Liberty Health Cover
Application Form (Individuals)

LIBERTY

LIFE INVESTMENTS INSURANCE **HEALTH** PROPERTIES ADVICE

FOR OFFICIAL USE ONLY Policyholder number

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.
- Please submit your completed forms and documents required (see table below) to our Liberty Health Cover in-country office or your financial adviser
- Commencement date will be the first of the month following the date the application is signed (backdating will not be permitted).
- Existing policyholders who wish to register additional dependant(s), should complete the Liberty Health Cover Amendment Form available on www.libertyhealth.net
- Each page other than the signature page is to be initialled by the applicant.
- In instances where a broker completes a form on behalf of the policyholder and material information is not disclosed as the policyholder directed, the policyholder and not the broker will be liable since policyholders are legally required to read, understand and be made aware of the information disclosed in the application forms before they sign such applications.

Please note: Where the applicant is a minor, the parent/guardian must sign and initial the form.

DOCUMENTS REQUIRED FOR REGISTRATION

WHO THIS APPLIES TO	DOCUMENT/S REQUIRED AS PROOF
Your spouse	• Marriage Certificate
Your living-partner	• Proof of Dependency Affidavit stating how long the couple have been living together, which is signed and stamped by a Commissioner of Oaths
Your adopted child / child placed in custody of the policyholder or their spouse or living-in partner	• Copy of the abridged birth certificate • Proof of legal adoption • Proof of custody
Your or your spouse or living-in partner's biological or natural child (including stepchildren)	• Copy of the birth certificate, or hospital confirmation reflecting baby's name (for newborns)
A child dependant due to disability	• Medical report as proof of disability
A child dependant student (up to 25 years of age)	• A dependant who is up to the age of 22 • A dependant up to the age of 25 provided that the policyholder submits proof of studies, e.g., written proof of registration for this dependant

1. PERSONAL DETAILS | MAIN APPLICANT

Please complete in block capitals

Last name

First name(s) Title

Other names

Initials Date of birth Y Y Y Y M M D D

Gender (tick where appropriate) M F

Commencement date of cover Y Y Y Y M M D D

Height (cm) Weight (kg) Smoker Y N

Plan Option (tick where appropriate)

☐ Classic ☐ Classic Evacuation

☐ Classic Roaming ☐ Enhanced ☐ Plus ☐ Elite

Physical Address

Postal Code

Postal Address (if different to Physical Address)

Postal Code

Occupation

Town/Village of residence

Home telephone (please include country and area code) +

Work telephone (please include country and area code) +

Mobile (please include country and area code) +

E-mail

2. BANKING DETAILS

Please complete in block capitals

Account holder name

Account number

Account type ☐ Savings ☐ Cheque ☐ Transmission ☐ Other

Bank

Branch name Branch code

NIB (if applicable) Swift code

IBAN (if applicable)

Signature of Account Holder

3. REGISTRATION OF DEPENDANTS

Please complete in block capitals

Dependant 1

Full Name

Please put the full name that will appear on the Liberty Health Cover membership card

Town/Village of residence

Date of birth Y Y Y Y M M D D Gender M F Relationship to the policyholder

Occupation

Height (cm) Weight (kg) Smoker Y N

Dependant 2

Full Name

Please put the full name that will appear on the Liberty Health Cover membership card

Town/Village of residence

Date of birth Y Y Y Y M M D D Gender M F Relationship to the policyholder

Occupation

Height (cm) Weight (kg) Smoker Y N

Dependant 3

Full Name

Please put the full name that will appear on the Liberty Health Cover membership card

Town/Village of residence

Date of birth Y Y Y Y M M D D Gender M F Relationship to the policyholder

Occupation

Height (cm) Weight (kg) Smoker Y N

Dependant 4

Full Name

Please put the full name that will appear on the Liberty Health Cover membership card

Town/Village of residence

Date of birth Y Y Y Y M M D D Gender M F Relationship to the policyholder

Occupation

Height (cm) Weight (kg) Smoker Y N

Dependant 5

Full Name

Please put the full name that will appear on the Liberty Health Cover membership card

Town/Village of residence

Date of birth Y Y Y Y M M D D Gender M F Relationship to the policyholder

Occupation

Height (cm) Weight (kg) Smoker Y N

Please see the descriptions of the type of relationship to the policyholder in the first column, first table, page 01 of this document.

4. PERSONAL DETAILS - MAIN APPLICANT AND DEPENDANTS

Please complete in block capitals. Please order dependants from oldest to youngest when completing the photo section below.

To register you and your dependants on Liberty Health Cover, please fill in all the details below. Please attach a photograph of yourself (Main Applicant) and photos of your dependants to this page. Please note that all photographs should have the name of the person written on the back of the photo.
Please note that these photos will not be returned to you.

