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Total Risk Administrators (Pty) Ltd (TRA)
an authorised financial services provider
FSP No 40815

Female CANCER COVER 2027

OPTION CHANGE FORM



FEMALE CANCER COVER

PRODUCT	GRAND	SUPREME	ULTIMATE
LUMP SUM PAYOUT - A predetermined sum of money paid upon the confirmed diagnosis of one of the following female cancers (paid out only once per Cancer type): Cervical Cancer, Uterine Cancer, Cancer of the Fallopian tubes, Breast Cancer, Ovarian Cancer, Vaginal Cancer and Bladder Cancer.	R50 000 per unrelated occurrence	R100 000 per unrelated occurrence	R150 000 per unrelated occurrence
ACCIDENTAL DEATH BENEFIT - A predetermined sum of money is paid upon the death of the Policyholder, due to an accident.	R5 000	R10 000	R15 000
MONTHLY PREMIUM			
18 - 55 years old	R149	R258	R361
56 - 64 years old	R183	R366	R550
65+ years old	R287	R572	R859

OPTIONAL FOR HIM BENEFIT - conditional upon there being a Female Cancer Cover Policy in place. This is not a stand-alone product.	SELECT	PRIME	PEAK
LUMP SUM PAYOUT - A predetermined sum of money paid upon the confirmed diagnosis of one of the following male cancers (paid out only once per Cancer type): Prostate cancer, Testicular cancer, Penile cancer, Bladder cancer, Male breast cancer.	R25 000 per unrelated occurrence	R50 000 per unrelated occurrence	R75 000 per unrelated occurrence
ACCIDENTAL DEATH BENEFIT - A predetermined sum of money is paid upon the death of the male dependant, due to an accident.	R5 000	R10 000	R15 000
Additional MONTHLY PREMIUM per Policy per month for Optional For Him Benefit			
18 - 55 years old	R 75	R125	R180
56 - 64 years old	R110	R170	R260
65+ years old	R180	R300	R480

For Office Use Only

Broker / Brokerage

Broker Code

ELIGIBILITY

- Female Cancer Cover: **One** female Policyholder per Policy only.
- The Optional For Him Benefit is conditional upon there being a Female Cancer Cover Policy in place (it is not a stand-alone option), and the For Him option will also cover **One** male per Policy only - who is a dependant on the female's Female Cancer Cover Policy - she is the main Policyholder.
- The male dependant on the For Him option should be the female Policyholder's legal spouse or common law partner (common law partners need to provide an affidavit proving cohabitation of at least 12 months).
- Both the main female Policyholder and the male dependant must be at least 18 years old. Child dependants are not covered under this Policy.

SECTION 1: PERSONAL DETAILS

The main member/Female Policyholder must only complete the Full Names, Surname, Option Change Effective From and Identity No/Passport Number fields below. Please also complete any other fields which may have been changed/updated since your original Policy Inception/Join Date.

Med. Aid Membership Number (if applicable)

Med. Aid Inception/Join Date (if applicable) Y Y M M D D

Med. Aid Benefit Option (if applicable)

Option Change Effective from Y Y 0 1 D D

Title

Policy Inception/Join Date Y Y 0 1 D D

First Names (in full)

Initials

Surname

Date of Birth Y Y M M D D

Cell no.

Alt. Contact no.

Email Address

Postal Address

Employer

Identity No.

Passport Number (Only complete if you don't have a valid RSA ID number)

SECTION 2: PRODUCT CHOICE (PLEASE TICK ONE)

	☐ GRAND	☐ SUPREME	☐ ULTIMATE
MONTHLY PREMIUM			
18 - 55 years old	R149 ☐	R258 ☐	R361 ☐
56 - 64 years old	R183 ☐	R366 ☐	R550 ☐
65+ years old	R287 ☐	R572 ☐	R859 ☐

SECTION 3: NOMINATED BENEFICIARY DETAILS

PLEASE NOMINATE A BENEFICIARY IN THE CASE OF THE ACCIDENTAL DEATH OF THE MAIN FEMALE POLICYHOLDER. THE BENEFICIARY WILL RECEIVE THE LUMP SUM PAYOUT APPLICABLE TO THE ACCIDENTAL DEATH BENEFIT, DEPENDANT ON PRODUCT CHOICE.

