Platinum Direct Plus - Day1 Health

The Insured Health Solution – A Stated Benefit Insurance Policy

Personal details (Principal Member)

Surname:		ID Number:	
Title	Dr/Mr/Mrs/Miss	Full Names:	
Employer:		Broker: Profile Corporate Services - 224	

Postal Address:

Code:

Work:	Cell:	Fax:	Home:

Email Address:

Member to be covered

Spouse:		ID No:	
Child 1:		ID No:	
Child 2:		ID No:	
Child 3:		ID No:	
Child 4:		ID No:	

Beneficiary

Name		ID No:	

Additional Information

Are you currently receiving treatment of any medical or dental condition?	Yes	No
Are you concerned about or aware of any condition which may require medical or dental attention?	Yes	No
Are you on any form of medication?	Yes	No
Are you pregnant?	Yes	No
Have you undergone any major operations in the past 5 years?	Yes	No
Are you or your spouse a member of a medical scheme or hospital plan?	Yes	No

Member:
Condition or event:
Medication:

Member:
Condition or event:
Medication:

Monthly Premium	**Section 1 Pre-Paid Preventative**		**Section 2 Hospital Stated Benefit only**		**Both Sections 1& 2 (Complete package)**		
Single Policy	R226.00		R332		R499		
Single + 1 Child	R335.00		R363		R650		
Single + 2 Child	R444.00		R400		R780		
Single + 3 Child	R553.00		R436		R915		
Single + 4 Child	R553.00		R473		R950		
Couple	R390.00		R643		R985		
Couple + 1 Child	R499.00		R679		R1125		
Couple + 2 Child	R608.00		R717		R1260		
Couple + 3 Child	R718.00		R753		R1390		
Couple + 4 Child	R718.00		R790		R1425		

I warrant that I have been provided with all the intermediary, insurers and benefit details, or any additional information as I may have requested. I warrant that all details and facts provided herein are accurate and properly disclosed, even if completed by the intermediary or a representative on my behalf. I understand that the benefits offered are risk benefits only and that there are no surrender values. Failure to pay premiums will result in benefits lapsing. 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 Day1 official for the purposes of resolving the query. In the event of no nominated beneficiary, I agree that necessary burial costs will be paid directly, or to the person who paid for such costs. Thereafter any remaining benefit will be payable to the first claimant with reasonable title to claim any benefits. Finally, I acknowledge that the Day1 Insured Health Plan is not a Medical Aid.

Your chosen Network Provider (applicable to Option 1 only):

Name of Account holder		Name of Bank	
Branch		Branch Code	
Account Number		Account Type	
Inception Date			

I authorise the payroll administrator/Day1 Health to deduct the above premium from my salary/account each month.

_____ _____

Signature of Principal Member Date

_____ _____

Signature of Accountholder Date