



# **GAP SHIELD - 2022 APPLICATION VOLUNTARY GROUP – DEBIT ORDER DEDUCTION**

Thank you for deciding to apply for Gap Shield gap insurance cover with Admed, 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: gapshield@guardrisk.co.za

#### Who we are

Admed, a division of Guardrisk Insurance Company Limited – Registration number 1992/001639/06, Financial Service Provider No. 75

#### What you must do

- 1. Fill in the form.
- 2. Submit the necessary supporting documents with your completed claim form.
- 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 gapshield@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						

TELL US ABOUT YOU	TELL US ABOUT YOUR EMPLOYER																				
Name of employer																					
Branch (if applicable)																					
Employee no.													Date employed	d	d	m	m	У	У	У	У

TELL US ABOUT YOU	J																			
Title						Surn	ame													
First Name																				
Identity number												Date of birth	d	d	m	m	У	У	У	У
Medical aid name												Plan option								
Medical aid no.												Date joined	d	d	m	m	У	У	У	У
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 medical aid membership certificate (not older than 1 month) or medical aid application form if you are a taking medical aid at the same time as																				

your gap cover. Please note that it is your responsibility to inform us if you are not on a medical aid when your gap cover is incepted. All dependents 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.

TELL US HOW TO CONTACT YOU										
Postal address	Physical address									
	Physical address									
	Postal code Postal code									
Email address:										
Office tel. no.	Mobile no.									

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# Tel: 0860 102 936 | Email gapshield@guardrisk.co.za





# TELL US WHAT YOU WOULD LIKE YOUR COVER OPTION AND START DATE TO BE

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 15<sup>th</sup> day of the month, we may make a double deduction from your bank account.

Please select your cover and monthly premium option:

The monthly premium is inclusive of commission and VAT.

When do you want your cover to start?

Gap Shield R120

d	d	m	m	У	У	У	У

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

# TELL US IF YOU HAD 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	У	У	У	У	End date	d	d	m	m	У	У	У	У

Please attach proof of your previous gap cover if applicable.

All dependents must reflect on this certificate in order to benefit from reduced or no waiting periods being applied to their cover. If your dependents 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.

<b>Details</b>	of your	general	doctor
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Name:	Tel No:	

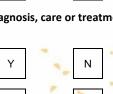
# Please select a "Y" or "N" for each of the below questions. Please answer honestly, accurately and completely.

# \* 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	
2.	Have you recently given birth?	Y	
3.	Have you ever been diagnosed with any form of cancer, malignant or pre-malignant tumours?	Y	
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	
5.	Do you 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?

- 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
- 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



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# Admed

GUARDRISK TAILORED RISK SOLUTIONS	
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8. Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bl uterine fibroids or prolapse	eeding, Y	Ν
9. Stroke, spinal cord injury or any other brain, spinal or nerve condition	Y	Ν
<ol> <li>Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bo disease, intestinal polyps or any other abdominal condition</li> </ol>	owel Y	Ν
11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Y	Ν
12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochle implants, tonsillitis, or adenoiditis	ar Y	Ν
13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistr	y Y	Ν
14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic- condition	related 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, polycysti kidney disease or any other renal or urinary condition	c Y	Ν
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	Υ	Ν
*Please provide detail where "Y" has been ticked:		

# TELL US ABOUT YOUR BENEFICIARY

In the event of your de	In the event of your death while you are covered on the policy, please tell us who to pay any claim amounts to																					
Title					Name	e								Surname								
Identity number														Date of birth	d	d	m	m	У	У	У	У
Mobile number											Phy	sical	addre	ess:								
Relationship to you																						

# YOUR DEPENDENTS' DETAILS

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

Any dependent 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.

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# 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	anch d	ode									
Account number																							
			Ту	/pe of	ассс	ount						Che	que			Savi	ings			Trar	smiss	sion	
		l	Pleas	se cho	oose	your	debit	day:	1	st	7th		10t	h	1	5th		20t	h	2	5th		
DEBIT ORDER MANDAT	ΓE																						

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 be issued once your application form has been captured.
- 14. Understand that the debit order transaction on your bank statement will reflect as 'GSHIELD'.

