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COMPLETE IN PRINT USING BLACK INK

E-MAIL COMPLETED FORM TO hello@crisoncall.co.za

ONLY FORMS COMPLETED IN BLACK INK WILL BE ACCEPTED

REFERRED BY NAME / AGENT	NAME	MEMBERSHIP NO.
HANDLED BY EMPLOYEE	NAME	EMAIL ADDRESS

1. MAIN MEMBER – PERSONAL, MEDICAL, ID WRISTBAND INFORMATION

Personal Information

TITLE SURNAME FULL NAMES

ID NUMBER PASSPORT NUMBER NICK NAME

HOME ADDRESS

City Province Code

POSTAL ADDRESS

City Province Code

HOME TEL NR. WORK TEL NR. CELL NR.

FAX NR. LANGUAGE Eng Afr E-mail

ARE YOU INTERESTED IN RECEIVING OUR MONTHLY NEWSLETTER? Yes No

Medical Information

MEDICAL AID NAME MEDICAL AID PLAN

MEDICAL AID NR. MEDICAL AID TEL NR.

WRISTBAND NR. SEX MALE FEMALE

6 @O8; FCUD

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A+	A-	B+	B-	AB+	AB-	O+	O-	UNKNOWN	

Mark only what is applicable below with a tick mark. If not applicable, leave the block open.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood Pressure	Contact Lenses	Epilepsy	Asthma	False Teeth	Diabetes	Pace Maker
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood sugar	Kidney Failure		Low Blood Pressure	Hearing Impaired	Dementia	Porphyria

SPECIAL REQUESTS / DISABILITIES

MAJOR OPERATIONS (past 5 years)

CHRONIC MEDICATION (IF NECESSARY, USE SEPARATE SHEET AND ATTACH TO THE ORIGINAL APPLICATION)

ALLERGIES

PLEASE COMPLETE THE FOLLOWING FIELDS ONLY IF DIFFERENT FROM THE FAMILY INFORMATION AS IN SECTION 7

NEXT OF KIN (Not residing with you) TEL NR.

DOCTOR TEL NR.

ARE YOU INTERESTED IN THE PROTECT ME PLUS PRODUCT AT R31 PER PERSON PER MONTH? Yes

Identification Items

Only one item is allowed per person. Form is part of the application form. Please look on the website www.crisisoncall.co.za or contact the office for examples.

MEMBERSHIP NO.

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2. SPOUSE – PERSONAL, MEDICAL, ID WRISTBAND INFORMATION

Personal Information

WRISTBAND NR SURNAME SEX M F

FULL NAMES ID NUMBER

PASSPORT NUMBER NICK NAME CELL NR.

HOME TEL NR. WORK TEL NR.

RELATIONSHIP TO MAIN MEMBER E-MAIL

BLOOD GROUP A+ A- B+ B- AB+ AB- O+ O- UNKNOWN

Mark only what is applicable below with a tick mark. If not applicable, leave the block open.

High blood Pressure	Contact Lenses	Epilepsy	Asthma	False Teeth	Diabetes	Pace Maker
Low Blood sugar	Kidney Failure		Low Blood Pressure	Hearing Impaired	Dementia	Porphyria

SPECIAL REQUESTS / DISABILITIES

MAJOR OPERATIONS (past 5 years)

CHRONIC MEDICATION (IF NECESSARY, USE SEPARATE SHEET AND ATTACH TO THE ORIGINAL APPLICATION)

ALLERGIES

D'YUgY'Wta d'YH'BYxhcZ?']b (not residing with you) 'UbX'8 cWcf']bZ'fa U]cb'cb'm]ZX]ZfYbhZca 'ZLa]m]bZ'fa U]cb']b'GYW]cb'+

NEXT OF KIN TEL NR.

DOCTOR TEL NR.

MEDICAL AID NAME MEDICAL AID PLAN

MEDICAL AID NR. MEDICAL AID TEL NR.

