

ANNEXURE A

NAME:

MEMBER NUMBER:

Important questions that must be answered by the member and information which must be conveyed to the member:

QUESTIONS:

1. When did the pre-existing condition first occur?

2. What is the pre-existing condition?

3. Could you please give us permission to contact the medical practitioner/s for more information if necessary?

4. Who is the doctor who first diagnosed the pre-existing condition? Please provide his contact details.

Name: _____ Tel: _____

5. Please provide the contact details of the doctor who is currently treating you for the pre-existing condition.

IMPORTANT INFORMATION:

1. The member will be covered for all events other than the pre-existing condition for one year from date of application. (Except if the Fund's medical advisor determines otherwise.)
2. Please note that failure to disclose any pre-existing condition could disqualify you from the risk benefits.

ACTIONS BY THE ADMINISTRATOR UPON RECEIPT OF APPLICATION:

1. The Administrator will contact the medical advisor to give his opinion as to what effect the pre-existing condition that was disclosed would affect the risk to the Fund for a one year period after joining.

SIGNATURE: SATU OFFICIAL/CLERK

SIGNATURE: MEMBER

DATE:

DATE: