



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.

- 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 COM	MPLETIN	NG THIS	S 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									

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Underwritten by Guardrisk Insurance Company Limited. Guardrisk is part of Momentum Metropolitan Limited An Authorised Financial Services Provider (FSP No 75)







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Cover can only sta	art on th	ne firs	st da	ay of tl	he cale	endar	[.] mon	th follo	wing a	ppli	cation. No re	eque	ests fo	or bac	kdati	ng of	cov	er w	ill be	cons	idere	d.	
YOUR PREVIOU	S GAP	covi	ER																				
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months after	cover s	tarts.																					
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	Ide or received within the last 12 months? d or do you currently have, any of the medical conditions listed below, for which medical ad led or received within the last 12 months? the or joint condition including ongoing back, shoulder, hip or knee problems, arthritis, rheur ralgia or any other musculoskeletal (back, bone and muscle) condition bod pressure, high cholesterol or lipids, ischaemic / coronary heart disease, chest pains, irregi- tat, heart murmur, heart failure, myocardial infarction, angina, peripheral vascular disease, v or any other heart-related medical condition rcysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bl fibroids or prolapse spinal cord injury or any other brain, spinal or nerve condition ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bod , intestinal polyps or any other abdominal condition s, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other r of the eye dition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochle s, tonsillitis, or adenoiditis rightion of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistr is, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic- on and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycysti disease or failure, cystic fibrosis or any other liver-related condition and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycysti disease or any other renal or urinary condition didition of the prostate including undescended testes or urinary incontinence ter medical condition not listed above that may require treatment or surgery die detail where "Y" has been ticked: EFICLARY DETAILS														ce, dia	gnosi	is, care	or trea	tment	was
	ad or do you currently have, any of the medical conditions listed below, for which medical adv led or received within the last 12 months? ne or joint condition including ongoing back, shoulder, hip or knee problems, arthritis, rheums valgia or any other musculoskeletal (back, bone and muscle) condition bood pressure, high cholesterol or lipids, ischaemic / coronary heart disease, chest pains, irregu at, heart murmur, heart failure, myocardial infarction, angina, peripheral vascular disease, va or any other heart-related medical condition 10 cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual ble fibroids or prolapse spinal cord injury or any other brain, spinal or nerve condition ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory boo , intestinal polyps or any other abdominal condition ts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other r of the eye dition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochec is, tonsilitis, or adenoiditis dition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry as, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolicr- on is, liver disease or failure, cystic fibrosis or any other liver-related condition and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycystic disease or any other renal or urinary condition and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycystic disease or any other renal or urinary condition ener medical condition not listed above that may require treatment or surgery ide detail where "Y" has been ticked: EFICIARY DETAILS EFICIARY DETAILS First Name														diagno	osis,	care or	treatme	ent wa	S
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				nent	ther	ару, (endo	metri	osis,	abnoi	mal pa	p sme	ears	or menstrual bleedir	ng,	Y		N		
9. Stroke, spinal core	d inju	iry or	any c	othe	r brai	in, sp	inal c	or ner	ve co	onditio	on					Y		N		
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11. Cataracts, glaucom disorder of the ey		quint,	, blurr	y vi	sion,	blind	ness	(parti	al or	full),	retinal o	detacl	hme	ent or any other		Y		N		
	condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry															Y		N		
13. Any condition of t	betes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-re															Y		N		
14. Diabetes, thyroid condition	ndition															Y		N		
15. Cirrhosis, liver dis	dition hosis, liver disease or failure, cystic fibrosis or any other liver-related condition															Y		N		
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18. Any condition of t	he p	rosta	te inc	ludi	ng un	desc	ende	d test	es oi	r urina	ary inco	ntine	nce			Y		Ν		
19. Any other medica	l con	ditio	n not	liste	ed abo	ove tl	nat m	ay re	quire	e treat	ment o	or surg	gery	,		Y		N		
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YOUR DEPENDANTS' DETAILS

