



Alexander Forbes

DIRECT

ALEXANDER FORBES INSURANCE COMPANY
HOSPITAL CASH PLAN (COVER FOR LIFE)
DIRECT DEBIT APPLICATION FORM

CONSULTANT

[Empty box for Consultant Name]

PLEASE COMPLETE YOUR PERSONAL DETAILS

Form for personal details including Title, Surname, Initials, First Name, ID Number, Postal Address, Telephone No., Cellphone No., Email Address, Company, and Beneficiary.

PLEASE COMPLETE YOUR SPOUSE'S DETAILS

Form for spouse's details including Title, Surname, Initials, First Name, and ID Number.

PLEASE COMPLETE YOUR CHILDREN'S DETAILS (maximum 4)

Form for children's details including Name and Date of Birth for up to four children.

RATES AND BENEFITS

Table with columns for age groups (18-49 and 50-69 years), Individual rates, and Family rates. Includes checkboxes for selection.

(Premiums include 14% VAT, 20% commission and a R 10.00 administration fee)
If you are married and you want to cover your spouse and your dependent children, you must select "Family" cover.
If you are a single parent and you want to cover your children, you must select "Family" cover.

EASY PAYMENT AUTHORITY (We regret that we cannot accept cash, postal orders, cheques, credit cards)

For your convenience, payment of your Alexander Forbes Hospital Cash Plan is by monthly debit order against your bank account. Please indicate which day you would prefer your bank account to be debited (preferably the day on which your salary is deposited): [D][D] of each month. If your preferred debit date falls on a weekend, we will debit your account on the Friday prior to that weekend.

BANK PAYMENTS

You must sign this section so that your premiums can be deducted from your bank account. If this section is not signed, you will not be covered!

I confirm that I understand the details of the Policy. On receipt of my Policy Terms and Conditions and Statutory Notice, I have 30 days to cancel the policy, should I change my mind. I authorise Alexander Forbes Insurance Company or their designated administrator to draw on my bank account (as indicated below) the monthly premium required in terms of the cover I have chosen.

Form for bank payment details including Name of Accountholder, Name of Bank, Branch Name, Branch Code, Account Number, Type of Account, Transmission, Cheque, Savings, and Signatures.

DECLARATION

You should receive your Policy Contract within 30 days from the date that you sent your application to us. However, should you not have received it by then, please call our Communication Centre on 0861 4 26837 and we can arrange to send you a copy.

- 1. I am comfortable that this chosen Plan satisfies my financial needs.
2. My current financial position makes it possible for me to meet the monthly contribution due on this Plan.
3. I undertake to keep AFI informed of changes to any banking details and my address to enable AFI to communicate with me.
4. I understand that the Plan Contract will be issued in English.

I, the undersigned, confirm that I have read this declaration and authorisation and understand the implications.

Signature

[Signature line]

Date

[Date selection grid]

IMPORTANT

Please keep a copy of this application form in a safe place in case you need to claim.
Return via Fax: 0861 268 374 or Email: afdsales@forbes.co.za