



**PLAN OPTION**

The products presented are Short Term Insurance stated benefit products under the Short Term Insurance Act no: 53 of 1998. Cover will be provided for a family of 5 members. There is a general 3 month waiting period and no maximum entry age. Pre existing conditions may be excluded for a period longer than 12 months or permanently.

**Gap Cover**

This product covers the difference between the Medical Scheme Rate and private rates charged by Registered Medical Professionals for in-hospital treatment. Gap Cover will settle up to a total of 500% of the Medical Scheme Rate. No annual limit / No excess payable.

**CoPay and Admission Fee Cover:**

This product is a Short Term Insurance stated benefit product that will cover your co-payments for procedures performed as an in-patient or as an out-patient. This includes MRI, CT and Ultrasound scans. In addition, cover is provided for the admission fees payable to a hospital as imposed in terms of your Medical Scheme Rules. An incident limit of R12,500.00 will apply per claim. This means that your co-payment / admission fees will be covered up to a maximum amount of R12,500.00 per insured, per incident. Utilisation per beneficiary is limited to no more than 3 claims per annum and an overall annual limit of R100,000.00 per family.

**Out-patient Cover**

This product is a Short Term Insurance stated benefit product that covers the difference between your Medical Scheme Rate and private rates charged by a Registered Medical Professional. The policy will cover you for any out-patient surgical procedure that would normally be performed as an in-patient. An incident limit of R3,500.00 will apply per claim. This means that your specified out-patient treatment will be covered up to a maximum amount of R3,500.00 per insured, per incident. Utilisation per beneficiary is limited to no more than 3 claims per year and an overall limit of R15,000.00 per family per annum.

X

Premium per Month	R	170.00
*Intermediary Fee (Optional)	R	_____00
Total Premium Payable	R	_____00

Signature of Insured: \_\_\_\_\_

\* This Intermediary fee is optional and is paid to the intermediary on top of the statutory commission on your approval.

**SPECIFIC HEALTH QUESTIONS**

Have you or any insured under this policy ever received treatment or expect to receive treatment for any of the following illnesses?

1	Blood disorders	Yes	No
2	Cancer or growths of any kind	Yes	No
3	Gastro-Intestinal disorders	Yes	No
4	Musculo-skeletal disorders	Yes	No
5	Neurological disorders	Yes	No
6	Renal disorders	Yes	No
7	Cardiovascular disorders	Yes	No
8	Ear, nose and throat disorders	Yes	No
9	Skin disorders	Yes	No
10	Endocrine disorders	Yes	No
11	Eye related disorders	Yes	No
12	Respiratory disorders	Yes	No
13	Psychological disorders	Yes	No
14	Male Genito-urinary system	Yes	No
15	Is any female currently pregnant?	Yes	No
16	Gynaecological and obstetrical disorders	Yes	No
17	Are you aware of any condition/illness that would need treatment in the next 12 months?	Yes	No
18	Have you or any dependant in the past 5 years been hospitalised or had any x-rays, examinations or testing done?	Yes	No
19	Have you or any of your dependents received medical advice or treatment for any infectious diseases?	Yes	No

If YES, provide details:

Question	Applicant/Dependents	Full details (Including details of disorder, date diagnosed, nature and duration of treatment and details of consulting doctor)

Should the above space be insufficient, please add an extra page to this application form.

## DEBIT ORDER DETAILS

Name of Account Holder																								
Bank Name													Branch Code											
Account No.													Branch Name											
Account Type																								
Debit order date	1st		5th		10th		15th																	

I hereby instruct and authorise you to draw against my bank account from my bank the amount necessary for payment of my monthly premium due in respect of the above mentioned insurance, without prejudice to the rights of Resolution Underwriters (Pty) Ltd. I further authorise you to increase the amount due in the terms of the policy from time to time and authorise my bank to effect payment.

