

KELLY GROUP ELECTIVE INSURANCE BENEFITS APPLICATION FORM

Details of Applicant

First Names: Surname:
 Identity Number: Date of Birth:
 Employer:..... Contact no.
 Employee no.: Mobile No.:
 Temp Employee:..... Permanent Employee.....
 Next of kin: Contact No.
 Postal Address;.....
 Date/Month of first contribution:.....
 (Permanent employees please submit your application before the 10th of the month if you wish cover to begin on the first day of the coming month)

ELECTIVE INSURANCE COVER	MONTHLY RATE For monthly paid employees	WEEKLY RATE For weekly paid employees	BENEFIT TICK COVER SELECTED
FUNERAL PLANS The plan offers a lump sum benefit to assist with funeral costs. Funeral Plan Funeral Plan – Member only Funeral Plan – Member only Funeral Plan – Member only	R11.00 R14.00 R20.00	R2.75 R3.25 R5.00	R7 500 Funeral Cover <input type="checkbox"/> R10 000 Funeral Cover <input type="checkbox"/> R15 000 Funeral Cover <input type="checkbox"/>
Funeral Plan A – Member & Family Funeral Plan	R30.00	R7.50	R15 000 Member <input type="checkbox"/> R15 000 Spouse R10 000 Children 14-21 years R 7 500 Children 6 – 13 years R 5 000 Children 0 – 5 years R 1 000 Still birth
Funeral Plan B – Member & Family Funeral Plan	R21.00	R5.25	R10 000 Member <input type="checkbox"/> R10 000 Spouse R 7 500 Children 14-21 years R 5 000 Children 6 – 13 years R 3 000 Children 0 – 5 years R 1 000 Still birth
Funeral Plan C– Member & Family Funeral Plan	R16.50	R4.15	R7 500 Member <input type="checkbox"/> R7 500 Spouse R5 000 Children 14-21 years R 3 500 Children 6 – 13 years R 2 500 Children 0 – 5 years R 500 Still birth

If you have elected any of the family cover options above, please complete below where applicable providing full names:

Spouse name _____ i.d. no: _____
 Child name _____ i.d. no: _____
 Child name _____ i.d. no: _____
 Child name _____ i.d. no: _____

Cover is not extended to siblings, relatives, parents and children over the age of 21 years.

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ELECTIVE INSURANCE COVER	MONTHLY RATE For monthly paid employees	WEEKLY RATE For weekly paid employees	BENEFIT TICK COVER SELECTED
HOSPITAL CASH PLAN – Member only cover If you are hospitalised due to an accident, injury or illness, the plan will pay you out a benefit for each day that you are in hospital. Cash payment benefit for hospitalisation as a result of illness will only be covered after the third day in hospital. Cash benefit payment for hospitalisation as a result of an accident or injury will proceed on the first day of admission.	R11.00 R22.00 R33.00 R44.00 R56.00 R84.00	R2.75 R5.50 R8.25 R11.00 R14.00 R21.00	R100 Per day Hospital Cover <input type="checkbox"/> R200 Per day Hospital Cover <input type="checkbox"/> R300 Per day Hospital Cover <input type="checkbox"/> R400 Per day Hospital Cover <input type="checkbox"/> R500 Per day Hospital Cover <input type="checkbox"/> R750 Per day Hospital Cover <input type="checkbox"/>
HOSPITAL INDEMNITY PLAN – Member only cover If you are hospitalised due to an accident only, the benefit will pay you any costs that are not recoverable from your medical aid including ambulance fees. This cover is highly recommended for temporary employees that do not have any type of medical aid cover. The benefit reimburses any expenditure incurred as a result of the hospitalisation from an accident directly to the member. An accident as a result of member being intoxicated will not be covered.	R26.00 R33.00 R36.00	R6.50 R8.25 R9.00	R50 000 Accidental Cover <input type="checkbox"/> R100 000 Accidental Cover <input type="checkbox"/> R200 000 Accidental Cover <input type="checkbox"/>

Declaration:

I declare that I have not withheld any information and I accept that this application and declaration shall be the basis of the Contract of Insurance between me and Constantia Insurance Company Limited and Constantia Life (hereinafter called Constantia) which will become effective on the first day of the period for which premiums are paid. Having applied for this Policy and on acceptance of my application by the Insurer, I hereby irrevocably authorise my employer to deduct from my weekly/monthly salary the premium as quoted. Should the relevant premium be adjusted by Constantia or should I request Constantia to increase/decrease the premium for whatever reason I confirm that the adjusted amount be deducted from my salary. Such authorisation shall remain in force and effect until cancelled by myself, in writing with one calendar months notice. I, the client am satisfied that a financial needs analysis has not been completed. I further understand and acknowledge that absence of a financial needs analysis could have the effect that all my financial needs may not be addressed properly.

