



2018 APPLICATION FORM

Membership Enquiries: 0861 843 842 Claims: 0861 372 343 / (012) 741 5101 Email: smile@dentalrisk.co.za
 Applications received after the 15th of a month will result in policy inception being the 1st of the next month



BROKER CODE: HPX00213
BROKER NAME: HealthGroup

NOTE: ONLY 1 PLAN / POLICY PER INSURED FAMILY

PRINCIPAL MEMBER DETAILS

Title:		Name:														
Surname:											Policy Commencement Date: 01/___/201__					
ID number:												Marital Status (X):	Married	Divorced	Separated	Single
Postal Address:											Code:					
Physical Address:											Code:					
Cell Number:						Home Number:										
Work Number:						Email Address:										

BENEFIT AVAILABLE PER ANNUM TO APPLICANTS IF AGREEMENT IS ENTERED INTO BEFORE THE AGE OF 65

DESCRIPTION	WAITING PERIOD	PRIME Cover per person	BRONZE Cover per person	SILVER Cover per person	GOLD Cover per person
BASIC DENTISTRY BENEFITS					
Consultations (including Infection Control, Local Anaesthetic & Sterilisation)	3 months	2 @ R340 each	3 @ R340 each	4 @ R340 each	5 @ R340 each
Fillings	3 months	2 @ R300 each	3 @ R300 each	4 @ R400 each	4 @ R400 each
X-rays	3 months	2 @ R75 each	3 @ R75 each	5 @ R85 each	6 @ R90 each
Extractions	3 months	2 @ R180 each	2 @ R180 each	3 @ R200 each	4 @ R260 each
Emergency Root Canal	3 months	2 @ R190 each	3 @ R200 each	3 @ R300 each	3 @ R300 each
Bite Plate	3 months	-	1 Per annum @ R600	1 Per annum @ R800	1 Per annum @ R1 000
Mouth Guard	3 months	-	1 Per 24 month cycle @ R400	1 Per 24 month cycle @ R400	1 Per 24 month cycle @ R600
PAN Scan – over 18's	1 months	-	1 Per policyholder @ R300	1 Per policyholder @ R300	1 Per policyholder @ R300
Preventative – Scale & Polish	3 months			1 @ R150	2 @ 200 each
SPECIALISED DENTISTRY BENEFITS (PRE-AUTHORISATION REQUIRED FOR ALL BENEFITS LISTED BELOW)					
Wisdom Teeth in Chair	6 months	2 @ R580 each	-	4 @ R1 000 each	4 @ R1 250 each
Wisdom Teeth in Hospital	6 months	-	-	2 @ R3 500 each	4 @ R3 500 each
Root Canal	6 months	-	-	2 @ R1 300 each	3 @ R1 500 each
Dentures	6 months	-	1 full set every 5 years @ R3 000	1 Full set every 5 years @ R3 000	1 Full set every 5 years @ R3 500
Temporary Crowns	6 months	2 @ R450 each	1 @ R450 each	2 @ R600 each	3 @ R600 each
Crowns and Bridge work	6 months	-	1 @ R3 000	1 @ R3 000	2 @ R3 500 each
Implants (pin and placement)	6 months	-	-	1 @ R5 000	2 @ R6 000 each
PROTECTOR BENEFIT					
Trauma	1 month	R16 000.00	R25 000.00	R25 000.00	R25 000.00
Premium Waiver	1 Month	Not covered on this option	3 Months premium	3 Months premium	6 Months premium

MONTHLY CONTRIBUTIONS (MARK WITH X)

	PRIME Contribution		BRONZE Contribution		SILVER Contribution		GOLD Contribution	
	Monthly	Number of Persons	Monthly	Number of Persons	Monthly	Number of Persons	Monthly	Number of Persons
Principal	R31.00		R115.00		R225.00		R320.00	
Adult	R27.00		R98.00		R170.00		R260.00	
Child	R23.00		R64.00		R110.00		R163.00	

FAMILY MEMBERS TO BE COVERED

“Spouse” is defined as a spouse in accordance to common law as entered into by legal marriage or any partner by nature of cohabitation for longer than 6 (six) months. Only one spouse is covered under the policy.
 “Child Dependant” is defined as children under common law (biological, adopted or under legal guardianship) under the age of 21 (twenty one) years. A maximum of 6 (six) children can be nominated.

FULL NAMES	INITIALS	SURNAME	ID NUMBER / DATE OF BIRTH	AGE
Spouse				
Dependent 1				
Dependent 2				
Dependent 3				
Dependent 4				
Dependent 5				

Signature of Principal Member _____ Full Name _____ Date _____

PAYMENT INSTRUCTION

Name of Account Holder:	Monthly Contribution:	R				
ID Number:	Monthly Deduction Date:	1st	7th	15th	25th	30th
Name of Bank:	Bank Account Number:					
Branch Code:	Account Type (x):	Savings			Cheque/Current	

I warrant that I have been provided with the intermediary, insurer and cover details and any additional information as I may have requested. I warrant that all details and facts provided herein are accurate and properly disclosed. I understand that the covers offered are risk covers only and that there are no surrender values. Failure to pay your premium will result in a double deduction the following month plus a R10.00 fee. Should you default twice the policy will lapse. In the event of any query regarding this policy or any claim in terms of this policy, I consent to the disclosure of any relevant information to the Intermediary or any Official of the Administrator/Insurer for the purposes of resolving the query. In the event of no nominated beneficiary, I agree that any claim amount due will be paid directly to the Insured Estate or will be payable to the first claimant with reasonable title to claim.