ARE YOU INTERESTED IN THE PROTECT ME PLUS PRODUCT AT R31 PER PERSON PER MONTH? Yes

Identification Items

Only one item is allowed per person. Form is part of the application form. Please look on the website www.crisisoncall.co.za or contact the office for examples.

3. FIRST DEPENDANT – PERSONAL, MEDICAL, ID WRISTBAND INFORMATION

Personal Information

WRISTBAND NR SURNAME SEX M F

FULL NAMES ID NUMBER

PASSPORT NUMBER NICK NAME CELL NR.

HOME TEL NR. WORK TEL NR.

RELATIONSHIP TO MAIN MEMBER

BLOOD GROUP A+ A- B+ B- AB+ AB- O+ O- UNKNOWN

Mark only what is applicable below with a tick mark. If not applicable, leave the block open.

High blood Pressure	Contact Lenses	Epilepsy	Asthma	False Teeth	Diabetes	Pace Maker
Low Blood sugar	Kidney Failure		Low Blood Pressure	Hearing Impaired	Dementia	Porphyria

SPECIAL REQUESTS / DISABILITIES

MAJOR OPERATIONS (past 5 years)

CHRONIC MEDICATION (IF NECESSARY, USE SEPARATE SHEET AND ATTACH TO THE ORIGINAL APPLICATION)

ALLERGIES

D'YUgY'Wta d'YH'BYxhcZ?']b (not residing with you) 'UbX'8 cWcf']bZ'fa U]cb'cb'm]ZX]ZfYbhZca 'ZLa]m]bZ'fa U]cb']b'GYW]cb'+

NEXT OF KIN TEL NR.

DOCTOR TEL NR.

MEDICAL AID NAME MEDICAL AID PLAN

MEDICAL AID NR. MEDICAL AID TEL NR.

ARE YOU INTERESTED IN THE PROTECT ME PLUS PRODUCT AT R31 PER PERSON PER MONTH? Yes

Identification Items

Only one item is allowed per person. Form is part of the application form. Please look on the website www.crisisoncall.co.za or contact the office for examples.

MEMBERSHIP NO.

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4. SECOND DEPENDANT – PERSONAL, MEDICAL, ID WRISTBAND INFORMATION

Personal Information

WRISTBAND NR SURNAME SEX M F

FULL NAMES ID NUMBER

PASSPORT NUMBER NICK NAME CELL NR.

HOME TEL NR. WORK TEL NR.

RELATIONSHIP TO MAIN MEMBER

BLOOD GROUP A+ A- B+ B- AB+ AB- O+ O- UNKNOWN

Mark only what is applicable below with a tick mark. If not applicable, leave the block open.

High blood Pressure	Contact Lenses	Epilepsy	Asthma	False Teeth	Diabetes	Pace Maker
Low Blood sugar	Kidney Failure		Low Blood Pressure	Hearing Impaired	Dementia	Porphyria

SPECIAL REQUESTS / DISABILITIES

MAJOR OPERATIONS (past 5 years)

CHRONIC MEDICATION (IF NECESSARY, USE SEPARATE SHEET AND ATTACH TO THE ORIGINAL APPLICATION)

ALLERGIES

D'YugYW'a d'YH'BYxhcZ? Jb'(not residing with you) UbX'8 cWcf']bZ'fa Ujcb'cb'mjZX]ZfYbhiZca 'Zla]m]bZ'fa Ujcb']b'GYWfjcb'+

NEXT OF KIN TEL NR.

DOCTOR TEL NR.

MEDICAL AID NAME MEDICAL AID PLAN

MEDICAL AID NR. MEDICAL AID TEL NR.

ARE YOU INTERESTED IN THE PROTECT ME PLUS PRODUCT AT R31 PER PERSON PER MONTH? Yes

Identification Items

Only one item is allowed per person. Form is part of the application form. Please look on the website www.crisisoncall.co.za or contact the office for examples.

