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GUARDRISK TAILORED RISK SOLUTIONS

GAP SHIELD - 2020 APPLICATION FOR VOLUNTARY GROUPS – DEBIT ORDER DEDUCTION

Thank you for deciding to apply for gap insurance cover with Gap Shield, a division of Guardrisk Insurance Company Limited (Reg. 1992/001639/06, FSP No. 75). This document is an application form for cover. Please complete the form accurately and completely in order that we may process your application.

Contact us

Tel: 0860 102 936, Email: admed@guardrisk.co.za

Who we are

Gap Shield Gap Cover is a gap product underwritten by, Guardrisk Insurance Company Limited – Registration number 1992/001639/06, Financial Service Provider No. 75

What you must do

1. Fill in the form.
2. Please complete the Dependant Declaration at the end of this application for each dependant that you wish to add to your cover. Only those dependants that are named on your cover will be eligible for benefits and they may have to serve waiting periods before their cover begins.
3. Submit your application by emailing the form to us, with your medical aid membership certificate.

Once you have submitted your application form:

- If any details are missing or we need more information, we will contact you.
- We will activate your membership and we will email you a confirmation of cover, along with your policy wording.
- If you do not hear from us 2 weeks after sending us your application, please contact us on 0860 102 936 or email admed@guardrisk.co.za.

When you sign this application, you confirm that you have read and understood the terms and conditions of cover and agree to them.

TELL US WHO IS COMPLETING THIS FORM			
Client / Applicant	Yes	No	Please read and initial each declaration under Client / Applicant declaration and consent
Appointed Broker	Yes	No	Please read and initial each declaration under Broker declaration and consent

DETAILS OF YOUR EMPLOYER																			
Name of employer																			
Branch (if applicable)																			
Employee no.													Date employed	d	d	m	m	y	y	y	y

TELL US ABOUT YOU																			
Title			Surname																
First Name																			
ID / Passport No.													Date of birth	d	d	m	m	y	y	y	y
Medical aid name													Plan option								
Medical aid no.													Date joined	d	d	m	m	y	y	y	y

Please ensure that your application is emailed to the correct scheme email address

Rumed - membership@rumed.co.za
Sisonke - membership@sisonkehealth.co.za
Medimed - membership@medimed.co.za
Suremed - membership@suremedhealth.co.za

Please attach an up-to-date medical aid membership certificate.
All dependants must reflect on your medical aid certificate, be named on your cover with us and must be covered on your medical aid at the time of a claimable event.

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YOUR CONTACT DETAILS

Postal address		Physical address	
	Postal code		Postal code
Email address:			
Office tel. no.		Mobile no.	

SELECT YOUR COVER OPTION AND START DATE

You confirm that you have read and understand the benefits that are covered on the selected cover option.
If we receive your application after the 15th day of the month, we may make a double-deduction from your bank account.

Please select your cover and monthly premium option:	**Gap Shield R112**		

The monthly premium is inclusive of binder fee of R5.60 and VAT.

When do you want your cover to start? m m y y y y

Cover can only start on the first day of the calendar month following application. No requests for backdating of cover will be considered.

YOUR PREVIOUS GAP COVER

Have you previously belonged to any other gap provider? If yes, please give us the details.

Previous Insurer			
Previous cover option		Previous Policy Number	
Start date	d d m m y y y y	End date	d d m m y y y y

Please attach proof of your previous gap cover.

All dependants must reflect on this certificate in order to benefit from reduced or no waiting periods being applied to their cover. If your dependants are moving cover from a different insurer, please also attach their proof of cover with your application.

PROVIDE US WITH MORE INFORMATION ABOUT YOUR HEALTH

Failure to disclose pre-existing medical conditions may result in limited or excluded benefits.

Important to note:

- Any cancer, birth or pregnancy-related medical condition that existed within 12 months before the first day of cover will be excluded for 12 months after cover starts;
- Any other physical defect, medical condition, illness or injury that existed within 12 months before the first day of cover will be excluded for 9 months after cover starts.
-

Details of your general doctor	Name:	Tel No:	

Please select a "Y" or "N" for each of the below questions. Please answer honestly, accurately and completely.

* Where you have selected "Y" you must supply us with more information in the space below the questionnaire.

