

## Individual application for membership

**Important notes:**

- Asterio Group Solutions (hereon forward referred to as Asterio) is not a medical scheme registered under the Medical Schemes Act, 131 of 1998.
- Asterio Medical is a registered medical insurance product underwritten by African Unity Group.
- Please do not resign from your current medical scheme/insurer until you have received written notification of acceptance from Asterio.
- Please provide the ID number and copy of ID for the principal member and all dependents.
- Please ensure that the first name and surname of the principal member, spouse and dependents are completed in accordance with the ID or passport.
- Please provide certificates of membership for previous schemes, where applicable.

**Cover may only commence on the first day of a nominated month. Which month would you like cover to commence?**

<b>Section 1: Personal details</b>
<b>Principal member:</b>

Title:		Initials:		First name:											
Surname:															
Previous surname:															
ID/Passport number:															
Country in which passport was issued:															
Gender:	Male	Female		Date of birth:	Y	Y	Y	Y	/	M	M	/	D	D	
Country of residence:															
Marital status:	Single			Married			Separated			Divorced			Widowed		
Home address:															
Postal address: (if different)															

**Contact Details:**

Home:		-		Cellular:			
Email address:							

Please note that the email address you provide will be used when Asterio communicates with you.

**Spouse or partner (If spouse or partner is also applying for membership)**

Title:		Initials:		First name:										
Surname:														
Previous surname:														
ID/Passport number:														
Gender:	Male	Female		Date of birth:	Y	Y	Y	Y	/	M	M	/	D	D

**Dependents:**

	Full Names	Surname	Relationship to member	ID number / Date of birth
Dependent 1				
Dependent 2				
Dependent 3				
Dependent 4				

**Section 2: Previous medical scheme information**

List each medical scheme or medical insurer that you have been a member of (note that only medical schemes/insurers registered in South Africa apply). This information needs to be supplied for the principal member and all dependants applying for membership. If more space is required, please include additional pages.

Name of member:	Name of scheme:	Membership number:	Date joined:	Date terminated or current:

Are the details completed above the same for all dependants applying for cover?	Yes	No
If no, please provide details in the space above.		
Are you changing your medical scheme or medical insurer due to a change in your employment?	Yes	No
Have you, your spouse or any of your dependants had a waiting period, pre-existing conditions exclusions or a late joiner penalty?	Yes	No
<b>If yes, please provide details:</b>		
Name:	Details:	

How would you like to receive the welcome pack?	Mail to Member	Send to Broker
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**Section 3: Medical details**

**Section 3.1**

Complete this section if you have been a member of a medical scheme or medical insurer registered in South Africa for at least 24-months. Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership.

**Have you or your dependants had any of the following:**

3.1.1 Disorders or problems with an organs/(s) e.g. heart or cardiovascular system, respiratory or lung, digestive system, stomach, gall bladder, pancreas or liver, kidneys, bladder or reproductive organs, nervous system or brain?	Yes	No
3.1.2 Diabetes, sugar in urine, thyroid or other glandular or blood disorders. E.g. anaemia, bleeding disorders, growth disorder, Cushing’s disease or Addison’s disease?	Yes	No
3.1.3 Cancer, a growth or tumour of any kind including moles removed (malignant/benign)? Please specify if these were benign or malignant.	Yes	No
3.1.4 Are you or any of your dependants taking ongoing medication for any condition not listed in any other question?	Yes	No
3.1.5 Are you or any of your dependants currently undergoing, or anticipating any specialised dental / maxillo facial treatment?	Yes	No
3.1.6 Have you or any of your dependants had an operation or admission to any hospital (including for injuries sustained in an accident or motor vehicle accident) in the last 12 months?	Yes	No
3.1.7 Are you or any of your dependants awaiting or planning an operation or admission to any hospital in the next 12 months?	Yes	No



