

Insurer:
Lombard Insurance Company Limited
(Reg. No. 1990/001253/06) FSP no. 1596

Risk and Underwriting Managers:
Turnberry Management Risk Solutions (Pty) Ltd
(Reg no : 2007/026488/07) FSP no. 36571

Broker Name:

Broker Code:

| | | | | |
|---------------------|-----------------|----------------------|------------|----------------------|
| FOR OFFICE USE ONLY | Application No. | <input type="text"/> | Client No. | <input type="text"/> |
| | Policy No. | <input type="text"/> | Debtor No. | <input type="text"/> |

Tel: 011 677 9891 | Fax: 0861 000 508 | Email: newbusiness@turnberry.co.za | Address: 4 Osborne Lane, Bedfordview, 2007

A. DETAILS OF PRINCIPAL INSURED PERSON

Title: First Name: Surname:

ID/Passport No. Date of Birth:

Home Tel No. Cellphone No.

Residential or Physical Addresses:

Postal Addresses:

Email: Medical Scheme:

Medical Scheme No: Option: Date Membership Commenced:

Date of First Employment at Digital Outsource Services: Employee No.

Do you have an existing Turnberry Policy: Yes No If Yes, please supply your Policy Number:

B. MEDICAL EXPENSE SHORTFALL PRODUCTS

THE PRODUCTS OFFERED IN THIS APPLICATION FORM ARE NOT A MEDICAL SCHEME AND THE COVER IS NOT EQUIVALENT TO THAT OF A MEDICAL SCHEME. THESE PRODUCTS ARE NOT A SUBSTITUTE FOR A MEDICAL SCHEME MEMBERSHIP. Please tick your chosen option

Commencement Date: If you are transferring your Policy from another provider please attach your existing policy.

| SYNERGY | LAUNCH |
|---|---|
| <input type="radio"/> R245/month for under 65 yrs | <input type="radio"/> R122/month for under 65 yrs |

C. DEPENDANT DETAILS

Spouse/Partner and children up to the age of 26 years who are registered on the Principal Insured person or Spouse/Partner's Medical Scheme may be added to the Policy at no additional cost

| Name of Dependant | | Identity Number (Date of Birth if no ID No) | Gender M/F | Relationship to Policyholder |
|----------------------|----------------------|--|----------------------|---------------------------------|
| Surname | First Name | | | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

PLEASE NOTE APPLICATION FORMS RECEIVED AFTER THE 10TH OF EACH MONTH WILL ONLY BE LOADED ON THE TURNBERRY SYSTEM AND PLAN COMMENCEMENT DATE OF THE FOLLOWING MONTH

E.

WAITING PERIODS

PLEASE NOTE, New employees joining within 30 days of employment, no waiting periods to apply

Existing employees who wish to join will have full underwriting applied to their Policy as per the brochure.

F.

EMPLOYEE AUTHORISATION FOR DEDUCTION OF PREMIUM FROM SALARY

I, (full name) _____ ID No. _____

I hereby authorise my employer to deduct from my salary my portion where applicable, of the monthly premium, future increases, arrears and any other amount due by me to the Insurer.

DOS DP DGC SGHC SA Holdings

Signature: _____

Date: _____

G.

DECLARATION BY THE PRINCIPAL INSURED PERSON

I have been informed of my rights in terms of the Policyholder Protection Rules to have the following information disclosed to me before entering into any insurance contract: 1) The Statutory Notice; 2) Intermediary's accreditation and mandate confirmation; 3) Mandatory disclosures. I hereby apply for the benefits stipulated in this document, subject to the terms and conditions of the Policy contract and I agree that this application and declaration shall be the basis of the contract between me and Lombard Insurance Company Limited ("Insurer"). I hereby warrant that the answers and statements provided in the application form are true and correct in every particular and that I have withheld no information whatsoever, which is material to or is likely to affect the assessment of the risk under the proposed insurance. I undertake to advise Turnberry in writing if a change takes place in the health of the Insured person/persons between the date of signing the application and the date of acceptance of the risk or the date of commencement of the Policy whichever occurs last. I understand that any inaccurate and untrue statements or failure to notify Turnberry of a change in health prior to the acceptance and/or commencement of the Policy may render my Policy null and void and all premiums paid will be forfeited to the Insurer. I acknowledge that no representation made to me by any agent or employee of the Insurer shall in any way bind the Insurer unless it is thereafter confirmed in writing by the Insurer. I hereby irrevocably authorise a) the Insurer to obtain from any person any information the Insurer needs to which this application relates; b) the person concerned to give the Insurer the information it requests under the authorisation in (a); the Insurer to share with other insurers and the ASISA any information to assess risks or claims. Any information may, under this authorisation, be obtained or given at any time, even after death. I agree that a photocopy or fax of this application form is as effective and valid as the original. If I have an email address for correspondence with Turnberry, I accept the risks of email correspondence and shall not hold Turnberry liable for any loss or damage arising through any unauthorised access to the email correspondence with or any interception of any communication between Turnberry and me.

I acknowledge that should any of my personal and/or banking details change it is my responsibility to ensure that Turnberry are notified of the changes.

I acknowledge that the premium is due monthly in advance on the first day of each calendar month ("due date") and if not received by Turnberry by the 15th day of the following calendar month, then this Policy shall be deemed to have been cancelled at midnight on the due date. I acknowledge and accept that for the purposes of effectively administering my policy and dealing with all other matters related thereto, Turnberry Management Risk Solutions may process and share my and the persons I represent herein private information with Lombard Insurance Company Limited and any associated party, any third party service provider, and/or agent who will assist in the administration and performance of my policy.

Have you been advised of and exercised your free choice to take out insurance with the Insurer and intermediary of your choice? YES NO

I confirm that the product benefits have been explained to me YES NO

Is this Policy replacing a Policy of the same or similar type? YES NO

If "YES", have the product benefits and restrictions been adequately compared and explained to you? YES NO

Signature: _____

Date: _____