

## Option and Detail Change Form

**IMPORTANT NOTE:** Please complete and sign this form and return it to your broker who will submit it to Kaelo on your behalf. Kaelo will only accept applications received by a broker. Applications received after the 15th of the current month will only activate on the 1st of the following month. Kaelo Gap email address: kaelogap@kaelo.co.za.

### A Policyholder Details:

First Name: \_\_\_\_\_  
Surname: \_\_\_\_\_  
ID Number: \_\_\_\_\_ Cellphone: \_\_\_\_\_  
Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Email: \_\_\_\_\_  
Address: \_\_\_\_\_  
Medical Aid Name & Option: \_\_\_\_\_ Medical Aid Number: \_\_\_\_\_

### B Policy Option Updates:

I want to change my Gap Cover to:  
 Kaelo Gap Optima       Kaelo Gap Core

I confirm that I have consulted my broker and understand the Benefits offered by the Gap Cover option that I have selected above.

**NOTE:** No additional waiting periods will apply. The unexpired portion of any existing waiting periods on your current Kaelo Gap Policy will be transferred to your new plan.

### C Declaration:

I, \_\_\_\_\_ (full name) declare that this Option and Change form, whether in my handwriting or not, is accurate and complete and forms the basis of the contract of insurance between the Insurer and myself. I apply for the insurance product/s and agree to abide by its Policy rules and/or those of its Insurer and any amendments which may be made from time to time. I confirm that all the information provided is complete and true and that I have not concealed any relevant information that may affect the evaluation of risk considered under this Policy of cover. I understand that the provision of any false, misleading or missing information could result in my application being rejected, my Policy being cancelled or claims being rejected. Should this occur, I agree to refund all Benefit payments that I have received in relation to this Policy of insurance.

I provide irrevocable authority for Kaelo and its Insurer to obtain any of my or my dependant's medical history from any healthcare provider, Medical Scheme, insurance company or healthcare broker to assess this application for insurance and the underwriting of any future risk or the assessment of any claim that relates to this insurance cover. Premiums due to Centriq are payable monthly. Premiums that are in arrears will result in my Policy being suspended or possibly terminated. If any Policy Benefit becomes payable after or as a result of my death, I provide an irrevocable authority for such Benefits to be paid directly to my surviving Spouse or failing such circumstance to the nominated guardians or trustees responsible for the future care of my minor children or failing either of the preceding events to my estate. Where applicable, I authorise Centriq to draw against the above bank account all amounts due to Centriq in terms of this insurance cover. Should the Insurers adjust the relevant Premiums, I confirm that the adjusted amount may be drawn from the above account subject to the notice period outlined in the Policy document. This request is to remain in force unless cancelled by one month's written notice. Where my employer deducts the Premium from my salary, I provide authority for my employer to deduct such Premiums and pay this across to Centriq. I accept that any notice given to my employer is deemed to have been given to me.

I, \_\_\_\_\_ (full name) agree to the above option change.

I consent to Centriq and its operators processing and further processing my personal information in accordance with the Protection of Personal Information Act to conclude and perform in terms of this insurance contract.

For further information please read our Privacy Notice, which can be found on [www.centriq.co.za](http://www.centriq.co.za)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_