1.	Are you currently pregnant or trying to become pregnant?	Y		N
2.	Have you recently given birth?	Y		N
3.	Have you ever been diagnosed with any form of cancer, malignant or pre-malignant tumours?	Y		N
4.	Have you had any surgical procedure during the past 12 months or are you planning a surgical procedure during the next 12 months?	Y		N
5.	Do you take chronic or ongoing medication?	Y		N

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Have you had or do you currently have, any of the medical conditions listed below, for which medical advice, diagnosis, care or treatment was recommended or received within the last 12 months?

Have you had or do you currently have, any of the medical conditions listed below, for which medical advice, diagnosis, care or treatment was recommended or received within the last 12 months?

6. Any bone or joint condition including ongoing back, shoulder, hip or knee problems, arthritis, rheumatism, fibromyalgia or any other musculoskeletal (back, bone and muscle) condition	Y		N	
7. High blood pressure, high cholesterol or lipids, ischaemic / coronary heart disease, chest pains, irregular heartbeat, heart murmur, heart failure, myocardial infarction, angina, peripheral vascular disease, valve lesions or any other heart-related medical condition	Y		N	
8. Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse	Y		N	
9. Stroke, spinal cord injury or any other brain, spinal or nerve condition	Y		N	
10. Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition	Y		N	
11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Y		N	
12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	Y		N	
13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	Y		N	
14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	Y		N	
15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	Y		N	
16. Kidney and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycystic kidney disease or any other renal or urinary condition	Y		N	
17. Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders	Y		N	
18. Any condition of the prostate including undescended testes or urinary incontinence	Y		N	
19. Any other medical condition not listed above that may require treatment or surgery	Y		N	

Please provide detail where "Y" has been ticked:

_____

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YOUR BENEFICIARY DETAILS

In the event of your death while you are covered on the policy, please tell us who to pay any claim amounts to

Title				First Name										Surname								
Identity number															Date of birth	d	d	m	m	y	y	y	y
Mobile number											Physical address:											
Relationship to you																						

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YOUR DEPENDANTS' DETAILS

Please complete a separate Dependant Declaration (last page of this form) for each dependant that you wish to add to your policy.

Any dependant for which we don't receive a completed and signed Dependant Declaration will not be covered on the policy and when adding them to cover, they may be subject to waiting periods from the date on which their cover begins.

PROVIDE US WITH YOUR BANKING DETAILS FOR YOUR MONTHLY PREMIUM DEDUCTION

Your premium is payable monthly in advance on the first day of each month. This means that depending on when we receive and process your application form, we may deduct the current and next month's premium at the same time.

Account holder name		Bank name	
Branch name		Branch code	
Account number			

Type of account		Cheque		Savings		Transmission	

By initialling this box you: ☐

1. Authorise Guardrisk to debit your account with the monthly premium due in respect of this policy.
2. Acknowledge that this authorisation will remain in force and effect until cancelled by you, in writing with one calendar month's notice.
3. Understand that cancelling the Mandate does not cancel the Agreement. Agreement that the account holder is not entitled to refund for when the Mandate was still active, if such amounts were owed to them.
4. Acknowledge that this Authority may be assigned to a third party if this agreement is also assigned to a third party.
5. Understand and accept that should your premium be adjusted annually on renewal and in the case of benefit restructuring necessitated by changing legislation, with one month's notice and subject to your right of cancellation of cover, the aforementioned authorisation will extend to the adjusted premium.
6. Undertake to inform Guardrisk of any change in your banking details and you authorise Guardrisk to verify such banking details with your bank.
7. Confirm that Guardrisk shall not be held liable for incorrect claim payments made as a result of your failure to inform Guardrisk of your change in banking details
8. Accept that Guardrisk may debit your account on a date other than that specified.
9. Notwithstanding the fact that you grant Guardrisk permission to collect premiums, you acknowledge that it is your responsibility to ensure that premiums are collected for cover to remain in force.
10. Acknowledge that the first payment date will be the first day of the month in which your cover starts.
11. Acknowledge that in the event that the payment day falls on a Sunday, or recognised South African public holiday, the payment day will automatically be the very next ordinary business day.
12. Acknowledge that payment instructions issued from this Mandate will be treated as payment instructions issued personally by the accountholder.
13. Understand that the agreement reference number will be your membership number which will only issued once your application form has been captured.
14. Understand that the debit order transaction on your bank statement will reflect as 'ADMED'.