3.1.8 Is there any other condition or symptom, which is not detailed in any other question, for which medical advice, diagnosis, care or treatment has already been recommended or received by you or your dependants, and could potentially result in a medical claim within the next 12 months?	Yes	No
3.2.9 Is there any other condition or symptom, which is not detailed in any other question, that you or any of your dependants have experienced and for which you have not yet sought medical advice?	Yes	No
3.2.10 Have you or any of your dependants had any of the following symptoms or conditions: abnormal pap smears or mammograms, endometriosis, ovarian cysts, fibroids, infertility, disorders of the cervix, recently missed or irregular menstrual cycles or do you suspect that you may be pregnant?	Yes	No

All questions above must be answered with a 'Yes or 'No'. If 'Yes' to any question, please provide full details below. If more space is required, please include additional pages					
Name of member:	Condition and date diagnosed:	Name of medication:	Are you currently on treatment?	Last treatment/ symptoms date:	Attending doctor:

3.2.11 Are you or any of your dependants currently pregnant?	Yes	No
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**Section 4: Plan Option choice**  
**Please indicate your selection with a**

<b>Combination plans</b>			
Green Combo	Blue Combo	Red Combo	
<b>Day-to-Day Cover only</b>			
Green D-2-D	Blue D-2-D	Red D-2-D	
Hospital Cover Only	Emergency Cover Only	Emergency and Hospital	



**Section 5: Banking details for payment of contributions**

You do not need to complete this section if your employer is paying for your Asterio contributions (as per the company application form). (Please do not provide credit card details. Asterio is not allowed to record your credit card details.)

Name of account holder:																				
Name of bank:																				
Account number:																				
Account type:	Current/Cheque:										Savings:									
Branch code:																				

**Section 6: Authorisation for contribution collection**

**Completion of this section is compulsory for all contribution payers**

The Collecting Agent may debit the above account with the amount due under the contract in accordance with their debit order system. The Collecting Agent will debit your bank account for contributions on the date specified by you every month. I understand that the Collecting Agent bills for contributions in advance and dependent on my commencement and activation dates there may be more than a single contribution payable to the Asterio. I further confirm that I have read and understand Terms and Condition under Section 10 of this application.

I wish for my premium to be deducted from the bank account specified in Section 9 above on the following date of every month:

1 <sup>st</sup>	15 <sup>th</sup>	25 <sup>th</sup>	30 <sup>th</sup>	31 <sup>st</sup>
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If a company account is to be debited:

- I/we warrant that the principal member referred to in this application is an employee of our organisation.
- The Collecting Agent may bill us for the amount due for this member in the same manner as for other members that our organisation employs.

Please note that if the company is paying contributions for more than one employee, a company application form needs to be submitted if the company is not already listed as an employer on Asterio Group Solutions.

Name:																				
Position in company:																				

\_\_\_\_\_  
Signature of account holder/  
Authorised signatory

\_\_\_\_\_  
Date

**Section 7: Banking details for claim refunds payable to member**

Tick here if we may use the same bank account details provided for your Asterio contribution payments.

If not, please complete the bank details below.  
(Please do not provide credit card details. Asterio is not allowed to record your credit card details)

Name of account holder:																				
Name of bank:																				
Account number:																				
Account type:	Current/Cheque:										Savings:									
Branch code:																				

Please note that you, as the principal member, need to sign this section, if somebody else's bank account details have been provided.

\_\_\_\_\_  
Signature of principal member

\_\_\_\_\_  
Signature of account holder

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**Section 8: Consent for Asterio Group Solutions to process personal information**

- 8.1 I declare to the best of my knowledge and belief that the given particulars are true and correct.
- 8.2 I am satisfied that the plan chosen by me suite my needs.
- 8.3 I can afford the monthly premium of the plan chosen by me.
- 8.4 I have chosen this plan purely out of free will and on my own account without the request for a financial needs analysis or financial advice from any person.

Asterio Group Solutions and the Administrator are committed to maintaining the confidentiality of your personal information and complying with the Protection of Personal Information Act, 2013 when processing your personal information. We request your consent to process your personal information and obtain your personal information from any other person for the purposes set out in this section. While your consent is voluntary, it is a requirement for your membership.

