LIBERTY

In it with you

Liberty Health Cover Application Form Corporate – New Employee

Important: please read the following before completing this application form

- Please write clearly using capital and block letters.
- It is compulsory to complete all the fields in this form.
- Each page, other than the signature page, is to be initialled by the Principal Member.
- Please submit your completed forms and documents required to our Liberty Health Cover in-country office.
- Existing members who wish to register additional dependant(s) at a later stage, should please complete the Liberty Health Cover Amendment Form.

1. PERSONAL DETAILS | PRINCIPAL MEMBER

Last name

First name(s)

Physical address

Title

Date of birth (Y Y Y Y M M D D)

Gender (tick where appropriate) M F

Height (cm)

Weight (kg)

Permanent employment start date (Y Y Y Y M M D D)

Cover start date (Y Y Y Y M M D D)

Benefit Plan (please fill in the Liberty Health Cover benefit plan name chosen. Ask your HR Department if you are unsure.)

Please disclose any known past illnesses / injuries and/or pre-existing medical conditions* which may present / recur / relapse at any time in the future. Please also list (and include associated dates, to the closest year) any previous operations/conditions where admission to hospital was needed.

*Pre-existing condition means any injury, illness, condition or symptom: for which treatment, or medication, or advice or diagnosis has been sought or received or was foreseeable by the Insured Person prior to the policy Commencement Date, or; which originated or was known to exist by the Policyholder (Employer) or the Insured Person prior to the policy Commencement Date whether or not treatment or medication, or advice, or diagnosis was sought or received.

Name of employer

Physical address

Employee code/number

Mobile (please include country and area code) +

Email 1

Email 2

Do you or any of your nominated dependents enjoy cover with any other Health Insurer? Y N

If yes, please complete the following details:

First name and last name of dependant

Name of Health Insurer

Date this cover may cease (Y Y Y Y M M D D)

2. BANKING DETAILS

Please provide your banking details to enable us to refund you electronically for reimbursement of claims paid by you.

Account holder name

Account number

Bank

Branch code

Swift code

Currency code

NIB (if applicable)

Please submit ALL the following documents with this application form to verify your bank details:

1. A certified copy of the account holder's identity document, passport or valid driver's license.
2. If the account holder is not a member of Liberty Health Cover, the principal member must please provide us with a signed letter to give consent to pay the refund into the third party's bank account.

No banking details will be accepted without the abovementioned mandatory documents.

DISCLAIMER:

- I agree to advise the Insurer in writing, in the prescribed form, of any changes to my banking details.
- I understand that failure to do so will result in me being liable for any subsequent banking charges or other costs/losses incurred due to the use of the incorrect banking details.

Signature of Account Holder

Employer Group Representative Details

Full name and surname

Designation

Signature

Date Y Y Y Y M M D D

Company Stamp
(This stamp is a mandatory requirement)

3. REGISTRATION OF DEPENDANTS

Should you wish to add more dependants, please provide the necessary information on a separate page.

Please disclose any known past illnesses / injuries and/or pre-existing medical conditions* which may present / recur / relapse at any time in the future. Please also list (and include related dates, to the closest year) any previous operations/conditions where admission to hospital was needed.

Dependant 1

Last name | Title

First name(s) | Gender M F

Date of birth (Y Y Y Y M M D D) | Relationship to Principal Member

Height (cm) | Weight (kg)

State any pre-existing medical conditions*:

Dependant 2

Last name | Title

First name(s) | Gender M F

Date of birth (Y Y Y Y M M D D) | Relationship to Principal Member

Height (cm) | Weight (kg)

State any pre-existing medical conditions*:

Dependant 3

Last name | Title

First name(s) | Gender M F

Date of birth (Y Y Y Y M M D D) | Relationship to Principal Member

Height (cm) | Weight (kg)

State any pre-existing medical conditions*:

Dependant 4

Last name | Title

First name(s) | Gender M F

Date of birth (Y Y Y Y M M D D) | Relationship to Principal Member

Height (cm) | Weight (kg)

State any pre-existing medical conditions*:

Dependant 5

Last name | Title

First name(s) | Gender M F

Date of birth (Y Y Y Y M M D D) | Relationship to Principal Member

Height (cm) | Weight (kg)

State any pre-existing medical conditions*:

I

(Name of Principal Member)

certify that the persons whose names appear above, are my legal, registered dependants to be included under my Liberty Health Cover. I am aware that any false representation of any person as my dependant will result in me and all my dependants being removed from Liberty Health Cover, and I will be liable for any cost incurred for health services provided. I further certify that I have read, understood and agree to all the information in the Declaration by Principal Member (Corporate Application) on page 4.

Signature of Principal Member

Date signed (Y Y Y Y M M D D)

DECLARATION BY PRINCIPAL MEMBER (Corporate Application)

1. I, the principal member, hereby apply to have my nominated dependants sign up for Liberty Health Cover.

2. I understand that this application, together with any supporting documents and the Liberty Health Cover Policy Conditions, form the basis of my contract with the Insurer.

