HEALTH PROFESSIONALS GROUP
Your Needs, Our Responsibility

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Application: HPG Legal Defender Package

PERSONAL DETAILS:

Title: _____Full Names: _____

Surname: _____

Residential Address:

_____

_____

_____ Code: _____ Postal

Address:

_____

_____

_____ Code: _____

Id number: _____ Passport

Number: _____

APPLICANTS CONTACT DETAILS:

Tel: (w) _____ (h)_____

Cell: _____

Email: _____

INSURED PERSONS:

Spouse:

Title: _____Full Names: _____

Surname: _____

Identity Number: _____

Cell: _____

DEPENDENT CHILDREN:

Surname:	Full Names:	Id number:	Gender:

EMPLOYMENT DETAILS:

Company Name: _____

Industry: _____

Department: _____

Personnel/Salary number (if Government) _____

Pay point (if applicable) _____

PAYMENT DECLARATION:

R166.60 per month membership fee

A once-off activation fee of R100.00 is payable and will be deducted with your first premium

I, _____ the undersigned hereby authorise and mandate Legal Defender to deduct monthly with effect from _____20_____ the premium of R_____, from my bank account, in terms of this instruction using NAEDO and tracking for however many days and to remit to Constantia Insurance Company Limited until such time as I cancel this authorisation in writing, or until such time as I substitute it with a new authorisation. Should my monthly deduction date selected fall on a public holiday or weekend, I authorise Legal Defender to debit my account on the previous working day. Should the relevant total premium be adjusted by Legal Defender as a general increase or should I request Legal Defender to upgrade or downgrade my policy selection which affects the premium payable, I confirm that the adjusted premium may be deduction from my account monthly until such time as I cancel this authorisation. Furthermore, I authorise Legal Defender to perform the necessary verification, validation and correction of the debit order details, supplied by me, with my bank or other third parties to ensure that the application form can be processed.

BANKING DETAILS

Account Holder Name: _____

Bank Name: _____

Account Number: _____ Branch

Code: _____

Type of Account: Cheque ☐ **Savings** ☐ ☐ **Transmission**

Date of deduction: 1 ☐ **month end** ☐

☐ **15** ☐ **20** ☐ **25** ☐ **28** ☐

_____ _____

Signature of Account Holder **Date**

Authorisation to request information

I, the undersigned _____

Identity number _____

Hereby authorize Constantia Insurance Company Limited and or Abacon Bluestar or any member of their staff to obtain any information on my behalf regarding my insurance portfolio, my assurance and/or investment portfolio, and any of my employee benefits, from any life office, retirement fund or other financial institution.

I hereby give consent to any financial institution or employer in possession of information regarding my insurance-, investment-, and employee benefits portfolio to release that information upon request to the person who is in terms of this document entitled to request it.

It was explained to me, and I understand, that this consent may possibly have a restricting influence on my constitutional right to privacy. This authorisation shall remain valid for 6 months (180 days) from date of my signature.

2. Appointment of new official care intermediary

I further request the financial institutions with whom ABACON Bluestar has a sales agreement, to indicate the business on their records as my official care intermediary. I have been properly counselled on the consequences of this letter of appointment.

Client signature _____

DECLARATION

I hereby declare that the information above is true and correct to the best of my knowledge

The application has been completed in full at the time of signature and the signature that appears on this document is mine.

I have made an informed decision after fully understanding the benefits offered, to sign up for this policy and was not forced or coerced in any way.

I acknowledge that all the legal benefits are subject to the terms and conditions of the specific product guide and including any alternations or amendments thereto that might be made from time to time.

I accept that I will not qualify for any benefit contained herein should my premium not be paid up to date.

STATEMENT

I/we acknowledge that the sharing of claims information (including credit information) with insurers is essential to enable the insurance industry to underwrite policies and assess risks fairly and to reduce the incidence of fraudulent claims in the public interest, and with a view of limiting premiums. On my behalf of a person I represent herein, I/we waive any right to privacy and any insurance information provided by me may be verified against other legitimate sources and databases. I/we also waive any rights to privacy and consent to disclosure of any information relevant to any insurance policy or claim concerning me.

I/we agree that if any legal claim lodged under any policy issued by Constantia Insurance Limited to me/us or any person or company on my/our behalf be in any respect fraudulent, or if any fraudulent means or devices be used by me/us or anyone actioned on my/our behalf or with knowledge or consent to obtain any benefits under this policy, or if any event be occasioned by the willful act or with the convenience of me, to bring the benefits afforded under this policy in respect of such claim, shall be forfeited.

I/we declare that the proposal / application contains full details of the risk and is complete and true and correct in every respect. I/we agree that this application and the declaration form the basis of the contract between me and Constantia Insurance Company Limited. Further I/we understand that if any fraudulent information is provided or any fraudulent means or devices be used by me or on my behalf to obtain cover, the cover / benefit will be inoperative as from the inception and any premiums paid shall be forfeited.

_____ _____

Signature of account holder **Date**