IMPORTANT: IF THE MAIN MEMBER DOES NOT NOMINATE A BENEFICIARY, THE POLICY BENEFIT DEFAULTS TO THE SPOUSE. IF SUCH PERSONS ARE NOT AVAILABLE, THE INSURER PAYS THE PROCEEDS TO YOUR ESTATE.

1. Spouse/Common Law Partner/Primary Beneficiary: I nominate my Spouse to receive the insured amount.

Spouse's Full Name

Spouse's ID Number

Spouse's Date of Birth Y Y M M D D

2. Non-Spouse: I nominate the following person to receive the insured amount:

Name

Relationship

Identity No.

Common Law partners need to provide an affidavit proving 12 months of cohabitation for membership to be considered.

If you are married/have a proven long-term common law partner and you have not nominated your spouse as primary beneficiary, please have your spouse provide consent below.

SPOUSE CONSENT: I understand that I have a legal right to a death benefit equal to the participant's entire insured amount. I consent to waive that legal right in accordance with the beneficiary nomination set forth above. I acknowledge that I have a right to limit my consent only to a specific beneficiary and that I voluntarily elect to relinquish such right. I further understand and acknowledge that if I sign this form, no death benefit will be payable to me.

SPOUSE'S SIGNATURE

DATE Y Y M M D D

SECTION 4: OPTIONAL FOR HIM BENEFIT/MALE DEPENDANT

(This is an optional additional product for a male dependant - not compulsory - conditional upon there being a Female Cancer Cover Policy in place. This is not a stand-alone product.) You have to complete section 3 above if you want to complete section 4. If a male dependant is added, his benefits are subject to a 3 month waiting period.

Full Name and Surname	Contact Number	Email Address	ID Number (Passport Number if no valid RSA ID number is available)	Relationship to Main Member

	SELECT	PRIME	PEAK
Additional MONTHLY PREMIUM per Policy per month for Optional For Him Benefit			
18 - 55 years old	R 75 ☐	R125 ☐	R180 ☐
56 - 64 years old	R110 ☐	R170 ☐	R260 ☐
65+ years old	R180 ☐	R300 ☐	R480 ☐

The male dependant on the For Him option should be the female Policyholder's legal spouse (proven with a marriage certificate) or common law partner (common law partners need to provide an affidavit proving cohabitation of at least 12 months).

NB: The Beneficiary for the Accidental Death Cover benefit for this product defaults to the main female policyholder of the TRA Cancer Cover product.

PLEASE NOTE THAT THE THE FEMALE CANCER COVER PRODUCT OPTION AND OPTIONAL FOR HIM PRODUCT OPTION WILL BE DEBITED AS ONE TOTAL PREMIUM AMOUNT.

SECTION 5: DEBIT ORDER DETAILS (PERSON RESPONSIBLE FOR PAYMENT TO COMPLETE)

You only need to complete the banking details if they have changed since your original Policy Inception/Join date.

Bank ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Branch ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Branch Code ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Type of Account Cheque ☐ Savings ☐ Transmission ☐ Other ☐

Debit order date (including December) 1st ☐ 7th ☐ 15th ☐ 25th ☐ 26th ☐

Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Account Holder ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(please specify) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

The abbreviated short name TRA CancerCover is the reference which should appear on your bank statement. Any queries relating to your debit order can be made by calling 011 372 1540.

PLEASE NOTE THAT THE THE FEMALE CANCER COVER PRODUCT OPTION AND OPTIONAL FOR HIM PRODUCT OPTION WILL BE DEBITED AS ONE TOTAL PREMIUM AMOUNT.

