APPLICATION FORM

Membership Enquiries: 0861 843 842 **Claims:** 0861 372 343 / (012) 741 5101 **FSP License Number:** 27838

Applications received after the 15th of a month will result in policy inception being the 1st of the next month

DENTAL RISK INSURANCE

NOTE: ONLY 1 PLAN PER INSURED FAMILY

SACA MEMBERS ONLY

PRINCIPAL MEMBER DETAILS						
Title:		Name:				
Surname:						
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	SILVER Usage	SILVER Cover
Consultations	3 months	4 visits	R660.00
Fillings	3 months	8 fillings	R2 800.00
X-rays	3 months	8 x-rays	R520.00
Extractions	3 months	4 extractions	R1 000.00
Emergency Root Canal	3 months	4	R2 800.00
Root Canal	6 months	2	R3 000.00
Dentures	6 months	1 full set	R3 500.00
Crowns	6 months	2	R12 000.00
Implants	6 months	2	R36 000.00
Wisdom Teeth (chairs)	6 months	2	R16 000.00
Wisdom Teeth (hospital)	6 months	2	R30 000.00
Orthodontist	6 months	1	R25 000.00
Trauma	1 month registration	1	R25 000.00
Concierge Booking Full Service		Included	
Stem Cells: Skin Burn Growth Service		R950 000 skin growth service	

MONTHLY CONTRIBUTION		
Member	Monthly	Number of Persons
Principal	R199.00	
Adult	R153.00	
Child	R98.00	
Mark chosen plan with X		

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					
Child 1					
Child 2					
Child 3					
Child 4					
Child 5					
Child 6					

Signature of Principal Member ____Full Name ____ Date ___________________________

CURRENT AND PRE-EXISTING CONDITIONS							
This refers to current conditions and treatment plans which have commenced before the policy inception date. All current treatment will not enjoy cover on this policy if said treatment, quote, or treatment plan has been accepted by the policy holder prior to the inception date of this policy. With the exception of fillings, crowns and dentures which have a specific benefit periods stated in this document with relation to new claims / post policy inception date claims							
Condition	**Current treatment in progress**				**Last date of treatment**	**Number of teeth treated**	**Beneficiary details**
Fillings	YES		NO				
Extractions	YES		NO				
Root Canal	YES		NO				
Dentures	YES		NO				
Implants	YES		NO				
Crowns	YES		NO				
Wisdom Teeth	YES		NO				
Orthodontist	YES		NO				

PAYMENT INSTRUCTION						
Name of Account Holder:		Monthly Contribution:	R			
ID Number:		Monthly Deduction Date:				
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 Assistance Assurance 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, email or SMS.

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 posted to my requested address in the month after the first premium deduction was successfully done and cleared by the Administrator's Bank. 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 or credit card account each month. This signed Authority and Mandate refers to our contract as dated as 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 indicated above. 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.								
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-UP, FSP Number 45810) : 107 Haymeadow Crescent, Boardwalk Office Park, Unit 1, Block 1, Faerie Glen, Pretoria | Postal Address: Postnet Suite 341, Private Bag X2, Raslouw, 0109 | Tel. No.: 087 231 0200							
Administrator:	**Dental Risk Company (Pty) Ltd** (Accredited at the Council for Medical Schemes) | 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 087 231 0200 or email customercare@thethaniaadmin.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.

HW/03/14 V1

Signature of Principal Member ____Full Name ____ Date ______________________________