3. Declaration in respect of my living-in partner (if applicable): I confirm that my partner and I are in a committed relationship akin to a marriage based on mutual dependency and a shared household.

4. **Liberty Health Cover Policy Conditions and benefits**
   a. I agree that I, and my dependants, will be bound by the Liberty Health Cover Policy Conditions and will abide by them.
   b. The Insurer shall not be bound in any way by any representations or undertakings made or given by any person save as contained in the Liberty Health Cover Policy Conditions.

5. **Exclusions**
   a. I understand that the Insurer may impose exclusions in respect of myself and / or any of my nominated dependants. This may include one or more of the following:
      - A Waiting Period of up to 24 months applicable for a specified condition, benefit limit (including maternity), avocation, occupation or general health status.
      - Lifetime exclusion of cover in respect of a specified condition, avocation or occupation.
      - Declining of cover.
      - Three-month condition-specific waiting period for COVID-19 treatment (in and out-patient treatment).
   b. I accept any such exclusion that may be imposed in terms of the Liberty Health Cover Policy Conditions.

6. **Banking Details**
   a. I agree to advise the Insurer in writing of any changes to my banking details.
   b. I understand that failure to do so will result in me being liable for any subsequent banking charges or other costs / losses incurred due to the use of the incorrect banking details.
   c. I agree that I am liable for any loss that may arise as a result of me providing the wrong bank account details in the Liberty Health Cover Bank Details section of this form.

7. **Premiums and any other amounts owed to the Insurer**
   a. I acknowledge that it remains my responsibility to ensure that any amounts due by me to the Insurer are paid to the Insurer.
   b. I agree that any amounts owing by me as a result of claims debt must be paid to the Insurer.
   c. I also accept that I will be responsible for any costs associated with the recovery of any debts.

8. **Disclosure of information**
   a. I confirm that I have the necessary authorisations to disclose the information that the Insurer may require and provide the necessary authorisations in respect of my nominated dependant(s).
   b. I confirm that the information provided in this application, and in any other documents submitted in support of this application, is true, correct and complete and that I have not withheld, concealed or misstated any information, including any information that the Insurer should know to assess my eligibility to receive health insurance.
   c. I furthermore confirm that I understand that my membership will become null and void should the above statement be found to be incorrect and that in such an event, all monies paid in respect of my membership shall be forfeited and that the Insurer shall furthermore be entitled to recover any amounts paid for services rendered from the provider and/or myself.
   d. I undertake to promptly advise the Insurer of any change in status of health of myself and any of my nominated dependants that occurs prior to the date of registration with the Insurer and acknowledge that the additional information may be subject to underwriting. I acknowledge that not doing so may lead to the Insurer reconsidering the basis of my membership application.
   e. By signing the above agreement, I hereby and expressly consent to indemnifying Liberty Health Cover, its agents and/or administrator against any claim, of whatsoever nature, which may be made against any of them; arising from, as a result of or in connection with the disclosure(s) of any medical information in fulfilling this agreement.
   f. I irrevocably authorise any medical practitioner, hospital, medical institution or other person to disclose information about my own, or my nominated dependants' health status to the Insurer or any entity contracted by the Insurer in order to fulfil its functions, duties and obligations in terms of this agreement and I agree that this authorisation shall remain in force after my/their death(s).
   g. I authorise the Insurer to collect, process and share my personal information and that of any nominated dependants(s) with any entity, ***including any foreign entity***, contracted by the Insurer in order to fulfil its functions, duties and obligations in terms of this agreement, agree that this authorisation shall remain in force after my/their death(s) and understand that this may partially limit my/their right to privacy.

9. **Cancellation**
   a. I acknowledge that upon cancellation of my policy, any amounts owing to the Insurer will be deducted from any amounts due to me.
   b. I confirm that I, and all my dependants, will cancel any existing health insurance cover prior to commencement on Liberty Health Cover.

10. **Personal contact**
    a. I consent to the use of any of the contact details given in this application to send me information pertaining to my policy (confidential or other).
    b. I undertake to inform the Insurer of any change of address and contact details. The Insurer shall not be held liable as a result of my neglecting to inform the Insurer of any changes to the aforementioned.
    c. I consent to my telephone conversations with the Insurer being recorded and forming part of the Insurer's records. I also agree that such records shall remain the sole property of the Insurer.

11. **Marketing**
    In order to keep you updated on activities about Liberty Health Cover (LHC), we would like to communicate, where necessary, via email or SMS.
    a. Do you wish to receive LHC marketing communications? Y N
    b. If yes, how would you like to receive them? Email Y N SMS Y N
    c. I consent to LHC marketing products, services and special offers being sent to me from time to time. Y N
    d. I consent that any Third Party contracted to perform services relating to Liberty Health Cover may contact Y N