MAIN APPLICANT

NAME

DEPENDANT 1

NAME

DEPENDANT 2

NAME

DEPENDANT 3

NAME

DEPENDANT 4

NAME

DEPENDANT 5

NAME

I

(Name of Main Applicant)

of

(Address)

certify that the persons whose names and photographs 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.

Signature of Main Applicant

Date signed Y Y Y Y M M D D

5. HEALTH STATEMENT

Please complete in block capitals. All sections below must be completed - failure to do so will delay processing of this application.

Note: If you answer "YES" to any of the questions in this section, and if the space provided to complete your answer is not sufficient to disclose the necessary information, please provide the additional information on separate pages.

Name and last name of current family doctor

Telephone

How long has he/she been your doctor? year(s)

Postal address

Postal code

Have you or any of your nominated dependants received medical advice, care or treatment for any of the following?

1. Heart & Circulation	e.g. Chest pain/Angina; Heart attack; Heart failure; Heart valve defects; Rheumatic fever; High blood pressure (Hypertension); High cholesterol; Heart murmurs; Circulatory problems/disorders; Varicose veins; Deep Vein Thrombosis (DVT) or any other heart or circulatory problems.	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

2. Breathing & Respiratory	e.g. Asthma; Difficulty with breathing; Bronchospasm; Tuberculosis (TB); Coughing up blood; Emphysema; Pneumonia; Cystic Fibrosis; Chronic bronchitis; Shortness of breath or any other respiratory problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

3. Bladder & Kidneys	e.g. Blood in urine; Kidney failure; Polycystic kidneys; Kidney or bladder infections; Kidney removal (Nephrectomy); Kidney stones; Abnormal kidney or urine tests or any other bladder or kidney problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

4. Reproductive Organs	e.g. Endometriosis; Infertility; Ovarian Cysts; Hysterectomy; Abnormal pap smears; Cervix or breast biopsies; Fibro-adenosis of the breast; Laparoscopies; Hormone Replacement Therapy (HRT); Prostate infections or surgery; Prostate enlargement or any other reproductive problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

5. Digestive System	e.g. Duodenal ulcers; Gastric ulcers; Hiatus hernia; Colon problems; Crohn's Disease; Ulcerative colitis; Gall bladder problems; Pancreas; Liver problems or any other digestive system problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

6. Ear, Nose & Throat	e.g. Deafness; Ear infections; Sinus problems; Nasal surgery; Throat surgery; Orthodontics; Dental surgery; Speech impairments; Harelip; Cleft palate or any other nose or throat problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

7. Eyes	e.g. Blindness (partial or full); Eye surgery; Lens implants; Cataracts; Glaucoma; Retinitis Pigmentosa; Retinal detachment; Impaired vision or any other eye or eyesight problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

8. Endocrine	e.g. Diabetes ("high blood sugar"); Underactive thyroid; Overactive thyroid; Thyroid surgery; Cushing's Syndrome; Addison's Disease; Pituitary gland problems or any other endocrine or glandular problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

9. Back & Muscles	e.g. Neck or back problems or operations; Recurrent back pain; Osteoporosis; Ankylosing Spondylitis; Rheumatoid arthritis; Osteoarthritis; Paget's Disease or any other bone or skeletal disorders	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

10. Neurological	e.g. Epilepsy; Stroke (CVA); Migraine; Brain injuries; Spinal cord injuries; Paralysis; Cerebral palsy; Multiple Sclerosis; Mental retardation; Narcolepsy; Motor Neuron Disease; Parkinson's Disease; Alzheimer's Disease or any other neurological problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

11. Psychological	e.g. Depression; Anxiety; Psychosis; Suicide attempts; Bipolar disorders; Manic depression; "Stress"; Schizophrenia; Tourette's Syndrome; Anorexia Nervosa; Received advice, counselling or treatment for alchohol or drug abuse; Attention Deficit Disorder, Bulimia or any other psychological problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

12. Tumours & Growths	e.g. Benign or malignant growths or lumps or tumours including but not limited to: Melanoma; Lymph gland cancer; Leukemia and breast cancer or any other tumours, growths and cancers	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

13. Blood	Blood or bleeding disorders, e.g., Haemophilia; Christmas factor deficiency; Platelet or any other blood clotting disorders	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

14. Skin	e.g. Eczema; Acne; Dermatomyositis; Pemphigus; Psoriasis; Scleroderma or any other skin disorders	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

15. Sexuality Transmitted Infections (STIs)	e.g. Advice, treatment or counselling for any of the following: HIV/AIDS; Syphilis; Gonorrhoea; Herpes; Genital Ulcers; Pelvic Infectious Disease (PID); Genital Warts; Hepatitis B or any other STIs or disorder	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