X

Signature of Account Holder: \_\_\_\_\_

Date 

D	D	M	M	Y	Y	Y	Y
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## DECLARATION BY APPLICANT

I, the undersigned, hereby declare:

1. that to the best of my knowledge and belief the information provided in connection with this application whether in my own handwriting or not, is true and I have not withheld any material facts which are known to me. NB: A material fact is likely to influence the assessment of this application by Resolution Underwriters (Pty) Ltd. (If you are in any doubt as to whether a fact is material or not, you should disclose it.)
2. that I understand that any relevant material fact omitted in this proposal form may lead to Resolution Underwriters (Pty) Ltd. not meeting claims, should the omitted fact have been of such importance that the risk may not have been accepted in the first instance, in terms of the policy. This may lead to cancellation of this policy or rejecting claims, without refund of premiums if applicable.
3. 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.
4. that I acknowledge that the sharing of claims information and underwriting (including credit information) by Insurers is essential to enable the insurance industry to underwrite policies and assess risk fairly and reduce the incidence of fraudulent claims, in the public interest and a view to limiting premiums. I hereby waive any rights to privacy in any claims information supplied by me or on my behalf in respect of any insurance claim made or lodged by me and I consent to such information being disclosed to any other insurance company or its agent. I also waive any rights of privacy and consent to the disclosure of any information relevant to claims concerning me or any person I represent. I also acknowledge that information provided by me may be verified against other legitimate sources or databases.
5. I specifically consent to Resolution Underwriters (Pty) Ltd contacting my current Medical Scheme and/or medical practitioner to verify any medical details as provided in my application

X

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Spouse (If married in community of property)

D	D	M	M	Y	Y	Y	Y
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## INTERMEDIARY DETAILS

Intermediary	PETER PYBURN												Brokerage Code	565										
Email Address	peter@peterpyburn.co.za																							
Telephone No.	(	C	O	D	E	)	0833778893				Fax No.	(	C	O	D	E	)	0866688122						

Consultant

S BRUNNER

## IMPORTANT INFORMATION

- A family means two adults and three children under the age of 18. Concessions can be made for children whom are financially dependant (21), or full time students (25). A letter from the insured should be sent to prove that the child is financially dependant, and a letter from a recognised educational institution to prove full time studency.
- Adult dependants (e.g. mother, grandfather) would need a separate application.
- Please make sure FULL details are given for questions answered YES. Hence, what, when, how severe, what's current status?
- Application forms could be underwritten and conditions may be excluded for longer than 12 months, or permanently. A concession letter would be sent to the insured to confirm this.
- This policy can be taken with any Medical Scheme. Family members could be on different Medical Schemes, and still have the same policy.
- The onus lies on the insured to make sure that premiums are paid on a monthly basis. Reference on bank statements read: MULTID\_FORRESOLUTION
- Effective from 1 January 2012





## INTERMEDIARY DISCLOSURE

In terms of the Financial Advisory and Intermediary Services Act (FAIS) (ACT NO 37 OF 2002) the following information must be disclosed to clients and potential clients:

**Full Name:** Jenus Health  
**Representative:** Peter J Pyburn  
**Physical address:** No. 6 Robin Drive Fourways  
**Postal Address:** P.O. Box 70687 Bryanston 2021  
**Telephone:** 011 467-3535  
**Fax:** 011 467-0027  
**e-mail:** [alexia@jenus.co.za](mailto:alexia@jenus.co.za) or [info@jenus.co.za](mailto:info@jenus.co.za)

I am an Independent Financial Advisor and have been in practice for 10 years.

I have training and experience to advise my clients on the following business lines:

Health Care                       Short term Insurance                       Other

Reference to licence, authority achieved in terms of licence (i.e. products).

I have achieved the following formal qualifications:

IMM Diploma  
Manchester Management Development Programme

I am the Principal/ Representative of the above-mentioned brokerage.