5. THIRD DEPENDANT – PERSONAL, MEDICAL, ID WRISTBAND INFORMATION

Personal Information

WRISTBAND NR SURNAME SEX M F

FULL NAMES ID NUMBER

PASSPORT NUMBER NICK NAME CELL NR.

HOME TEL NR. WORK TEL NR.

RELATIONSHIP TO MAIN MEMBER

BLOOD GROUP A+ A- B+ B- AB+ AB- O+ O- UNKNOWN

Mark only what is applicable below with a tick mark. If not applicable, leave the block open.

High blood Pressure	Contact Lenses	Epilepsy	Asthma	False Teeth	Diabetes	Pace Maker
Low Blood sugar	Kidney Failure		Low Blood Pressure	Hearing Impaired	Dementia	Porphyria

SPECIAL REQUESTS / DISABILITIES

MAJOR OPERATIONS (past 5 years)

CHRONIC MEDICATION (IF NECESSARY, USE SEPARATE SHEET AND ATTACH TO THE ORIGINAL APPLICATION)

ALLERGIES

D'YugYW'a d'YH'BYxhcZ? Jb'(not residing with you) UbX'8 cWcf']bZ'fa Ujcb'cb'mjZX]ZfYbhiZca 'Zla]m]bZ'fa Ujcb']b'GYWfjcb'+

NEXT OF KIN TEL NR.

DOCTOR TEL NR.

MEDICAL AID NAME MEDICAL AID PLAN

MEDICAL AID NR. MEDICAL AID TEL NR.

ARE YOU INTERESTED IN THE PROTECT ME PLUS PRODUCT AT R31 PER PERSON PER MONTH? Yes

Identification Items

Only one item is allowed per person. Form is part of the application form. Please look on the website www.crisisoncall.co.za or contact the office for examples.

MEMBERSHIP NO.

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6. VEHICLE INFORMATION (Roadside Assistance R59 per month per vehicle)

Please note: Vehicle refers to motor vehicle, trailer or caravan

	VEHICLE 1				VEHICLE 2				VEHICLE 3				VEHICLE 4			
ROADSIDE ASSISTANCE * @ R59 / month	YES*		NO*		YES*		NO*		YES*		NO*		YES*		NO*	
* Mandatory Field																
MAKE																
MODEL																
COLOUR																
YEAR																
REG NR.																
TRACKING COMPANY																
INSURANCE COMPANY																
TEL NR.																
POLICY NR.																

Only vehicles marked YES for roadside assistance will be eligible for roadside assistance benefits. Vehicles marked NO will only be listed for information purposes. If no is selected above, it is not necessary to fill in the information.

Number of vehicles on Roadside Assistance

Please complete section 9.5 if YES for Roadside Assistance

7. GENERAL INFORMATION IN CASE OF EMERGENCY

RELIGIOUS LEADER (NAME AND SURNAME)		TEL NO.	
DOMESTIC WORKER 1 (NAME AND SURNAME)		TEL NO.	
DOMESTIC WORKER 2 (NAME AND SURNAME)		TEL NO.	
GENERAL PRACTITIONER (NAME AND SURNAME)		TEL NO.	
FIRE STATION (NAME / AREA)		TEL NO.	
POLICE (NAME / AREA)		TEL NO.	
NEXT OF KIN 1 (NOT LIVING WITH YOU)		TEL NO.	
NEXT OF KIN 2 (NOT LIVING WITH YOU)		TEL NO.	
NEIGHBOUR 1 (NAME & SURNAME)		TEL NO.	
NEIGHBOUR 2 (NAME & SURNAME)		TEL NO.	
EXECUTOR (NAME & SURNAME)		TEL NO.	
SECURITY COMPANY		TEL NO.	
SHORTTERM INSURANCE (HOUSE AND GENERAL)		TEL NO.	

