	FOR OFFICE USE ONLY														
Employer No.															
Branch No.															



05.10 1/4

EMPLOYER APPLICATION FORM

A. EMPLOYER DETAILS																																
Please complete in Black Ink and	use lai	ge blo	ck lett	ers. W	here tl	here ar	e YES	S/NO o	questio	ns ma	rk like	this [Y] for	a yes a	and [N] for a	No ar	nswer_	Where	e there	are tic	k box	es, ma	rk wit	h a tic	k.						
Name of employer																																
Legal entity (Pty. Ltd, partn	ershi	p etc.	.)																													
Registration No																																
Owners/Directors Deta	ails																	ID	No.	or P	assp	ort N	lo									
Name and Surname																																
Name and Surname																																
Name and Surname																																
Name and Surname																																
Business Address																Posta	al Ad	dress														
									Co	de						Code																
B. EMPLOYER CONTACT PERSONAL DETAILS - Medical Scheme Liaison																																
											T-10													<u> </u>				_				
Surname	Ļ	<u> </u>	<u> </u>																													
First names (s)													L															Ш				
Initials	Title Gender Are you a member of Mutual Alliance Health Plan? Are you a member of Mutual Alliance Health Plan?																															
Date of Birth	D	D	M	M	Y	Y	Y	Y]	Bran	ch															
Tel (W)	C	0	D	E															(Cell												
Fax (W)	C	0	D	E											•																	
E-mail Address																																
Position / Designation																																
C. BRANCH D	EΤ	AILS	S																													
* Only complete this section				estab	lish c	conta	ct at l	branc	h lev	el an	d plea	ase at	ttach	sepa	rate l	ist if	more	than	3 br	anch	es											
Branch 1 - Name																						Coc	le									
Contact Person																																
Tel No	C	0	D	E										E-m	nail																	
Fax No	C	0	D	E														•						•		•						
Branch 2 - Name																						Coc	le									
Contact Person																																
Tel No	C	0	D	E										E-m	nail																	
Fax No	C	O	D	E																												
Branch 3 - Name																						Cod	le									
Contact Person																																
Tel No	C	0	D	E										E-m	nail																	
Fax No	C	O	D	E																												

D. MEMBERSH	IP DE	TAI	LS																										
Details of your company's em	Details of your company's employee base																												
Number of staff employed by	your con	npany	y, inc	luding	g tem	pora	ry sta	aff ar	ıd sta	ff pa	id	on hour	ly ba	sis															
Total number of main membe	rs to be	cover	ed on	Mon	nentu	m H	ealth	Plan	ı																				
Is Mutual Alliance Health Pla	n compu	lsory	for a	ll emp	ploye	es wi	thin	a spe	cific ;	grouj	рo	of your c	ompa	ny (e	e.g. m	anag	gemen	t etc.	.)						Yes	L	<u> </u>	No	
If "YES" Define the	compuls	ory gı	roup																								<u> </u>		\bigsqcup
Is Mutual Al	lliance He	alth Pla	an coi	mpulso	ory for	r all fu	iture	emplo	yees v	vithin	the	e group?													Yes			No	
																		_											
E. OPTION SE	LECT	ľЮ	N (1	Plea	se ti	ick	app	orop	oria	te b	02	xes)																	
Indicate the options appro	ved by	the e	mple	oyer i	for t	he r	espe	ctive	emp	oloye	ee	groups	1																
Champagne																													
Burgundy																													
Turquoise																													
Orange																													
Beige																													
F. BILLING ME	ETHOL	D																											
Quarterly in Advance OR Yearly in advance																													
Monthly statement required				Щ	day	y of t	he m	onth	(Sele	ct 15	th	or 21st)																	
Breakdown of billing required	l			Щ	On	e sta	teme	nt fo	r enti	re gr	ou	ıp																	
Detail in billing statement required					Yes	s	L		No																				
																		_											
G. PAYMENT D	ETAI	LS																											
Debit Order	YI	ES																											
Name of Bank														I	Branc	ch													
Account type														I	Branc	ch Co	ode				-			-	-		-	_	
Name of Account holder		\sqcup	_									_																L	
Account Number The Scheme may debit this ba	nk accou	int wi	ith th	e amo	ount o	due i	n teri	ms of	this	agree	em	ent, who	ereve	r it m	ay bo	e con] ducte	d in a	accor	dan	ice wi	ith							
the Scheme's debit order syste	em. We f	urthe]		advis	e the	Sch	eme i	n wri	ting	of	any cha	nges	whic	h may	y occ	ur												
Cheque We hereby agree that, if sent by ma	ail, the Po	st Offic	ce bec		our ag	ent ar	nd tha	t we a	ıre lial	ole for	r th	ne consequ	uences	of lat	te or n	on- re	eceipt (of pay	ment	by tl	he Sch	eme							
Electronic Funds Transfer (EFT)			YE	ES																									
Authorised signatory (ies)			_																										
N ()			_					<u> </u>	I	I	<u> </u>	<u> </u>]]					<u> </u>	<u> </u>	1	<u> </u>	_		<u> </u>	_	=	\dashv
Name (s)			<u> </u>								<u>L</u>] 1									+	<u> </u>		\vdash	\vdash	\boxminus
Designation (s)		Ш													J														