General Conditions

No provision or condition of the policy may be waived, altered or varied except in writing or by endorsement on the policy under the signature of an authorised official of Constantia. In addition, no act or omission to act by Constantia or any officer, employee or servant of Constantia shall be deemed to be a representation on behalf of Constantia upon which the insured's heirs, executors or assigns is entitled to act. This policy is issued on the basis that the statements and information made and set forth in the proposal and/or all declarations made in respect thereof are true and correct. Notwithstanding anything contained in the policy document, the policy and all its provisions are and shall be at all times, subject to such limitations as may be imposed from time to time by any Act of Law of the Republic of South Africa.

1.1 Restriction free

The policy is free from all restrictions to residence, travel and occupation unless otherwise stated herein or as endorsed.

1.2 Currency and Law

All amounts payable in terms of the policy, whether premium payable to Constantia, or benefits payable by Constantia, are expressed and payable in the lawful currency of the Republic of South Africa. Any question of law arising under or in respect of the policy shall be decided according to the laws of the Republic of South Africa.

1.3 Beneficiary

The owner of the policy may, in writing to Constantia, nominate a beneficiary or beneficiaries to receive the proceeds of the policy following upon the death of the owner. The owner of the policy may change or withdraw such nomination at any time. Any such nomination or change thereof or withdrawal thereof shall not be binding on Constantia unless made in writing in such form as Constantia may require and recorded by Constantia. In the absence of any beneficiary nomination, the proceeds of the policy will be paid to the Estate of the owner.

1.4 Premium payments

The policy shall not be binding until the first premium has been paid and received by Constantia. All premiums are payable to Constantia commencing on the date of commencement and thereafter at the intervals stated in the Schedule. A grace period of one calendar month will be allowed for the payment of each premium after the first. Unless stated otherwise elsewhere in this policy, the policy will automatically lapse, or become paid up, if a premium has not been paid upon the expiry of the grace period.

1.5 Termination of policy

A full month's calendar notice is required to terminate this policy. Premiums are not refundable on cancellation or termination of this policy.

1.6 Dependants and Spouse

Refers to the Kelly Group employee's wife/recognised partner and natural children. This cover does not include parents and extended family.

CONSTANTIA INSURANCE COMPANY LIMITED

Contact Details Unit 1 Tulbagh 360 Oak Avenue Randburg 2194
 PO Box 3518 Cramerville 2060
 For complaints and Compliance Officer of Constantia Insurance Company Limited, please call 011 789 3342
 Underwritten by Constantia and Constantia Life

Signed at.....

Name

Signature.....

Date.....

Conditions

This application will not constitute a policy unless accompanied by an acceptance letter and a policy schedule. Constantia agrees and undertakes to pay the benefits described in the policy and schedule, subject to:

- The actual receipt at its head office of the total premium due and payable;
- In the currency of the Republic of South Africa;
- The accuracy of the information given in the insured's declaration in the proposal and policy applications;
- The terms and conditions contained in the policy or endorsed hereon;
- The declaration being made without qualification; and
- The policy having commenced in terms of the application.

Signature of Applicant:..... Date.....

(Temp Employees only) Branch Manager Name: Date.....

Division:..... Signature:.....

Permanent Employees Please fax your application form to Grace Mbedzi 088 011 722 8008 or email Grace.mbedzi@kellygroup.co.za tel 011 722 8008

Temp Employees Please fax your application form to Nomali Khumalo 088 011 722 8261 or email Nomali.khumalo@kellygroup.co.za tel 011 722 8261

For Claims contact Ambleedown on 0861262533. For further information on cover, conditions excluded from cover (hospital cash and hospital indemnity plans only) or if you require to view a copy of the policy document for either of the above benefits, please request from Grace Mbedzi.

PLEASE ENSURE YOUR FORM IS FULLY COMPLETED FOR YOUR APPLICATION TO BE PROCESSED. ALSO RETAIN A COPY OF YOUR APPLICATION.