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8. IDENTIFICATION ITEMS

Identification Item List (Go to website www.crisisoncall.co.za or contact office for examples of the items)

Item	Colour	Code	Price
Woven Wristband	Blue and Yellow	WW1	R48 Each
	Black and White	WW2	
Woven Clip Wristband	Blue and Yellow	WC1	R58 Each
	Black and White	WC2	
Rubber	Blue and Yellow	RW12	R65 Each
Available sizes: 12cm (RW12), 14cm (RW14), 16cm (RW16), 18cm (RW18),		RW14	
20cm (RW20), 22cm (RW22), 24cm (RW24)		RW16	
Measure size of wrist and select next available size		RW18	
Rubber Elite	Purple	E1	R325 Each
	Dark Blue	E2	
	Yellow	E3	
	Green	E4	
	Pink	E5	
	Black	E6	
	White	E7	
	Red	E8	
Rubber Elite Pinstripe	Black with Red Stripe	EP1	R350 Each
	Black with Blue Stripe	EP3	
	Black with Green Stripe	EP4	
	Pink with White Stripe	EP5	
	Black with White Stripe	EP6	
Pet Tag		PT1	R30 Each
Member Card		LK	R30 Each

Identification Item Order

Name	Colour	Code	Price

Total

=====

1. CrisisOnCall and service providers accepts no responsibility for any damage, injury or loss that may be the result of the choice of the member and/or family to not wear their identification items at all times.
2. CrisisOnCall and it's service providers accepts no responsibility for any damage, injury or loss that may be the result of incorrect or insufficient information with regards to any members of the family.
3. Do not wear each other's wristbands under any circumstances.

Please Note: Delivery of wristbands are included in the administration fee with joining. Any subsequent delivery is payable by the member.

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9. SERVICES REQUIRED

Mark the appropriate services that you need

ALPHA SERVICE

1.	ALPHA PACKAGE (COMPULSORY)	@ R139 / Month			R
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VALUE ADDED SERVICES

2.	HOUSEHOLD ASSISTANCE	@ R51 / Month			R
3.	EXTENDED FAMILY (RESIDING WITH MAIN MEMBER)	@ R69 / Month / Person	NO.	<input type="text"/>	R
4.	DOMESTIC WORKER ASSISTANCE (INDICATE NUMBER OF WORKERS)	@ R46 / Month / Worker	NO.	<input type="text"/>	R
5.	ROADSIDE ASSISTANCE (INDICATE NUMBER OF VEHICLES)	@ R59 / Month / Vehicle	NO.	<input type="text"/>	R
6.	CARAVAN / TRAILER ASSIST (INDICATE NUMBER OF VEHICLES)	@ R59 / Month / Vehicle	NO.	<input type="text"/>	R
7.	TAKE ME HOME	@ R68 / Month			R
(TRANSPORT FROM FUNCTION TO HOME WITH OWN VEHICLE – AVAILABLE FOR METROPOLITAN AREAS ONLY)					
8.	PROTECTMEPLUS	@ R31 / Month / Person	NO.	<input type="text"/>	R

TOTAL MONTHLY PREMIUM

A R

ADMIN FEES AND ONCE OFF COSTS

9.	IDENTIFICATION ITEMS				
9.1	As per order form on previous page				R
10	DISPATCH OF ITEMS	Collect from MONUMENTPARK Offices	<input type="checkbox"/>		FREE
		Courier	<input type="checkbox"/>	ADDRESS:	

CrisisOnCall indemnifies itself from loss of items due to negligence of service providers

11.	ADMIN FEE – ONCE OFF	Non-Pensioners @ R250		R
		Pensioners @ R200		R

TOTAL WRISTBANDS AND ADMIN FEES

B R

TOTAL FIRST AMOUNT

A + B R

AUTHORISATION: I / WE AGREE TO PAYMENT OF ABOVE FEES

PLACE		DATE	YYyy-mm-dd	SIGNATURE	
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Terms & conditions apply

MEMBERSHIP NO.