_____ Signature of bank account holder	Date signed:	d	d	m	m	y	y	y	y

BROKER DECLARATION AND CONSENT – only applicable when broker is completing application form on behalf of client

Please initial each of the following sentences below to confirm that you are in agreement with the statement:

1. The applicant has authorised you to complete this application form on their behalf and you confirm that the information provided is true and accurate as advised by your client. ☐
2. You can provide proof of your client's above mentioned authorisation timeously on request by Guardrisk. ☐
3. You declare that your client has read the below Client /Applicant declaration and that your client accepts each declaration that you are signing on their behalf. ☐

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YOUR DECLARATION AND CONSENT

Please initial each of the following sentences below to confirm that you are in agreement with the statement:

1. I hereby apply for the Gap Shield product and I agree to abide by its rules. ☐
2. I declare that the information that I have supplied is correct and complete and that this declaration shall be the basis of my membership of my employer's group scheme with Guardrisk Insurance Company Limited (Guardrisk), which will become effective on the first day of the month for which premiums are paid.. ☐
3. I confirm my understanding that should this application be incomplete, my application may not be processed by Guardrisk. ☐
4. I confirm my understanding that should any material information be withheld or incorrectly furnished during the application process, Guardrisk may cancel my cover and premiums paid may be used to offset expenses incurred by Guardrisk. ☐
5. I understand that my and my dependants' cover may be subject to waiting periods and that these waiting periods have been communicated to me prior to my application for cover. ☐
6. I declare my understanding that this insurance product is not a substitute for medical scheme cover and that it does not replace my, or my dependants' medical scheme cover. ☐
7. I understand that this product does not insure against every shortfall in medical scheme cover and that I am aware of the circumstances in which my and my dependants' cover will and will not pay. ☐
8. I further declare my understanding that my and my dependants' eligibility for cover is dependant on my, and my dependants remaining active members of a registered medical scheme and I undertake to advise Guardrisk if I terminate my, or my dependants' medical scheme membership at any time. ☐
9. I confirm that I have read and understand the terms and conditions of my and my dependants' cover under this policy and I indemnify Guardrisk against any and all claims in regard to the appropriateness of this policy for my personal circumstanced. ☐
10. I indemnify Guardrisk against all and any claims that may arise if, without the benefit of advice from a financial adviser, my understanding of this product and its associated terms and conditions are incorrect. ☐
11. I understand that no advice has been or will be provided to me by Guardrisk and that I am solely responsible for my decision and the implications of this decision, to purchase this policy. ☐
12. I confirm that I have read and completed this declaration, that I understand its implications, that I have signed it of my own free will and that I regard it as a binding contract. ☐
13. I understand that the information in this application and any marketing material and/or documentation regarding this policy does not constitute advice in terms of the Financial Advisory and Intermediary Services (FAIS) Act 37 of 2002 and I indemnify Guardrisk against any and all claims in terms of my right to advice under FAIS. ☐
14. I accept that any notice given to my employer is deemed to have been given to me. ☐
15. I authorise the disclosure of relevant medical information by my medical scheme to Guardrisk to assist in the processing of claims under this policy. This information could include my (or one of my dependants') diagnosis, treatment and medical history. I further confirm that my dependants and/or beneficiaries have also provided the necessary authority for their medical scheme to disclose their relevant medical information to Guardrisk to assist in the processing of claims under this policy. ☐
16. I authorise Guardrisk to obtain from any person, medical practitioner or institution, any information that Guardrisk requires for purposes of claims arising from this policy. I authorise such person(s) to give the said information to Guardrisk, and to share with other insurers and medical schemes any information in this application or in any related policy or other document, either directly or through a database operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as Guardrisk or the operators of such database may decide from time to time. I acknowledge that I cannot cancel this authorisation and that it will endure after my death. ☐
17. I authorise Guardrisk to collect, process and store my and my dependants' personal information for the purpose of administering cover under this policy. I further confirm that my dependants and/or beneficiaries have also provided me with the authority to disclose their personal information to Guardrisk. ☐