Signature of bank account holder

Date signed:

d m

# **PROVIDE US WITH YOUR BROKER'S DETAILS**

## INTERMEDIARY DETAILS

Brokerage name								
Branch name		FSP No	0.					
Advisor name	Mobile No.							
E-mail address						1 3	•	1

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By initialling this box you confirm that your financial adviser has communicated the below to you:

- 1. That he/she is mandated by an authorised Financial Services Provider (FSP), as set out above, to act on behalf of that FSP as a representative.
- 2. That he/she is an accredited financial adviser in terms of the FAIS Act at the date of signing this application form.
- 3. That he/she accepts their appointment by you to provide advice and ongoing intermediary services in respect of this policy.
- 4. That he/she has made you aware of the commission payable by Guardrisk to him/her in respect of this policy.
- 5. That he/she has conducted a financial needs analysis and this insurance product is suitable to meet your insurance needs.
- 6. That he/she has explained the insurance product to you and you understand how the product works, what is covered and what is not covered, as well as how to claim from the policy.
- 7. That he/she is responsible for providing you with his/her contact details and he/she is accountable for any advice given to you about completion of this application form.

### 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.

# CLIENT / APPLICANT 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 through my employer 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 dependents' cover will and will not pay.
- I further declare my understanding that my and my dependents' eligibility for cover is dependent on my, and my dependents remaining active members of a registered medical scheme and I undertake to advise Guardrisk if I terminate my, or my dependents' medical scheme membership at any time.
- 9. I provide authority for my employer to make a cover nomination on my behalf and furthermore indemnify Guardrisk against liability for any loss that may result from an incorrect nomination of such cover by the employer.
- 10. I accept that any notice given to my employer is deemed to have been given to me.

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- 11. I declare my understanding that my employer has appointed an intermediary to the group policy and has authorised Guardrisk to make payment of monthly commission, calculated as 20% of the first R299 of monthly premium and 15% of the remaining monthly premium, to such appointed intermediary.
- 12. 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 dependents') diagnosis, treatment and medical history. I further confirm that my dependents 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.
- 13. 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.
- 14. I authorise Guardrisk to use, review and process any of my or my dependents' personal information provided to Guardrisk in the course of this application and for the purpose of administering cover and processing of future claims under this policy. I further confirm that my dependents and/or beneficiaries have also provided me with the authority to disclose their personal information to Guardrisk.
- 15. I confirm that I am aware of my right to request a copy of my and my dependents' 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.
- 16. I authorise Guardrisk, or its appointed service provider, to negotiate on my or my dependents' 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 (prescribed minimum benefits).
- 17. I authorise Guardrisk to negotiate discounts on my or my dependents' 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.
- 18. 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.
- 19. I authorise Guardrisk to disclose all relevant information to the appointed broker on my policy to assist in the processing of this application form, for the purpose of administering cover and processing of all future claims under this policy. This information could include my (or one of my dependents') medical diagnosis, treatment and history as well as personal information. I further confirm that my dependents 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, administrating of this policy and any claims processed by Guardrisk on this policy.

Date signed:

Signature of Applicant

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# **DEPENDENT DECLARATION**

Ple	ase comp	olete	the b	elow	for ea	nch de	epende	nt na	med	on y	our poli	су	Depei	ndant deo	clarat	ion n	o 1 c	of			
Title	è			F	irst na	me							Surname								
Ider	ntity numb	ber											Date c	of birth	d	d	m	m	У	У	уу
Rela	ationship												Gender		Ма	le			Fe	emale	
THE	EIR PREVI	1009	GAP (	COVE	R (if n	ot co	vered	on a p	revi	ous g	ap polio	cy of y	yours)								
Prev	vious Insu	rer																			
Prev	vious cove	er opt	ion										Previous Poli	cy Numbe	r						
Star	rt date			d	d r	n m	у	у у	У				End d	ate		d d	d r	n m	У	У	уу
Plea	ase attach	proc	of of thi	s prev	ious ga	ар соч	ver.														
PRO	OVIDE US	S WI	гн мо	RE IN	IFORM	ЛАТІС	ON ABC	DUT TI	HIS D	DEPEN	NDENT'S	S HEA	LTH								
-	months a	er, bi fter ( r phy fter (	: irth or cover st rsical de cover st	pregna arts; efect, arts.	ancy-ro medica	elated	l medica	ll cond	lition	that	existed v	vithin	result in lir 12 months b in 12 months	efore the	first d	ay of	cove	er will k			
							-						tly, accuratel space below	-	-	-					
1.	Is this de	pend	ent cur	rently	r pregn	ant o	r trying t	o beco	ome	pregn	ant?					Y	,		N		
2.	Has this c	leper	ndent r	ecentl	ly giveı	n birth	1?									Y	,		N		
3.	Has this c	lepei	ndent e	ver be	een dia	agnose	ed with a	any for	m of	fcance	er, malig	nant c	or pre-maligna	ant tumou	ırs?	Y	,		N		
4.	Has this c during th					ical pr	ocedure	durin	g the	past :	12 montl	hs or p	planning a sur	gical proc	edure	Y	,		N		
5.	Does this	dep	endent	take d	chronic	c or or	ngoing m	nedicat	tion?	•						Y	,		Ν		
	e you had ommende		-		-		-		cal co	onditio	ons listed	d belo	w, for which	medical a	dvice,	diagr	nosis,	, care d	or trea	atmen	t was
6.	Any bone fibromya	-				-							olems, arthrit	is, rheuma	atism,	Y	,		Ν		
7.		t, hea	art mur	mur, l	heart f	ailure	, myoca	rdial in					ease, chest pa ral vascular d			Y	,		N		
8.	Ovarian c uterine fi	-				nent ti	nerapy, (	endom	netric	osis, al	onormal	pap sı	mears or mer	istrual ble	eding,	Y	,		N	].	
9.	Stroke, sp	oinal	cord in	jury o	r any c	other b	orain, sp	inal or	nerv	ve con	dition					Y	,	?	N	•	- 1
10.	Gastric ul disease, i										GORD (ł	neartb	urn), inflamn	natory bov	wel	Y			N		
11.	Cataracts, disorder (	-		squint	, blurr	y visic	on, blind	ness (p	oartia	al or fu	ıll), retin	al det	achment or a	ny other		Y	,		N	•	•
An A	erwritten by uthorised Marc, Tow	Finar	ncial Se	rvices	Provid	ler an	d Licens	ed Nor					m Metropolitai	n Holdings	Limite	ed.	1				