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10. PAYMENT AGREEMENT (TERMS AND CONDITIONS)

I / We understand that this membership cannot be canceled within the first 3 months.

I / We understand that a calendar month's written notice is required for cancellation and communication hereof is to be sent to hello@crisoncall.co.za).

I / We agree to process membership fees via one of the following methods of payment. Please tick the correct one.

METHOD OF PAYMENT

DEBIT ORDER

PLEASE COMPLETE DEBIT ORDER MANDATE (SECTION 10)

MONTHLY PREMIUM

ANNUAL PREMIUM

- I acknowledge that all payment instructions to be issued in terms of this will be considered by my bank as authorised by myself.

- I agree that cancellation of this payment instruction will not automatically cancel the membership.

- I'm not entitled to reclaim any amounts that have been paid lawfully in terms of this contract.

- CrisisOnCall may not give, cede or delegate this instruction to any third party without my written permission.

- I hereby authorise CrisisOnCall to capture and store my personal and medical information on a safe and secure database in order to make it available to the CrisisOnCall appointed 24 hour contact centre and emergency personnel.

- I hereby confirm that I understand this contract and voluntarily agree to it.

ACTIVATION DATE OF MEMBERSHIP

DATE

OFFICE USE ONLY

YYyy-mm-dd

PLACE

DATE

YYyy-mm-dd

SIGNATURE

11. AUTHORISATION AND MANDATE FOR PAYMENT INSTRUCTIONS VIA DEBIT ORDER

A. AUTHORISATION

- I / We authorise CrisisOnCall to issue payment instructions to my/our banker for collection to draw against my/our bank on the condition that the amount of such payment Instructions will never exceed my obligations as agreed in the agreement.
- The individual payment instructions that have been duly authorised, has to be issued on a monthly / yearly* (interval) on or after the dates as agreed for payment and the amount may not be higher or less as the mandated amount payable (*Delete what is not applicable).
- The payment instructions that have been created and authorised has to include my membership number as reference at all times.
- Hereby I / we agree that the monthly debit order will be delivered and deducted on the

1st7th15th26th

(mark applicable block)

of every month.

The first payment instruction for amount **A+B R_____** will be issued and delivered during the first month. Thereafter the amount of **A R_____** and will be deducted every month. This mandate will be in effect until I / We have given written notice of cancellation. Member fees revised annually and amended accordingly on 1 March. Ad hoc costs for identification items may be added to the debit order from time to time with permission from the member.

B. MANDATE

- I / We agree that any payment instructions that have been issued by you will be treated by my / our bank as though I / we have personally given the instruction.

C. CANCELLATION

- I / We agree that although I / we can cancel this mandate and authorisation, it will not cancel the membership. I / We understand that I / we cannot reclaim the amounts that have been deducted from my / our account in terms of this mandate.

D. INSTRUCTION

- I / We agree that the party authorised here-in to make deductions against my / our account my not cede or transfer any of his rights to a third party without the written consent of myself / us and that I / we cannot delegate any of the responsibilities in terms of this contract or authorisation to any third party without the written consent of the authorised party.

E. BANK ACCOUNT REFERENCE

- I / we take note that the bank reference number on our statement will show: COCABC001234 (COC followed by member number)

NOTE: The NAEDO- and/or EFT-user may add to the above minimum conditions.

CRISONCALL CONTACT DETAILS FOR MEMBER ENQUIRIES:

e-pos: members@crisoncall.co.za

Telefonies: 0861 574747

ACCOUNT HOLDER (Name & Surname)		BANK NAME												
BRANCH NAME					TYPE OF ACCOUNT	Cheque	Savings	Transmission						
ACCOUNT NUMBER									BRANCH CODE					
MEMBER NUMBER (Office use)									DATE	dd	mm	yyyy		
PLACE					SIGNATURE									