1. The personal information we require relates not only to you but also to your child and adult dependants, and you confirm that you are authorised to provide consent in this section on behalf of your dependants on Asterio Group Solutions.
2. You authorise, and give consent to, Asterio Group Solutions and the Administrator to collect, store, collate, process, share and further process your personal information, including health information, and that of your dependants, for purposes of your membership of Asterio Group Solutions, risk profiling and management and as set out in this section.
3. If you have consented to the disclosure of your personal information to any other entity or person (person means any natural or juristic person, firm, company, corporation, state, agency or organ of a state, association, trust or partnership, whether or not having legal personality) or if a contractual relationship exists between Asterio Group Solutions or the Administrator which requires Asterio Group Solutions or the Administrator to provide your personal information to any other person, Asterio Group Solutions or the Administrator may do so.
4. You must give Asterio Group Solutions and the Administrator all information and evidence they may require from time to time for the purposes of assessing this application, your membership of Asterio Group Solutions, risk profiling or management. You authorise Asterio Group Solutions and the Administrator to obtain, from any person, including any medical doctor or other healthcare provider who has attended you or your dependants in the past or who will attend to you or your dependants in the future, any information we may require concerning you or any of your dependants in assessing any risk or claim in relation to this application, your membership of Asterio Group Solutions, risk profiling or management and you consent to that person providing, and instruct that person to provide, Asterio Group Solutions and the Administrator with this information on request. You waive the provisions of any law or regulation that restricts the disclosure of this information. You must also submit to any examination by Momentum Health's medical assessor as and when Asterio Group Solutions requires this.
5. You understand that your personal information will be shared between Asterio Group Solutions, the Administrator and contracted third parties both locally and outside the Republic of South Africa who require this information, for purposes related to your membership of Asterio Group Solutions and:
  - to grant you access to interact with Asterio Group Solutions on its website; and
  - to provide any credit bureau or registered credit provider with your credit information as defined in the National Credit Act, 2005 (credit information includes, for example, my credit history, financial history, pattern of payment or default under any credit agreements, debt re-arrangement arrangements or judgments obtained for outstanding debts).

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Signature of principal member

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Date



## Section 9: General Terms and Conditions

### DISCLOSURES:

I warrant that I have taken note and understand the cover limits, waiting periods and the limitations of this policy. Should there be any dispute as to the information provided, the policy wording that forms part of the Welcome Pack will be deemed to be correct and will be the basis of this agreement.

In no way do I expect that the policy will provide unlimited cover in the event of medical occurrences unless expressly indicated as such. This is an application for a binding insurance contract on the intermediary and myself and no further acceptance of terms and conditions or any other documents will be necessary for this contract to become binding. I fully understand that the Asterio Policy is based on insurance cover and is not a medical aid and that the policy is a month-to-month contract. The cover in this policy has no surrender/cancellation/maturity values and in the event that my premium is unpaid, the cover applicable to the policy will lapse, subject to the grace period offered by the Administrator being Asterio Group Solutions (Pty) Ltd.

I further declare that all the information entered by me on this application is true and correct and should any further information be required I will make this available to the Administrator or Insurer as necessary for my policy or any query related to the policy. The disclosure of medical conditions is true and correct and I am in no way entering this agreement with the knowledge of undisclosed conditions or expected future conditions. The policy wording necessary for this policy to be binding on the parties will be made available to me through communication by the Administrator.

### PAYMENT OF COVER:

I accept that the payment of any cover due to a valid claim will first be paid to the Administrator trust account held in my name, for distribution to the service providers who have presented valid invoices for services rendered to a beneficiary of this policy. I understand and accept that after these payments have been made only the remaining portion of the claim will be paid to me, the principle insured of this insurance product. I hereby issue power of attorney and a mandate to Asterio Investments (PTY) Ltd to act on my behalf for each and every claim. I understand that no additional charge will be levied against me for the services offered in assisting me with my claim.

### ACCEPTANCE:

The Administrator will advise me of the acceptance of the terms of the above policy and if there are any terms and conditions that require additional disclosure for my individual policy.

### ITC RATING CHECK:

I authorise the Administrator to submit my details to ITC to properly rate my account and credit record. The Administrator warrants that all information received from ITC in this regard will be treated as confidential and will not be disclosed to any third parties.