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	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
<ol> <li>Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders</li> </ol>	Y	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:		

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# **DEPENDENT DECLARATION**

Please complete the	-	ch dep	endent na	med on y	your polic	y Depei	ndant dec	claration no 2	of
Title	First nar	ne				Surname			
Identity number						Date c	f birth	d d n	n m y y y y
Relationship						Gender		Male	Female
THEIR PREVIOUS GA	P COVER (if n	ot cove	ered on a p	revious	gap policy	of yours)			
Previous Insurer									
Previous cover option						Previous Poli	cy Numbe	r	
Start date	d d n	n m	у у у	У		End d	ate	d d	m m y y y y
Please attach proof of	this previous ga	p cover	r.						
PROVIDE US WITH M	<b>NORE INFORM</b>	1ATION	N ABOUT TI	HIS DEPE	NDENT'S	HEALTH			
Important to note: - Any cancer, birth months after cove	or pregnancy-re r starts; l defect, medica	lated n	nedical cond	ition that	existed wi		efore the	first day of cov	er will be excluded for 12 over will be excluded for 9
Details of your gener	al doctor	ame:					Tel No:		
Please select a "Y" or * Where you have sele 1. Is this dependent	ected "Y" you m	iust sup	oply us with	more info	ormation in	-	-		Ν
2. Has this depender	it recently given	birth?						Υ	Ν
3. Has this depender	it ever been dia	gnosed	with any for	m of cano	cer, maligna	ant or pre-maligna	ant tumou	rs? Y	Ν
4. Has this depender during the next 12		cal proc	cedure durin	g the past	: 12 months	s or planning a sur	gical proce	edure Y	Ν
5. Does this depende	ent take chronic	or ongo	oing medicat	ion?				Y	N
Have you had or do yo recommended or rece	-	-		al condit	ions listed	below, for which	medical a	dvice, diagnosis	s, care or treatment was
<ol><li>Any bone or joint fibromyalgia or an</li></ol>					•	•	s, rheuma	itism, Y	Ν
<ol> <li>High blood pressu heartbeat, heart n lesions or any other</li> </ol>	nurmur, heart fa	ailure, n	nyocardial in						Ν
8. Ovarian cysts, hor uterine fibroids or		ent the	rapy, endom	ietriosis, a	abnormal p	ap smears or mer	strual blee	eding, Y	N
9. Stroke, spinal cord	l injury or any o	ther bra	ain, spinal or	nerve co	ndition			Y	- N
10. Gastric ulcers, her disease, intestinal		-			n, GORD (he	artburn), inflamn	natory bow	vel Y	N
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11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Υ	Ν
<ol> <li>Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis</li> </ol>	Υ	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	Υ	Ν
17. 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:		