16. Pregnancy	Are you or any of your dependants currently pregnant?	Y N
	If the answer to this question is "Yes", when is the expected date of delivery?	Y Y Y Y M M D D
	Name of patient	

17. Other medical conditions	Do you or any of your nominated dependants have any medical condition not mentioned in the above questions 1 to 16? If "Yes", please give details of the condition(s) in the table below.	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

18. Avocations (sport, hobbies, and pastimes)

Have you or any of your dependants participated in, currently participate in, or intend to participate in any hazardous activity, hobby or pastime where there is a possible risk of accident or injury? Y N

18.1 Big game hunting ☐ 18.2 Wrestling, boxing, martial arts ☐ 18.3 Ice hockey ☐

18.4 Jet skiing, water skiing ☐ 18.5 Base jumping ☐ 18.6 Competitive cycling ☐

18.7 Polo (Equestrian) ☐ 18.8 Other activities

If you have answered "Yes" to question 18, please provide the following details:

Avocation	Name of applicant/ dependant	Period and level of participation			
		Current	Intends to	Last 3 years	More than 3 years ago

19. Has a proposal/ application for life, health, dread disease, disability or functional impairment assurance ever been declined, deferred or accepted with certain provisions, e.g, a higher premium, or with exclusions?

19.1 Applicant Y N 19.2 Dependant(s) Y N

19.3 Reasons proposal/application was declined, deferred or accepted with provisions. Please give details of any illnesses/conditions that caused this decision by the Insurer.

Applicant

Dependant

6. TO BE COMPLETED BY FINANCIAL ADVISER

Broker House

Financial Adviser's Broker Code

Financial Adviser's Name and Surname

Commision %

Telephone number (please include country and area code) +

Mobile number (please include country and area code) +

Email address

Signature of Financial Adviser

Date Y Y Y Y M M D D

7. DECLARATION BY MAIN APPLICANT

1. I, the undersigned, hereby apply for myself and my nominated dependants to 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. Acceptance of risk: It is further agreed and understood that, notwithstanding any statement made to the applicant by any person, cover will not commence and no liability whatsoever will attach to the Insurer as a result of this application, unless and until: express written notice of acceptance is given by the Insurer to the applicant; the applicant has signed and returned such written notice; and, the full premium has been paid and received by the Insurer.
4. Declaration in respect of my 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.
5. 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.
6. Exclusions
   a. I understand that the Insurer may impose exclusions in respect of myself and / or any of my nominated dependants.
   b. I accept any such exclusion that may be imposed in terms of the Liberty Health Cover Policy Conditions.
7. 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.
8. Premiums and amounts owed to the Insurer
   a. I hereby acknowledge that any credit extended by the Insurer to myself in terms of the Liberty Health Cover Policy Conditions will become payable in full by the end of the benefit year in which it arose and that interest may be charged on all amounts due and owing to the Insurer.
   b. I acknowledge that it remains my responsibility to ensure that any amounts due by me to the Insurer are paid to the Insurer.
   c. I agree that any amounts owing by me may be off-set against any benefits or payments that may be due to me by the Insurer.
   d. I also accept that I will be responsible for any costs associated with the recovery of any debts.
9. 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.
   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. I indemnify the trustees, agents and administrator of Liberty Health Cover against any claim, of whatever nature, which may be made against them as a result of or arising out of the disclosure 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 irrevocably authorise the Insurer to collect, process and share my personal information and that of any nominated dependants/s with any entity contracted by the Insurer in order to fulfil its functions, duties and obligations in terms of this agreement. I 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.
10. Resignation
    a. I hereby acknowledge that any credit extended by the Insurer to myself in terms of the Liberty Health Cover Policy Conditions will become payable in full upon cancellation of my cover with the Insurer and that interest may be charged on all amounts due and owing to the Insurer.
    b. I further acknowledge that on cancellation of my cover, any amounts owing to the Insurer will be deducted from any amounts due to me.
    c. I understand that according to the Liberty Health Cover Policy Conditions, I may resign my membership of the Insurer on giving 30 days written notice and that all rights to benefits cease after the last day of my membership.
    d. I confirm that I and all my dependants will cease our current health insurance cover prior to commencement of my Liberty Health Cover.
11. Personal contact
    a. I consent to the use of any of the contact details given in this application to send me information pertaining to Liberty Health Cover (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.
    d. I also agree that such records shall remain the sole property of the Insurer.
12. Marketing

    In order to keep you updated on activities at Liberty Health Cover (LHC), we would like to communicate with you, where necessary, via email, SMS or post.

    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 Post 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 LHC may contact me from time to time regarding their products, services and special offers. Y N

Signed at _____ on this_____day of _____20___

Signature of Main Applicant _____
(Guardian/Parent)