Group Formation Form

To be completed by the Group Administrator

Intermediary (if applicable):

1. Group/Company Details

Company Name:

Type of Business:

Correspondence Address:

Group Administrator Name:

Job Title:

Telephone:

Fax:

Email:

2. Cover Details

Commencement Date: day 01 month year

Cover chosen: Multimed Alliance Health Options

Total Initial Number of Staff to be covered:

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

3. Underwriting

2 Year Moratorium (MORI)

Medical History Disregarded (MHD)

Continuous Transfer Enrolment

Lifetime Limit

Exclusion

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: Regardless of frequency, all contracts are annual and billed monthly.

Annually ☐ Bi-Annual ☐ Quarterly ☐ Monthly ☐

Payment Method: Cash ☐ Bank Transfer ☐ Cheque ☐ Other ☐

6. General Terms and Conditions

1. This document forms part of the contract and must be read together with the Multimed / Alliance Health Options **Plan Agreement**, Benefit Table and application form(s).
2. This Contract will take effect on the commencement date and shall continue for a period of 12 months or until the next **Renewal Date** or until the Plan is cancelled for whatever reason, whichever is sooner.
3. **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.
   iv) The minimum size of a Group at inception or renewal is three current employees or Affinity members.
   If the membership is below three at inception or at a subsequent Renewal Date then the Group cannot continue.
4. **The inception premium** must be received within a maximum of 7 working days from the commencement date of the Plan. No claims will be paid until this is received.
5. **Renewal premiums** must be received by Renewal Date. If full renewal premium and any applicable taxes or local levies are not received by Renewal Date claims will be suspended and cover will lapse.
   Multimed / Alliance Health Options may, at their discretion, reinstate cover if full premium and any applicable taxes or local levies are subsequently received.
6. Cover is only provided for Group Members (and eligible Dependants) where **declared and accepted** by Multimed / Alliance Health Options.
7. **(For Multimed Applications Only)** Unless the group has chosen MHD cover, employees or any of their dependants will not be covered under this Group Plan for any treatment relating to pre-existing medical conditions or related medical conditions, which they or their dependants first had symptoms of, knew about, or for which treatment was received in the two years prior to the start date of this Plan. However, if after a period of two years has passed during which your employees or their dependants have had no treatment or medication for the medical conditions, and being symptom and advice free, then we may begin cover for those medical conditions.
8. **(For Alliance Health Options Applications Only)** Unless the group has chosen CTT cover (to which a loading of 15% is to be applied on subscriptions), the benefits of membership to Alliance Health Options for employees or any of their dependants may be restricted or completely exclude the costs of treatment of any and all health conditions and any complications thereof which had first presented symptoms, or for which medical advice had been sought, or for which treatment had been sought or received prior to the start date of this Plan.

7. Declaration

I declare that I am authorized by the Company/Group to enter into this Medical Insurance Contract with Multimed / Alliance Health Options. I declare that I have understood and accept the **Plan Agreement**. I understand that premiums due for the Company/ Group cover must be paid in full by the agreed due date. In the event that premiums are not paid in full by the due date, I understand that cover will be automatically cancelled and/or all claims payments will be suspended. I declare that the information given to Multimed / Alliance Health Options 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: _____

MULTIMED PRIVATE MEDICAL COVER

Alliance Options HEALTH

Alliance HEALTH Healthcare Solutions