DENTAL PLAN APPLICATION FORM

denis INSURANCE ADMINISTRATORS

Application for Membership

Confidential

EMPLOYER INFORMATION

EMPLOYER NAME		DIVISION /DEPARTMENT NAME	
EMPLOYEE NUMBER:		OCCUPATION	
DATE EMPLOYED:		DATE THIS CONTRACT IS TO START:	

PERSONAL PARTICULARS

APPLICANT

TITLE:	**MR**	**MRS**	**Miss**	**DR**
SURNAME:				
FIRST NAMES:				

DATE OF BIRTH

ID NO:

DEPENDANTS (IF ADDITIONAL SPACE IS REQUIRED GIVE DEAILS ON SEPARATE SHEET)

NAME (AND SURNAME IF DIFFERENT)	BIRTH DATE OR I.D NUMBER	GENDER	RELATIONSHIP
1.		**M** **F**	**Spouse** **Child**
2.		**M** **F**	**Spouse** **Child**
3.		**M** **F**	**Spouse** **Child**
4.		**M** **F**	**Spouse** **Child**
5.		**M** **F**	**Spouse** **Child**

CONTACT DETAILS

POSTAL ADDRESS	PHYSICAL ADDRESS (IF OTHER)
POSTAL CODE:	POSTAL CODE:

TELEPHONE NUMBERS:

HOME: AREA CODE:

WORK: AREA CODE:

EMAIL ADDRESS:

CELL NUMBER:

PERSONAL BANKING DETAILS OF APPLICANT – FOR CLAIMS AND PREMIUM COLLECTION PURPOSES ONLY

NAME OF ACCOUNT HOLDER		BANK/ BUILDING SOCIETY	
BRANCH NAME		BRANCH CODE	
ACCOUNT NUMBER		ACCOUNT TYPE	CURRENT TRANSMISSION SAVINGS

MEMBERS 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 myself and Guardrisk Insurance Company Limited which will become effective on the first day of the month of which premiums are paid. I confirm that I am currently a full time member and irrecoverably authorised the Administrators of Dental Cover Holdings (Pty) Ltd to collect from my employer the monthly premium as quoted.

Signature of Applicant **Date**

Please fax the completed application form to Enquiries: 021 528 5878