Diagnosis	Treatment	Date of first Diagnosis/ Treatment	Date of last Treatment

SHOULD THE INFORMATION PROVIDED ABOVE BE INSUFFICIENT TO ASSESS THE RISK, ADDITIONAL MEDICAL INFORMATION WILL BE REQUESTED.
SHOULD THE SPACE PROVIDED ABOVE BE INSUFFICIENT PLEASE ATTACH A SUPPORTING SCHEDULE.

D. DECLARATION BY THE PRINCIPLE INSURED PERSON

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 Lombard 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 ASISA 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 ◯
If “YES”, please provide details.

Remarks: ____

Signature: ______________________________ Date: ____________