As the Principal /Representative of the brokerage I have access to and have been accredited to market products from the following product providers:

Discovery, Fedhealth, Medshield, Bonitas, Spectramed, Momentum Health, Keyhealth, Topmed, Liberty, Bestmed, Medihelp, Resolution (Health and short term), Profmed

I earn my income from commission that the Product Provider pays over to me on the products purchased by my clients / and or by charging a fee of R Nil per hour for services rendered to my clients on the following fee structure:

1. 3% per month of the total medical aid contribution to a maximum of R65.65 per member.
2. 20% on short term product contributions.

I have / do not have Professional Indemnity Insurance cover of R1 000 000

Moonstone Compliance (Pty) Ltd is the businesses compliance officer and is represented by Trevor Laubscher. Moonstone Compliance can be contacted at : Valerida Centre, Piet Retief Street, 1st Floor, Stellenbosch, 7600. Fax: (021) 883 8005; Tel: (021) 883 8000; E-mail address: Trevor Laubscher [TLoubscher@moonstonecompliance.co.za](mailto:TLoubscher@moonstonecompliance.co.za). Website: [www.moonstoneinfo.co.za](http://www.moonstoneinfo.co.za)

In terms of the FAIS Act we are obliged to set up a complaints resolution process. Please contact our office should you wish to get more detailed information in this regard. In the event where we cannot solve your complaint to your satisfaction you can approach the Ombud at PO Box 74571, Lynnwood Ridge, 0040, or at telephone number (012) 470 9080 / 99, fax (012) 3483447 or e-mail [info@faisombud.co.za](mailto:info@faisombud.co.za)

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Advisor Signature

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Date:

I hereby acknowledge that I have read the content of this document.

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Client Signature

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Date:

## Client advice record in terms of section 8(4)(a)

### Section 1: Client details

Title (e.g. Mr/Mrs/Ms/Prof./Dr) \_\_\_\_\_, Initials \_\_\_\_\_ First name \_\_\_\_\_

Surname \_\_\_\_\_

Identity/Passport number: \_\_\_\_\_

Date of birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Male  Female

Postal address


Postal code \_\_\_\_\_

Tel. work (code - number) \_\_\_\_\_ - \_\_\_\_\_ Fax work (code - number) \_\_\_\_\_ - \_\_\_\_\_

Tel. home (code - number) \_\_\_\_\_ - \_\_\_\_\_ Fax home (code - number) \_\_\_\_\_ - \_\_\_\_\_

Cell phone number \_\_\_\_\_

### Section 2: Advisor details

Please see attached disclosure regarding the Financial Services Provider.

### Section 3: Needs Analysis

Has a Needs Analysis been completed? Yes  No

If no, please supply reason - no time and electronic sales restrictions. Personalised quotes and plan specific brochures from at least 2 medical aids supplied so objective decision can be made.

Alternatively, please complete the below mentioned **Needs Analysis** form:

### Section 5: Declaration by the advisor

5.1. I declare that the advice record is an accurate and complete record of the recommendations and advice that I gave the client.

5.2. The advice that I provided is subject to Section 8(4) of the General Code of Conduct.



\_\_\_\_\_  
Signature of advisor

PETER PYBURN

\_\_\_\_\_  
Print name

Date: \_\_\_\_\_/\_\_\_\_\_/2011

## Section 6: Declaration by the client

6.1. I hereby declare that I am aware of the fact that:-

- should a full analysis not be completed, that there may be limitations on the appropriateness of the advice; and
- that I must carefully consider whether the advice on its own is appropriate considering my objectives, financial situation and needs;
- to prevent the risk of concluding a transaction that is not appropriate to my needs, objectives and circumstances, I should therefore obtain a full financial needs analysis.

\_\_\_\_\_  
**Signature of client**

\_\_\_\_\_  
**Print name**

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Directors:  
Ashley Smart, Alexia Graham  
Co. Registration No: 2004/018981/07  
FSP: 36088