SECTION 6: HEALTH DECLARATION

If you are changing to the Ultimate option, or are adding the Optional for Him Benefit, please complete the below:

	Female Policyholder	Male dependant
	I, (Full Name) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐, hereby declare that to the best of my knowledge: (tick the applicable blocks)	I, (Full Name) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐, hereby declare that to the best of my knowledge: (tick the applicable blocks)
1.a)	☐ I have never suffered from Cancer, **OR**	☐ I have never suffered from Cancer, **OR**
1.b)	☐ I have previously suffered from Cancer, as follows: Type of cancer: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Date diagnosed: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Date in remission: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	☐ I have previously suffered from Cancer, as follows: Type of cancer: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Date diagnosed: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Date in remission: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
2.a)	☐ None of my immediate family (biological parents and siblings) currently suffer from or have ever suffered from cancer, **OR**	☐ None of my immediate family (biological parents and siblings) currently suffer from or have ever suffered from cancer, **OR**
2.b)	☐ I am aware of the following immediate family member/s that currently suffers from or has previously suffered from cancer: Type of cancer: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Date diagnosed: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Date in remission: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	☐ I am aware of the following immediate family member/s that currently suffers from or has previously suffered from cancer: Type of cancer: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Date diagnosed: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Date in remission: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
3.a)	☐ I am in good health and there is nothing that could materially affect the application for cover under the Female Cancer Cover Policy, **OR**	☐ I am in good health and there is nothing that could materially affect the application for cover under the Optional For Him Benefit, **OR**
3.b)	☐ I am not in good health and currently suffer from ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐, which could materially affect the application for cover under the Female Cancer Cover Policy	☐ I am not in good health and currently suffer from ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐, which could materially affect the application for cover under the Optional For Him Benefit
4.a)	☐ I am not aware of any pre-existing condition (including for any Cancer) for which I have sought or should have sought medical advice and/or treatment during the 24 months before the join date of this cover, **OR**	☐ I am not aware of any pre-existing condition (including for any Cancer) for which I have sought or should have sought medical advice and/or treatment during the 24 months before the join date of this cover, **OR**
4.b)	☐ I am aware of the following condition, ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐, for which I have sought or should have sought medical advice and/or treatment during the 24 months before the join date of this cover.	☐ I am aware of the following condition, ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐, for which I have sought or should have sought medical advice and/or treatment during the 24 months before the join date of this cover.
	I hereby acknowledge that I have read and agree to the above declaration. _____ Y Y M M D D Signature of Female Policyholder Date	I hereby acknowledge that I have read and agree to the above declaration. _____ Y Y M M D D Signature of Male Dependant Date

If the Policyholder or the Insured male do declare that they were diagnosed with any form of cancer or a relevant pre-existing condition, prior to membership, the Insurer can: 1. Request more information, and has the right to decline cover for membership at its discretion, based upon medical evidence reviewed by an expert committee, who will remain fair and objective on the matter or 2. Accept cover, but subject to all the terms and conditions as stipulated in the Policy document.

SECTION 7: TERMS AND CONDITIONS

- Dependant membership under the For Him option is conditional upon there being a Female Cancer Cover Policy in place. It is not a stand-alone product.
- A 3 month waiting period may be applicable.

When are you not covered under the Cancer Cover policy?

- Where the claim is related in the opinion of the Insurer, directly or indirectly, to any pre-existing condition (including for any Cancer) for which the Policyholder and/or male dependant sought or should have sought medical advice and/or treatment during the 24 months before the join date of this cover.
- Where at the time of applying for cover, the person insured does not complete our declaration of good health.
- Where the Policyholder does not respond to our request for:
  - medical examination for the insured;
  - release of medical records and information.
- Where a claim relates to Cervical Intraepithelial Neoplasia defined by the World Health Organisation as CIN I,II or III.

Refer to the Policy document for a full list of terms and conditions.