H. COMMENCEMENT OF MEMBERSHIP

We hereby apply for our membership to commence on

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I. TERMS AND CONDITIONS

- 1. As a participating employer we hereby apply for our membership for our employees of the Mutual Alliance Health Plan ("the Scheme") administered by Momentum Health.
- 2. On behalf of our employees, we accept the benefits provided for in terms of the Rules of the Scheme and we agree to be bound by such rules, especially in terms of notice period of cancellation requirements.
- 3. We warrant the correctness of the statements and information contained in this application.
- 4. We consent to our employees and their listed dependants participating in this agreement, to submit medical examinations and tests the Scheme may request.
- 5. We acknowledge that all information pertaining to employees is confidential and we undertake to respect confidentiality in so far as this confidentiality is determined by the Scheme in its sole discretion at all times.
- We undertake to pay the full contributions to the Scheme in advance as per scheme rules, unless indicated otherwise in the service level agreement signed between the employer and the Scheme.
- 7. We acknowledge that the Scheme reserves the right to cancel membership if any of the contributions are not paid on the due date. The Scheme shall have the right to suspend all benefit payments in respect of claims which arose during the period of default.
- 8. We understand that the Scheme assumes no liability for any employee until such time as notice of acceptance of the risk is given by the Scheme.
- 9. We undertake to give the Scheme immediate written notice should any changes material to this assessment of this application occur before the date upon which the Scheme grants written acceptance. This will enable the Scheme to reconsider the terms of acceptance.
- 10. We understand that we may terminate our participation with the Scheme on giving three (3) months written notice in advance.
- 11. We acknowledge that should this application be submitted via the internet it is solely for the purposes of convenience and neither our employees, ourselves or the Scheme (subject to its sole discretion) shall rely on the information herein contained without us providing the Scheme with a signed hard copy of this application. We further agree that the hard copy submitted pursuant to an Internet application shall constitute an offer on our part for membership of our employees to the Scheme.

Signed at							th	is [day	of								2	0	0	
Authorised signatory (ies)																							
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													1 1	,	,								
Name (s)		T																					
Designation (s)																							

J. INTERMEDIARY DETAILS

FOR OFFICE US	ΕO	NLY	Y																									
Broker Name														Code								Com	m Spli	it				%
														Code								Com	m Spli	it				%
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Broker House														Code	. [Ī						Com	m Spli	it		T	_ (%
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Broker Consultant														Coa	e (Off	ice u	ise)											
Signature of intermediary (in	es)																											
Underwriting criteria/results	;																											
Window period																												
Rules pertaining to employe Membership Cards	r gro	oup] D	irect	to en	mploy	er						De	liver	to br	rokei	•										
																												\neg
Other specific requirements																							H		\dashv	\dashv	+	\dashv
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