### PREMIUM INCREASES/POLICY AMENDMENTS:

The Administrators reserve the right to increase premiums or amend the policy cover at their discretion. Notice of any premium increases or cover amendments will be given in writing 30 days (one calendar month) before any such changes come into effect.

### POLICY INITIATION FEE:

I consent to my account being debited with the once-off policy initiation fee of R 150.00 (One Hundred and Fifty Rand) on the same date as my first policy debit order.

### PREMIUM REFUNDS:

Should a policy be cancelled in writing within the first 30 days of the date of application (cooling off period), the premium and initiation fee will be refundable if it has been deducted from my nominated bank account. If the policy is cancelled after the 30 days cooling-off period, a one calendar month written notification period will apply and the policy will only be cancelled 30 days after the first day of the following month. I understand that my premium will only be refunded 30 days after it has been deducted and I may need to submit supporting documentation before any refunds are granted.

### CANCELLATION:

Cancellations requested after the inception date are subject to a full calendar month notice period and must be submitted in writing and a cancellation fee of R150.00 (One Hundred and Fifty Rand) may be levied.

### PAYMENT INSTRUCTIONS:

I hereby authorise Asterio Group Solutions (PTY) Ltd or appointed collection agent namely Insure Group Managers LTD t/a Epic, to deduct premiums, excess amounts or any amounts are per the policy wording or terms and conditions of the parties. I acknowledge that failure / rejection of said debits may result in my policy being suspended or cancelled. I agree that all payment instructions issued by the underwriter will be treated by my nominated bank as specified in Section 9 of the application, as if the instruction has been issued by me personally.

### PAYMENT:

I hereby agree and authorise the account specified in Section 9 of the application to be debited every month with the premium amount starting on the inception date or the next business day. The inception date is deemed to mean the next occurrence of the date chosen. Should this date have passed, the policy inception date will fall into the next calendar month. I acknowledge that premiums are collected in advance and not in arrears.

### DECLINED / FAILED PAYMENTS:

Will be debited on the next debit order date, or alternatively through a special debit that may be run at any time from the date of notification by our collection agent of the failed / returned payment as mentioned above. This will carry an administration charge of R50.00 (fifty rand), which will be levied to my account and collected with my premium. I acknowledge that in the event of declined / failed debits, I may incur additional bank charges as levied by my bank.

Should the payment be returned once, the policy cover will be suspended and the policy may be re-dated to begin on the first of the following month. No claim will be entertained until such time as the premium has been paid to the Administrator within the grace period. I hereby grant permission to the Administrator to double debit my account in the event of a rejected payment. If this double payment is returned, no further attempts will be made to collect premiums and cover will be cancelled with immediate effect. The Administrator reserves its right to collect cancellation fees with whatever means in law necessary to offset the costs of marketing collateral issued and charges as contained herein.

### EXCESSIVE CLAIMS:

I understand that should my claims history be deemed excessive, a policy increase may be levied on my premium. This increase is at the discretion of the Administrators and subject to a 30 day (one calendar month) written notice period.

### HEALTH LOADING:

I accept and understand that pre-existing conditions (known or unknown) may be excluded and/or may increase my monthly contribution. REACTIVATION FEE: Should the policy status become cancelled or suspended for whatever reason, a reactivation charge of R 150.00 (One Hundred and Fifty Rand) will be charged.

### TRANSACTIONAL CARDS:

Cards are issued per individual policyholder. Dependant cards are available at an extra charge of R50.00 (Fifty Rand) per card. This fee, upon request, will be deducted from my account upon a signed request received for new cards.

### POLICY DELIVERY:

The policy documents, Membership cards, policy guides and associated documents will be sent out within thirty days after the receipt of the initiation fee and successful collection of my first premium collection. The information in the policy wording as well as in all declarations made will form the basis of the contract, and it is warranted by Asterio that such information is accurate. This policy, however, shall not be invalidated on account of any incorrect statement made in good faith, unless the incorrectness of such statement is of such a nature as to be likely to have materially affected the assessment of the risk under the Policy at the time the policy was issued.

