



Healthcare

A division of A.W. Jack & Associates (Pty) Ltd

For Office Use

Date Received:

Date sent to AUA:

Date back from AUA:

Knights Hospiplan Application Form

Surname:		Title:	Inception:
First Names:		Male:	Female:
Postal Address:			
Residential Address:			
Tel (H):		Tel (W):	Fax:
Cell No:		E-Mail:	
Occupation:			
Date of Birth:		Nationality:	
I D Number:		Signature:	

Please let us have the name and address of your general practitioner as well as any specialist you may have consulted.

Doctor's Name:	Specialist's Name:
Address:	Address:
Tel:	Tel:

Health Declaration

State whether you have been treated or are currently being treated for any of the following diseases
If you answer yes to any of the questions below, please give a brief description in the space provided

1	Blood disorders, e.g. anaemia, bleeding ulcers, haemophilia, leukaemia	Yes	No
2	Cancer, growths or tumours whether benign or malignant	Yes	No
3	Cardio-vascular disorders, heart conditions, chest pains, coronary artery disease, high blood pressure, varicose veins, poor circulation	Yes	No
4	Endocrine disorders, e.g. high cholesterol, diabetes, thyroid abnormalities	Yes	No
5	Eye related disorders	Yes	No
6	Gastro-intestinal disorders	Yes	No
7	Gynaecological disorders and obstetric disorders	Yes	No
8	Musculo-skeletal disorders, e.g. arthritis, back problems, gout etc.	Yes	No
9	Neurological disorders, epilepsy etc.	Yes	No
10	Psychological disorders	Yes	No

11	Renal disorders	Yes	No
12	Respiratory disorders	Yes	No
13	Skin disorders	Yes	No
14	State whether you have been treated or been given medical advice for any infectious diseases	Yes	No
15	Are you expecting to receive surgery or treatment during the next 12 months?	Yes	No
16	Have you currently been receiving been receiving medication or treatment for longer than 3 months?	Yes	No

PLEASE READ CAREFULLY! FAILURE TO DISCLOSE MATERIAL INFORMATION MAY RESULT IN IMMEDIATE CANCELLATION

1. Failure to disclose material information or the provision of incorrect information can result in immediate cancellation of this policy.
2. I declare that any false statement in the above application or the non-disclosure of material information will render the Policy and the cover afforded hereby null and void.
3. I hereby authorise any Hospital, Physician or any other person who has attended to, or examined me, to furnish J & A Healthcare or their authorised representatives all information they require in order to facilitate my claim.
4. I hereby acknowledge that any benefits paid out on my/Insured's behalf not covered in terms of the policy will be refunded to J & A Healthcare.
5. I hereby apply for the insurance cover and agree that any benefits due will be payable provided all relevant premiums due are paid in full.
6. I accept that benefits will be payable directly into my nominated Diocese's bank account.
7. I hereby acknowledge that I have not been forced to purchase this policy and do so of my own free will.
8. I authorise Abelard Underwriting Agency to pay the benefits accruing to my nominated beneficiaries.

Signature of Applicant:

Date:

Block 1, Burnside Island
410 Jan Smuts Ave, Craighall Park
PO Box 2991, Pinegowrie, 2123
Tel: +27(011) 886-0100
Fax: +27 (011) 781-1715
www.awj.co.za
leon@awj.co.za

<u>Abelard – For Office Use</u>	
Accept:	<input type="checkbox"/>
Decline:	<input type="checkbox"/>
Date:	
Signature:	

Directors: A.W. Jack (Chairman), S.D. Jack (Managing), R.E. Lane ACII, D.A. Scholtz FCIS
Registration Number 2000/027363/07 VAT Number 4930194313
Licensed Financial Services Provider Number 26/10/8260

Underwritten by:



Licensed Financial Services Provider Number 28