SECTION 8: MAIN MEMBER DECLARATION AND CONSENT

	FULL SIGNATURES REQUIRED	
MEMBER HEALTH DECLARATION:	SIGN	Are you or the male dependant (if applicable) expecting surgery or planning hospitalisation or treatment in the next 12 months? ☐ Yes ☐ No If yes, please provide brief details of your planned treatment or hospitalisation:_____ Please note that certain medical conditions and related procedures may be subject to various limitations and waiting periods (see section 7 above).
MEMBER DECLARATION:	SIGN	I have read the terms and conditions above and I am fully aware of the contents thereof.
MEMBER CONSENT:	SIGN	I hereby authorise the disclosure of relevant medical information by my medical aid to Total Risk Administrators (Pty) Ltd ("TRA"). This type of information will typically include my diagnosis and ICD-10 diagnostic code. I understand and acknowledge that my medical information will not be disclosed to unauthorised persons.
PREMIUM BREAKDOWN:	SIGN	**SHORT TERM (ST):** Female Cancer Cover product option: R _____ Optional For Him Benefit product option (if applicable): R _____ Broker Fee (if applicable) R _____ **Total** R _____
USE OF PERSONAL INFORMATION:	SIGN	When you enter into this policy you will be giving TRA your personal information that may be protected by data protection legislation, including but not only, the Protection of Personal Information Act, 2013 (POPIA). We will take all reasonable steps to protect your personal information. You authorise us to: a. Process your personal information to: i. Communicate information to you that you ask us for. ii. Provide you with insurance services. iii. Verify the information you have given us against any source or database. iv. Compile non-personal statistical information about you. b. Transmit your personal information to any affiliate, subsidiary or re-insurer so that we can provide insurance services to you and to enable us to further our legitimate interests including statistical analysis, re-insurance and credit control. c. Transmit your personal information to any third party service provider that we may appoint to perform functions relating to your policy on your behalf. You acknowledge that this consent clause will remain in force even if your policy is cancelled or lapsed. d. Obtain access, make enquiries thereupon and request documentation in relation to your personal and medical information and that of any of your registered dependants, for the purposes of providing insurance services. You also give TRA full authority to perform these tasks as you would have done if you were personally present, with the required power of authority to perform the elected acts expressly granted in this policy. You acknowledge that this consent will remain in force even if your Policy is cancelled or lapsed. The TRA POPIA OVERVIEW can be found here: **https://totalrisksa.co.za/downloads/TRA-POPIA-Overview-2021.pdf**
MEMBER AUTHORISATION:	SIGN	I hereby authorise TRA to deduct an amount of R _____ from my bank account, monthly in advance, for my premiums to the insurance products chosen by me on this application form. Premiums are subject to an annual review. The Insured needs to submit notice of resignation to the Insurer 31 days prior to resignation date and must be received in writing. Details of each withdrawal will be printed on my bank statement, with the reference TRA CancerCover, which will enable me to identify the deduction. **Mandate:** I/We acknowledge that all payment instructions issued by you shall be treated by my/our above-mentioned Bank as if the instructions have been issued by me/us personally. **Cancellation:** I/We agree that although this Authority and Mandate may be cancelled by me/us, such cancellation will not cancel the Agreement. I/We shall not be entitled to any refund of amounts which you have withdrawn while this Authority was in force, if such amounts were legally owing to TRA. **Assignment:** I/We acknowledge that this Authority may be ceded or assigned to a third party if the Agreement is also ceded or assigned to that third party, but in the absence of such assignment of the Agreement, this Authority and Mandate cannot be assigned to any third party.
BROKER AUTHORISATION: (if applicable)	SIGN	I hereby appoint _____ as my healthcare consultant with immediate effect and understand that _____ will supply me with ongoing advisory services with regard to my healthcare solutions and has access to my personal documentation.

Y Y M M D D

NAME AND SURNAME	FEMALE POLICYHOLDER SIGNATURE	PREMIUM PAYER SIGNATURE (if different to Female Policyholder)	DATE

IMPORTANT INFORMATION

Total Risk Administrators (Pty) Ltd (TRA) is an authorised financial services provider. FSP No 40815. Please send this completed form to your intermediary for submission to TRA. Terms and conditions apply. Errors and ommisions excepted. The products reflected above are not medical aids. They are not substitutes for medical aids. They are not the same as medical aids. Consult your intermediary for guidance in choosing the product that is right for your needs. This application form does not constitute advice.

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Administered by:

Total Risk Administrators (Pty) Ltd (TRA), an authorised financial services provider - FSP No 40815

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