18. I confirm that I am aware of my right to request a copy of my and my dependants' personal information that Guardrisk holds, that I have the right to request that such personal information is updated, corrected or deleted by Guardrisk and that I have the right to object to the processing of my personal information by lodging a complaint with the Information Regulator. ☐

19. I authorise Guardrisk, or its appointed service provider, to negotiate on my behalf with my medical scheme in respect of shortfall claims that may have arisen from medical events which my medical scheme is legally obliged to cover in full. ☐

20. I authorise Guardrisk to negotiate discounts on my behalf with medical service providers in order to maintain a good risk profile for my cover. If successful, I acknowledge that payment will be made directly to the service provider's bank account and no further payment will be due to me. ☐

21. I undertake to notify Guardrisk of any change in my personal details within a reasonable time period and I indemnify Guardrisk against any liability for any loss that may result from my failure to notify Guardrisk of such change in a timeous manner. ☐

22. I authorise Guardrisk to disclose all relevant information to the appointed broker on my policy to assist in the processing of this application form. This information could include my (or one of my dependants') medical diagnosis, treatment and history as well as personal information. I further confirm that my dependants and/or beneficiaries have also provided the necessary authority to disclose their relevant information to the appointed broker to assist in the processing of this application form and any claims processed by Guardrisk on this policy ☐

Date signed:

d	d	m	m	y	y	y	y

_____

Signature of Applicant

Received by:_____ **Date Received:**_____	**HR Stamp**

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GUARDRISK TAILORED RISK SOLUTIONS

DEPENDANT DECLARATION

Please complete the below for each dependant named on your policy *Dependant declaration no 1 of _____*

Title		First name		Surname	
Identity number				Date of birth	d d m m y y y y
Relationship				Gender	*Male* / *Female*

THEIR PREVIOUS GAP COVER (if not covered on a previous gap policy of yours)

Previous Insurer			
Previous cover option		Previous Policy Number	
Start date	d d m m y y y y	End date	d d m m y y y y

Please attach proof of this previous gap cover.

PROVIDE US WITH MORE INFORMATION ABOUT YOUR DEPENDANT'S HEALTH

Failure to disclose pre-existing medical conditions may result in limited or excluded benefits.

Important to note:

- Any cancer, birth or pregnancy-related medical condition that existed within 12 months before the first day of cover will be excluded for 12 months after cover starts;
- Any other physical defect, medical condition, illness or injury that existed within 12 months before the first day of cover will be excluded for 9 months after cover starts.

Details of your general doctor	Name:		Tel No:	

Please select a "Y" or "N" for each of the below questions. Please answer honestly, accurately and completely.
*** Where you have selected "Y" you must supply us with more information in the space below the questionnaire**

1.	Is this dependant currently pregnant or trying to become pregnant?	Y	N
2.	Has this dependant recently given birth?	Y	N
3.	Has this dependant ever been diagnosed with any form of cancer, malignant or pre-malignant tumours?	Y	N
4.	Has this dependant had any surgical procedure during the past 12 months or planning a surgical procedure during the next 12 months?	Y	N
5.	Does this dependant take chronic or ongoing medication?	Y	N

Have you had or do you currently have, any of the medical conditions listed below, for which medical advice, diagnosis, care or treatment was recommended or received within the last 12 months?

6.	Any bone or joint condition including ongoing back, shoulder, hip or knee problems, arthritis, rheumatism, fibromyalgia or any other musculoskeletal (back, bone and muscle) condition	Y	N
7.	High blood pressure, high cholesterol or lipids, ischaemic / coronary heart disease, chest pains, irregular heartbeat, heart murmur, heart failure, myocardial infarction, angina, peripheral vascular disease, valve lesions or any other heart-related medical condition	Y	N
8.	Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse	Y	N
9.	Stroke, spinal cord injury or any other brain, spinal or nerve condition	Y	N

10. Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition	Y	N
11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Y	N
12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	Y	N
13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	Y	N
14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	Y	N
15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	Y	N
16. Kidney and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycystic kidney disease or any other renal or urinary condition	Y	N
17. Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders	Y	N
18. Any condition of the prostate including undescended testes or urinary incontinence	Y	N
19. Any other medical condition not listed above that may require treatment or surgery	Y	N

Please provide detail where "Y" has been ticked: _____

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GUARDRISK TAILORED RISK SOLUTIONS

DEPENDANT DECLARATION

Please complete the below for each dependant named on your policy *Dependant declaration no 2 of _____*

Title		First name		Surname	
Identity number				Date of birth	d d m m y y y y
Relationship				Gender	*Male* / *Female*

THEIR PREVIOUS GAP COVER (if not covered on a previous gap policy of yours)

Previous Insurer			
Previous cover option		Previous Policy Number	
Start date	d d m m y y y y	End date	d d m m y y y y

Please attach proof of this previous gap cover.