Signature of bank account holder

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														Bar	nk na	me									
Branch name														Bra	inch c	code									
Account number																									
				Тур	e of	acco	ount							Che	que			Sav	rings			Tra	nsmis	sion	
By initialling this box you: 1. Authorise Guardrisk to de 2. Acknowledge that this au 3. Understand that cancelling the Mandate was still active 4. Acknowledge that this Au 5. Understand and accept the changing legislation, with of the adjusted premium. 6. Undertake to inform Gua 7. Confirm that Guardrisk shi in banking details 8. Accept that Guardrisk ma 9. Notwithstanding the fact premiums are collected for 10. Acknowledge that the fif 11. Acknowledge that in the automatically be the very in 12. Acknowledge that the age been captured. 14. Understand that the de	ithor ng th e, if s uthor hat s ne m rdris nall r that cove that cove rrst p e eve ext o nent reem	isatic e Ma uch a rity m hould onth k of a not be you er to r ayme ent th ordina instru-	on v and amo nay d yo n's r any e ho gra gran gran ent ary uction	will i late (ount v be a our j notic y cha eld l r acc ant C main t date v bus ions eren	rema does ts wo assig pren ce ar inge iable oun Guar in fo e wi payr ines issu ce n	ain ir s not ree o ned nium d su in yo e for t on drisk orce. II be nent s day ed fr umb	n ford can owed to a be a bjec our k inco a dat c peri- the f c day /. rom	ce an cel th to th third adjus t to y pankin rrect te oth missi first c falls this N	d eff e Ag pert. part ted a courn ng de clair ner tl on tc day o on a Mand your	ect ur reem y if th nnua right c etails n pay han th o colle f the Sund late w	ntil ca ent. / his agg Ily or of car and y ment at sp ect pr mont ay, o vill be	Ancel Agree reem n rend focella you a ss ma ss ma ss ma ss ma ss ma th in n r reco threa hip n	ed by ment ent is ewal a tion o uthor de as ed. ms, y which ognise ted a: umbe	y you t tha s also and i of co ise C a re ou a r you ed Sc s pay	a, in v t the c assi, n the over, t Guard sult c cknoo ur cov outh / ymen hich v	vritin acco gned case che a risk t f you wled f vou wled f t inst t inst	unt h to a of b foren o ver ur fail ge th arts. n pu ructi	olde third enefi nenti rify su ure t at it i blic h	r is n part t rest oned uch b o info s you nolida	ot en y. ructu auth ankin orm C ur resp y, the	titled Iring r orisat g det Guard oonsil	to ref neces cion v ails w risk o bility ment y by t	fund f sitate vill ext ith you f you to ens day w he	d by tend our ba char char t	to ank. nge that
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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.

momentum 🔿 TYB





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:

t	d	m	m	У	У	У	У

Signature of Applicant

Received by:	HR Stamp
Date Received:	





Please complete the be	low for each dep	oendant name	ed on you	ur policy		Depende	ant decla	ration	no 1 o	f				
Title	First name					Surname								
Identity number						Date of b	birth	d	d m	m y	у у у			
Relationship						Gender		Male		Fe	emale			
THEIR PREVIOUS GAP C	COVER (if not cov	ered on a prev	vious ga	p policy o	of yo	ours)								
Previous Insurer														
Previous cover option					Pi	revious Policy	Number							
Start date	d d m m	у у у	У			End date	9	d	d m	m y	у у у			
Please attach proof of this	previous gap cover	r.												
PROVIDE US WITH MO	RE INFORMATIO	N ABOUT YOU	IR DEPEN	NDANT'S	HEA	LTH								
Failure to disclose pre-existing medical conditions may result in limited or excluded benefits. mportant 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.														
Details of your general o	loctor Name:						Tel No:							
Please select a "Y" or "N" * Where you have selecte		•				• •	-	-	9		_			
1. Is this dependant curr	ently pregnant or t	rying to become	e pregnar	nt?					Y	Ν				
2. Has this dependant re	cently given birth?								Y	Ν				
3. Has this dependant ev	ver been diagnosed	with any form	of cancer	, malignar	nt or	pre-malignant	tumours	?	Y	N				
4. Has this dependant had during the next 12 mc		cedure during th	ne past 12	2 months o	or pla	anning a surgic	al proced	ure	Y	Ν				
5. Does this dependant t	take chronic or ong	oing medication	n?						Y	N				
Have you had or do you c recommended or received			condition	ns listed b	elow	, for which me	edical adv	ice, dia	agnosis,	care or tre	atment was			
6. Any bone or joint con fibromyalgia or any of						ems, arthritis, I	rheumatis	im,	Y	N				
 High blood pressure, l heartbeat, heart murn lesions or any other h 	mur, heart failure, r	myocardial infar		•		· ·			Y	N	Ų			
8. Ovarian cysts, hormor uterine fibroids or pro		erapy, endometi	riosis, abr	normal pa	p sme	ears or menstr	rual bleedi	ing,	Y	N	\mathbf{Y}			
9. Stroke, spinal cord inj	ury or any other br	ain, spinal or ne	erve condi	ition				L	Y	N				





