Group Formation Form

Agent (if applicable):

1. Group/Company Details

Company Name:

Type of Business:

Correspondence Address:

Physical Address:

Group Administrator Name:

Job Title:

Telephone:

Fax:

Email:

2. Cover Details

Commencement Date: day month year

Cover chosen: NMAS Northern Alliance

Total Initial Number of Staff to be covered:

The Company Will Pay For The following: Employees only Employees and Dependants

4. Expiring Insurance Plan Details

Is Group Currently Insured? Yes No

Name of Insurer:

Current Plan Name:

Expiry Date: day month year

Expiring Underwriting Terms:

Variations to Standard Terms:

5. Premium Payment

Please tick which payment method **You** prefer. (Bank details will be sent to you with your invoice)

Frequency Note that, regardless of payment frequency, all contracts are billed monthly.

Annually		Bi-Annual		Quarterly		Monthly	

Payment Method:	Cash		Bank Transfer		Cheque	

6. General Terms and Conditions

1) This document forms part of the contract and must be read together with the **Management Rules**, Benefit Table and application form(s).
2) Group Eligibility
   i) A Group can only be made up of employees of the same company or members of an existing and registered Affinity Group.
   ii) For a Group that consists solely of members of the same family it must be fully substantiated that such members are all working for the same employer.
   iii) Where a husband and wife are both employed by the same company they are deemed to be one employee plus eligible dependants NOT 2 employees.
3) The inception subscription must be received by commencement date of the cover. No claims will be paid until this is received. No claims will be paid until this is received.
4) Cover is only provided for Group Members (and eligible Dependants) where declared and accepted by Northern Medical Aid / Northern Alliance.

7. Declaration

I declare that I am authorized by the Company/Group to enter into this Medical Insurance Contract with **Northern Medical Aid Society / Northern Alliance**.
I declare that I have understood and accept the **Management Rules and Schedule of Benefits.**
I understand that subscriptions due for the Company/ Group cover must be paid upfront in full by the 1st of every month.
In the event that subscriptions are not paid in full by the due date, I understand that cover will be automatically cancelled or all claims payments will be suspended.
I declare that the information given to **Northern Medical Aid Society / Northern Alliance** for the purpose of entering into this Contract is true and complete and that no material facts have been withheld.

Signature of Applicant: _____ Date: day month year

Please Print Name: _____ Position: _____

THE NORTHERN MEDICAL AID SOCIETY

northern Alliance

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