PROVIDE US WITH MORE INFORMATION ABOUT YOUR DEPENDANT'S HEALTH

Failure to disclose pre-existing medical conditions may result in limited or excluded benefits.

Important to note:

- Any cancer, birth or pregnancy-related medical condition that existed within 12 months before the first day of cover will be excluded for 12 months after cover starts;
- Any other physical defect, medical condition, illness or injury that existed within 12 months before the first day of cover will be excluded for 9 months after cover starts.

Details of your general doctor	Name:		Tel No:	

Please select a "Y" or "N" for each of the below questions. Please answer honestly, accurately and completely.
*** Where you have selected "Y" you must supply us with more information in the space below the questionnaire**

1.	Is this dependant currently pregnant or trying to become pregnant?	Y	N
2.	Has this dependant recently given birth?	Y	N
3.	Has this dependant ever been diagnosed with any form of cancer, malignant or pre-malignant tumours?	Y	N
4.	Has this dependant had any surgical procedure during the past 12 months or planning a surgical procedure during the next 12 months?	Y	N
5.	Does this dependant take chronic or ongoing medication?	Y	N

Have you had or do you currently have, any of the medical conditions listed below, for which medical advice, diagnosis, care or treatment was recommended or received within the last 12 months?

6.	Any bone or joint condition including ongoing back, shoulder, hip or knee problems, arthritis, rheumatism, fibromyalgia or any other musculoskeletal (back, bone and muscle) condition	Y	N
7.	High blood pressure, high cholesterol or lipids, ischaemic / coronary heart disease, chest pains, irregular heartbeat, heart murmur, heart failure, myocardial infarction, angina, peripheral vascular disease, valve lesions or any other heart-related medical condition	Y	N
8.	Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse	Y	N
9.	Stroke, spinal cord injury or any other brain, spinal or nerve condition	Y	N
10.	Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition	Y	N
11.	Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Y	N

12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	Y	N
13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	Y	N
14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	Y	N
15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	Y	N
16. Kidney and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycystic kidney disease or any other renal or urinary condition	Y	N
17. Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders	Y	N
18. Any condition of the prostate including undescended testes or urinary incontinence	Y	N
19. Any other medical condition not listed above that may require treatment or surgery	Y	N

Please provide detail where "Y" has been ticked: _____

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DEPENDANT DECLARATION

Please complete the below for each dependant named on your policy *Dependant declaration no 3 of _____*

Title		First name		Surname	
Identity number				Date of birth	d d m m y y y y
Relationship				Gender	*Male* / *Female*

THEIR PREVIOUS GAP COVER (if not covered on a previous gap policy of yours)

Previous Insurer			
Previous cover option		Previous Policy Number	
Start date	d d m m y y y y	End date	d d m m y y y y

Please attach proof of this previous gap cover.

PROVIDE US WITH MORE INFORMATION ABOUT YOUR DEPENDANT'S HEALTH

Failure to disclose pre-existing medical conditions may result in limited or excluded benefits.

Important to note:

- Any cancer, birth or pregnancy-related medical condition that existed within 12 months before the first day of cover will be excluded for 12 months after cover starts;
- Any other physical defect, medical condition, illness or injury that existed within 12 months before the first day of cover will be excluded for 9 months after cover starts.

Details of your general doctor	Name:		Tel No:	

Please select a "Y" or "N" for each of the below questions. Please answer honestly, accurately and completely.
*** Where you have selected "Y" you must supply us with more information in the space below the questionnaire**

1.	Is this dependant currently pregnant or trying to become pregnant?	Y	N
2.	Has this dependant recently given birth?	Y	N
3.	Has this dependant ever been diagnosed with any form of cancer, malignant or pre-malignant tumours?	Y	N
4.	Has this dependant had any surgical procedure during the past 12 months or planning a surgical procedure during the next 12 months?	Y	N
5.	Does this dependant take chronic or ongoing medication?	Y	N

Have you had or do you currently have, any of the medical conditions listed below, for which medical advice, diagnosis, care or treatment was recommended or received within the last 12 months?