I hereby accept and understand that this is an Short Term Insurance Policy and the premium is payable in advance on a month to month basis and that the Insurer can increase the premiums with one month's notice as per policy document in the event that the claims ratio increases above 70% of the risk premium. I authorise that such increase may be added to the current stated premium to be deducted from my bank account or salary after I was given 1 (one) Calendar months' notice by post or email.

I acknowledge that I have received a copy of the Statutory Notice and other Legal Requirements. I understand and accept that this service is rendered without a full financial needs analysis and I took particular care in the product selection.

I accept and understand that my documentation will only be emailed to my requested email address after the successful capturing of my application. I understand and accept the waiting periods that apply on the policy options chosen.

I authorise the Payroll Administrator or appointed Collecting Agent, namely Insure Group Managers LTD t/a Epic, to deduct the above premium from my salary or bank account each month. This signed Authority and Mandate refers to our contract as dated on signature hereof. I hereby authorise you to issue and deliver payment instructions to the bank for collection against the above-mentioned account at the above-mentioned bank (or any other bank or branch to which I / We may transfer my / our account) on condition that the sum of such payment instructions will never exceed my / our obligations as agreed to in the Agreement, and commencing on the commencement date and continuing until this Authority and Mandate is terminated by me / us by giving you notice in writing of no less than 20 ordinary working days, and sent by prepaid registered post or delivered to your address as indicated above or email to your designated email address. Each individual payment instruction may not be more or less than the obligation due. I understand that the withdrawals hereby authorised will be processed through a computerized system provided by the South African Banks and I also understand that details of each withdrawal will be printed on my bank statement. Each transaction will contain a number, which must be included in the said payment instruction and if provided to you should enable you to identify the Agreement. I / We shall not be entitled to any refund of amounts which you have withdrawn while this authority was in force, if such amounts were legally owing to you.

MANDATE: I / We acknowledge that all payment instructions issued by you shall be treated by my / our above-mentioned bank as if the instructions had been issued by me / us personally. I agree that although this Authority and Mandate may be cancelled by me, such cancellation will not cancel the Agreement. I acknowledge that this Authority and Mandate has been ceded to the current appointed Collecting Agent Insure Group Managers Ltd t/a Epic. E-mail address compliance@insuregroup.co.za, Tel 011 449 6800, Fax 011 781 7811. Registered address: IOM House, 6 St Giles Street, Randburg, 2194. Insure Group Managers hold a Professional Indemnity Policy and a Fidelity Guarantee with the Insurer AIG South Africa and an Intermediaries Guarantee Fund.

Signature of Bank Account Holder _____

Date _____

RECORD OF INFORMATION

Only information, and not advice, is provided in respect of dental policies. Should you require advice in any way, please contact Dental Risk Underwriting Managers (DRUM) Call Centre on 0861 843 842 for assistance or email smile@dentalrisk.co.za.

Information in respect of the dental plans has been provided to me, including cover amounts, commissions earned, waiting periods, premiums and when claims will not be paid.

Insurer/Underwriter:	Guardrisk (Pty) Ltd (An Authorised Financial Services Provider in terms of The Financial Advisory and Intermediary Services Act, FSP Number 75) 2nd Floor, 115 West Street, Sandton, 2196 Tel. No.: 011 669 1000				
Intermediary:	Dental Risk Underwriting Managers (DRUM) (Pty) Ltd (a juristic representative of FAIS-IT, FSP Number 45810) : 379 Queens Crescent, Sunwood Office Park – Building 2, Lynnwood, Pretoria, 0081 Tel. No.: 0861 843 842. DRUM only works through registered FSB Intermediaries. When applying on line, the Intermediary will be Thethani Administration a juristic representative of FSP45810.				
Administrator:	Dental Risk Company (Pty) Ltd acting on behalf of the Underwriting Manager and Guardrisk Insurance Company FSP 75. Physical Address: 266 Rose Avenue, Marula House, Centurion, 0046 Postal Address: Postnet Suite 341, Private Bag X2, Raslouw, 0109 Tel. No.: 0861 372 343				
Policy:	Dental Risk Insurance	Premium per month:		R	
Plan Selected:	PRIME	BRONZE	SILVER	GOLD	
This option was selected for the following reason:	Dental cover is required				

Name _____

Date _____

COMPLIANCE WITH THE REQUIREMENTS OF THE FAIS CODE OF CONDUCT

- I understand that only dental cover is being provided, and I shall take care when choosing the products suggested, as only affordability and family cover is being taken into consideration.
- I know that the accuracy and completeness of the information provided remains my responsibility, and not disclosing the correct information could result in claims not being paid and loss of benefits and premiums.
- I have seen and read a copy of the advisor's statutory disclosure. I confirm that only information, and not advice, has been provided to me.
- I understand that there is no refund of premiums in the event of cancelling a policy and that the advisor will be earning commission on the sale of any dental plan. This commission payable will be at a maximum of 20% of the premium I pay.
- I have not been coerced or induced in any way in the exercising of any of my rights.
- I confirm that the application form and/or any other documents (including this document) was fully completed before I signed it, and all information is to the best of my knowledge both true and correct.
- I confirm that I have received a copy of this record of transaction.
- I understand that if my debit order fails to collect, my policy benefits are at risk and it is my responsibility to notify Dental Risk Underwriting Managers (DRUM) on 0861 843 842 or email smile@dentalrisk.co.za as to how to collect arrear premiums. If I don't, my policy may lapse and I will lose my cover and all premiums.

Signature of Principal Member _____

Full Name _____

Date _____