10.	Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition	Y		Ν	
11.	Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Υ		Ν	
12.	Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	Y		Ν	
13.	Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	Y		Ν	
14.	Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	Y		Ν	
15.	Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	Y	[Ν	
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	[Ν	
18.	Any condition of the prostate including undescended testes or urinary incontinence	Y	[Ν	
19.	Any other medical condition not listed above that may require treatment or surgery	Y		Ν	
Plea	ase provide detail where "Y" has been ticked:				





Please complete the be	Gender Male Female OUS GAP COVER (if not covered on a previous gap policy of yours) Image: Covered on a previous gap policy of yours) er Image: Covered on a previous gap policy of yours) er Image: Covered on a previous gap policy of yours) er Image: Covered on a previous gap policy of yours) er Image: Covered on a previous gap cover. Image: Covered on a previous gap cover. Image: Covered on a previous gap cover. WITH MORE INFORMATION ABOUT YOUR DEPENDANT'S HEALTH Failure to disclose pre-existing medical conditions may result in limited or excluded benefits. note: er, birth or pregnancy-related medical condition that existed within 12 months before the first day of cover will be excluded																		
Title	First na	ime								Surname									
Identity number										Date of	birth	d	d	m	m	У	У	У	У
Relationship										Gender		Male	2			Fo	emale	2	
THEIR PREVIOUS GAP	COVER (if I	not co	overed or	n a pr	revio	ous g	gap	polic	y of y	ours)									
Previous Insurer																			
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Start date	d d	m m	у у	У	У					End dat	e	d	d	m	m	У	У	У	У
Please attach proof of this	s previous g	ар соч	ver.																
PROVIDE US WITH MO	RE INFORI	MATIO	ON ABOL	JT YC	OUR	DEP	EN	DANT	'S HE	ALTH									
Important to note: - Any cancer, birth or p months after cover st	oregnancy-r arts; fect, medic	elated	l medical o	condit	tion	that	exi	sted w	vithin	12 months bef	fore the fi	rst da	iy of c	cover	will b				
Details of your general	doctor	Name: Tel No:																	
 * Where you have select 1. Is this dependant cur 2. Has this dependant re 3. Has this dependant e 4. Has this dependant h during the next 12 m 5. Does this dependant 	etails of your general doctor Name: Tel No: asse select a "Y" or "N" for each of the below questions. Please answer honestly, accurately and complet /here you have selected "Y" you must supply us with more information in the space below the question Is this dependant currently pregnant or trying to become pregnant? Has this dependant recently given birth? Has this dependant ever been diagnosed with any form of cancer, malignant or pre-malignant tumours? Has this dependant had any surgical procedure during the past 12 months or planning a surgical procedure during the next 12 months? Does this dependant take chronic or ongoing medication?															N N N			
Have you had or do you or receive			-		al co	nditi	ons	listed	belov	v, for which m	edical adv	vice, c	diagno	osis, (care o	or tre	atme	nt w	as
 Any bone or joint cor fibromyalgia or any o 										ems, arthritis,	rheumati	sm,	Y			Ν			
 High blood pressure, heartbeat, heart mur lesions or any other h 	mur, heart	failure	, myocard	ial inf									Y			N			
8. Ovarian cysts, hormo uterine fibroids or pro		nent tl	nerapy, er	dome	etrio	osis, a	ibno	ormal p	oap sn	lears or menst	rual bleed	ling,	Y			N			
9. Stroke, spinal cord in	ury or any	other l	orain, spin	alor	nerv	e con	nditi	ion					Y			N	J		
10. Gastric ulcers, hernia disease, intestinal po	yps or any	othera	abdomina	l conc	ditio	n						el Y	Y			N	3		Y
11. Cataracts, glaucoma, s disorder of the eye	quint, blurı	ry visic	on, blindne	ess (pa	artia	l or fi	ull),	retina	l deta	chment or any	other		Y			N		Y	