6.	Any bone or joint condition including ongoing back, shoulder, hip or knee problems, arthritis, rheumatism, fibromyalgia or any other musculoskeletal (back, bone and muscle) condition	Y	N
7.	High blood pressure, high cholesterol or lipids, ischaemic / coronary heart disease, chest pains, irregular heartbeat, heart murmur, heart failure, myocardial infarction, angina, peripheral vascular disease, valve lesions or any other heart-related medical condition	Y	N
8.	Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse	Y	N
9.	Stroke, spinal cord injury or any other brain, spinal or nerve condition	Y	N
10.	Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition	Y	N
11.	Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Y	N

12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	Y	N
13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	Y	N
14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	Y	N
15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	Y	N
16. Kidney and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycystic kidney disease or any other renal or urinary condition	Y	N
17. Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders	Y	N
18. Any condition of the prostate including undescended testes or urinary incontinence	Y	N
19. Any other medical condition not listed above that may require treatment or surgery	Y	N

Please provide detail where "Y" has been ticked: _____

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GUARDRISK TAILORED RISK SOLUTIONS

DEPENDANT DECLARATION

Please complete the below for each dependant named on your policy *Dependant declaration no 4 of _____*

Title		First name		Surname	
Identity number				Date of birth	d d m m y y y y
Relationship				Gender	*Male* / *Female*

THEIR PREVIOUS GAP COVER (if not covered on a previous gap policy of yours)

Previous Insurer			
Previous cover option		Previous Policy Number	
Start date	d d m m y y y y	End date	d d m m y y y y

Please attach proof of this previous gap cover.

PROVIDE US WITH MORE INFORMATION ABOUT YOUR DEPENDANT'S HEALTH

Failure to disclose pre-existing medical conditions may result in limited or excluded benefits.

Important to note:

- Any cancer, birth or pregnancy-related medical condition that existed within 12 months before the first day of cover will be excluded for 12 months after cover starts;
- Any other physical defect, medical condition, illness or injury that existed within 12 months before the first day of cover will be excluded for 9 months after cover starts.

Details of your general doctor	Name:		Tel No:	

Please select a "Y" or "N" for each of the below questions. Please answer honestly, accurately and completely.
*** Where you have selected "Y" you must supply us with more information in the space below the questionnaire**

1.	Is this dependant currently pregnant or trying to become pregnant?	Y	N
2.	Has this dependant recently given birth?	Y	N
3.	Has this dependant ever been diagnosed with any form of cancer, malignant or pre-malignant tumours?	Y	N
4.	Has this dependant had any surgical procedure during the past 12 months or planning a surgical procedure during the next 12 months?	Y	N
5.	Does this dependant take chronic or ongoing medication?	Y	N

Have you had or do you currently have, any of the medical conditions listed below, for which medical advice, diagnosis, care or treatment was recommended or received within the last 12 months?

6.	Any bone or joint condition including ongoing back, shoulder, hip or knee problems, arthritis, rheumatism, fibromyalgia or any other musculoskeletal (back, bone and muscle) condition	Y	N
7.	High blood pressure, high cholesterol or lipids, ischaemic / coronary heart disease, chest pains, irregular heartbeat, heart murmur, heart failure, myocardial infarction, angina, peripheral vascular disease, valve lesions or any other heart-related medical condition	Y	N
8.	Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse	Y	N
9.	Stroke, spinal cord injury or any other brain, spinal or nerve condition	Y	N
10.	Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition	Y	N
11.	Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Y	N

12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	Y	N
13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	Y	N
14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	Y	N
15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	Y	N
16. Kidney and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycystic kidney disease or any other renal or urinary condition	Y	N
17. Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders	Y	N
18. Any condition of the prostate including undescended testes or urinary incontinence	Y	N
19. Any other medical condition not listed above that may require treatment or surgery	Y	N

Please provide detail where "Y" has been ticked: _____

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