



# LIBERTY

*In it with you*

## Liberty Health Cover Affidavit for Special Dependants

### 1. PERSONAL DETAILS | PRINCIPAL MEMBER

Principal member name and surname

Membership number

Date of birth

Dependant's relation to the principal member (e.g., mother, father, sibling etc.)

Select from the below what type of dependency there is and provide details:

1. Financial - please explain in what way are they dependent on you? \_\_\_\_\_
2. Medical - please explain in what way they are medically dependent on you? \_\_\_\_\_
3. Other - If yes, please explain \_\_\_\_\_

### 2. DETAILS | SPECIAL DEPENDANT

Name and surname

Date of birth

Physical address of the dependant (where they stay for most days of the week)

Medical conditions/treatment/medication taken by dependant \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### 3. DISCLAIMER | TO BE SIGNED BY PRINCIPAL MEMBER AND SPECIAL DEPENDANT

**Disclaimer:** Should any of the above information be incorrect or inaccurate, or if any relevant information is found to have been withheld from Liberty, cover for the special dependant will be cancelled from the date cover started. The principal member will then be held liable and will have to pay for any claims costs incurred.

*As part of the application review, we reserve the right to request a medical report from the Special Dependant's regular treating doctor as well as certain blood tests. These will not be funded by Liberty Health.*

*The principal member hereby acknowledges and understands that Liberty Health reserves the right to charge premiums for special dependants that are higher than our standard adult rates should the Fund Manager approve the principal member's request to add a special dependant/s to their policy.*

Signature of Principal Member \_\_\_\_\_

Signature of the affected dependant (over 18 years of age) \_\_\_\_\_

Date of birth