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





Please complete the b	elow for ea	ach de	ependar	nt nar	ned	on y	our p	oolicy	/	Depend	lant decla	iratio	on no	030	f				
Title	First na	ime								Surname									
Identity number										Date of I	birth	d	d	m	m	У	У	У	У
Relationship										Gender		Male	2			Fe	emale	2	
THEIR PREVIOUS GAP	COVER (if I	not co	vered o	n a p	revi	ous g	gap p	olicy	of y	ours)									
Previous Insurer																			
Previous cover option									F	Previous Policy	Number								
Start date	d d	m m	уу	У	У					End dat	e	d	d	m	m	У	У	У	У
Please attach proof of thi	s previous g	ар соv	er.																
PROVIDE US WITH MC	RE INFORI	ΜΑΤΙΟ	ON ABO	υτ γα	OUR	DEP	END/	ANT'S	S HE	ALTH									
Important to note: - Any cancer, birth or months after cover si	cer, birth or pregnancy-related medical condition that existed within 12 months before the fir after cover starts; er physical defect, medical condition, illness or injury that existed within 12 months before the after cover starts. your general doctor Name: Tel No: ct a "Y" or "N" for each of the below questions. Please answer honestly, accurately and comp																		
Details of your general	doctor	Name	e:																
 * Where you have select 1. Is this dependant cur 2. Has this dependant r 3. Has this dependant e 4. Has this dependant h during the next 12 m 	tails of your general doctor Name: Tel No: asse select a "Y" or "N" for each of the below questions. Please answer honestly, accurately and complet there you have selected "Y" you must supply us with more information in the space below the question is this dependant currently pregnant or trying to become pregnant? Has this dependant recently given birth? Has this dependant ever been diagnosed with any form of cancer, malignant or pre-malignant tumours? Has this dependant had any surgical procedure during the past 12 months or planning a surgical procedure during the next 12 months? Does this dependant take chronic or ongoing medication?															N N N			
Have you had or do you o recommended or receive	-		-		al co	onditio	ons li	sted I	belov	v, for which m	edical adv	ice, d	liagno	osis, o	care o	r trea	_ itme	nt wa	as
6. Any bone or joint cor fibromyalgia or any o										ems, arthritis,	rheumatis	sm,	Y			N			
 High blood pressure, heartbeat, heart mur lesions or any other h 	mur, heart	failure	, myocar	dial in							-		Y			N			
8. Ovarian cysts, hormo uterine fibroids or pr		nent th	nerapy, e	ndom	etrio	osis, a	bnorr	mal pa	ap sn	iears or menst	rual bleed	ing,	Y			N			
9. Stroke, spinal cord in	iury or any o	other b	orain, spi	nal or	nerv	ve con	nditio	n					Y			N	L		
10. Gastric ulcers, hernia disease, intestinal po							, GOR	RD (he	artbu	ırn), inflammat	tory bowe	Y	Y			N	$\left\{ \right\}$		Y
11. Cataracts, glaucoma, disorder of the eye	squint, blurr	y visio	n, blindn	iess (p	artia	l or fi	ull), re	etinal	deta	chment or any	other		Y			N		Y	\downarrow





 Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis 	Y	Ν
13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	Υ	Ν
14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	Υ	Ν
15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	Υ	Ν
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	Ν
 Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders 	Υ	Ν
18. Any condition of the prostate including undescended testes or urinary incontinence	Υ	Ν
19. Any other medical condition not listed above that may require treatment or surgery	Υ	Ν
Please provide detail where "Y" has been ticked:		





Please complete the below for each dependant named on your policy Dependant decl								aratio	on no	o 4 o	f								
Title	First name							Surname											
Identity number										Date of	birth	d	d	m	m	У	У	У	У
Relationship										Gender Mai				Female					
THEIR PREVIOUS GAP	COVER (if ı	not co	overed o	n a p	revio	ous g	gap	policy	y of y	ours)									
Previous Insurer																			
Previous cover option										Previous Policy	/ Number								
Start date	d d	m m	n y y	У	У					End dat	te	d	d	m	m	У	У	У	У
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	Nam	e:								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 cur	rently pregr	nant o	r trying to	beco	ome p	oregn	nantî	?					Y			N			
2. Has this dependant recently given birth?									Y										
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?								lure	Υ										
5. Does this dependant take chronic or ongoing medication?									Y										
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							sm,	YN											
 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										
8. Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse								ling,	Y										
9. Stroke, spinal cord injury or any other brain, spinal or nerve condition									YN										
10. Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition										YN									
11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye									Y			N		Y	\downarrow				





 Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis 	Y	Ν
13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	Υ	Ν
14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	Υ	Ν
15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	Υ	Ν
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	Ν
 Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders 	Υ	Ν
18. Any condition of the prostate including undescended testes or urinary incontinence	Υ	Ν
19. Any other medical condition not listed above that may require treatment or surgery	Υ	Ν
Please provide detail where "Y" has been ticked:		