# **DEPENDENT DECLARATION**

Please complete	the b	elow for	each d	epender	nt nar	ned	on y	our polic	:y	Depei	ndant dec	larati	on no	o 3 oj	f			
Title		First	name							Surname								
Identity number										Date c	of birth	d	d	m	m	у у	/ У	У
Relationship			•					• •	•	Gender		Mal	е			Ferr	nale	
THEIR PREVIOUS	GAP	COVER (i	f not co	overed o	n a p	revio	ous g	ap policy	y of y	yours)								
Previous Insurer																		
Previous cover opt	ion									Previous Poli	cy Number	r						
Start date		d d	m n	л у у	У	У				End d	ate	C	d d	m	m	У	/ У	У
Please attach proo	f of thi	s previous	s gap cov	/er.			_											
PROVIDE US WIT	н мо	RE INFO	RMATI	ON ABO	UT TH	IIS D	EPEN	NDENT'S	HEA	ITH.								
	Failu	ire to dis	close p	re-exist	ing m	edic	al co	nditions	may	result in lir	nited or e	exclud	ed b	enefi	its.			
<ul> <li>Important to note</li> <li>Any cancer, bi months after of</li> <li>Any other phy months after of</li> </ul>	rth or   cover st sical de	arts; efect, mec											-					
Details of your ge	eneral	doctor	Name:								Tel No:							
Please select a "Y' * Where you have	selecto	ed "Y" yo	u must s	upply us	with	more	e infoi	rmation i			•	•	•	_		[ <b></b> ]		
1. Is this depende	ent cur	rently pre	gnant o	r trying to	o beco	me p	oregn	ant?					Y			Ν		
2. Has this deper	ndent re	ecently gi	ven birtl	1?									Y			N		
3. Has this deper	ndent e	ver been	diagnos	ed with a	ny for	m of	cance	er, malign	ant c	or pre-maligna	ant tumour	rs?	Y			Ν		
<ol> <li>Has this deper during the nex</li> </ol>			rgical pr	ocedure	during	g the	past :	12 month	is or p	planning a sur	gical proce	edure	Y			N		
5. Does this depe	endent	take chro	nic or o	ngoing m	edicat	ion?							Y			Ν		
Have you had or d recommended or i						al co	nditio	ons listed	belo	w, for which	medical ac	dvice, o	diagn	osis,	care o	r treat	ment	was
<ol> <li>Any bone or jo fibromyalgia o</li> </ol>										olems, arthrit	is, rheuma	tism,	Y			Ν		
<ol> <li>High blood pre heartbeat, hear lesions or any</li> </ol>	art mur	mur, hear	rt failure	, myocar	dial in								Y			N		
8. Ovarian cysts, uterine fibroid			ement t	herapy, e	ndom	etrio	sis, al	onormal p	oap si	mears or mer	strual blee	eding,	Y	,	•	Ν		
9. Stroke, spinal	cord in	jury or an	y other	brain, spi	nal or	nerv	e con	dition					Y		,	N	•	.1
10. Gastric ulcers, disease, intest			-	-				GORD (h	eartb	ourn), inflamn	natory bow	vel	Y	1		Ν	•	•
																-		
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11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Υ	Ν
<ol> <li>Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis</li> </ol>	Υ	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	Υ	Ν
17. 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:		





# **DEPENDENT DECLARATION**

Tel: 0860 102 936 | Email gapshield@guardrisk.co.za

Please complete the be		ependent nam	ned on your policy	Denen	dant decla	ration no 4 c	of
Title	First name		, poney	Surname			,
Identity number				Date of	birth	d d m	m y y y y
Relationship				Gender		Male	Female
THEIR PREVIOUS GAP (	COVER (if <u>not co</u>	overe <u>d on a pr</u>	evious gap policy	of yours)			I
Previous Insurer							
Previous cover option				Previous Poli	cy Number		
Start date	d d m r	n y y y	У	End c	late	d d	m m y y y y
Please attach proof of this	previous gap co	/er.					
PROVIDE US WITH MO	RE INFORMATI	ON ABOUT TH	IS DEPENDENT'S H	IEALTH			
Important to note: - Any cancer, birth or p months after cover st	oregnancy-related arts; fect, medical con	l medical condit		hin 12 months be	fore the firs	st day of cove	fits. r will be excluded for 12 /er will be excluded for 9
Details of your general of	loctor Name:				Tel No:		
Please select a "Y" or "N' * Where you have selecter 1. Is this dependent cur	ed "Y" you must s	upply us with n	nore information in	•	•	•	Ν
2. Has this dependent re	ecently given birt	1?				Υ	Ν
3. Has this dependent e	ver been diagnos	ed with any form	n of cancer, maligna	nt or pre-maligna	nt tumours?	γ	Ν
4. Has this dependent h during the next 12 me		ocedure during	the past 12 months	or planning a surg	ical procedu	ure Y	Ν
5. Does this dependent	take chronic or o	ngoing medicati	on?			Y	N
Have you had or do you o recommended or receive	-	-	I conditions listed b	elow, for which n	nedical advi	ice, diagnosis,	care or treatment was
<ol> <li>Any bone or joint con fibromyalgia or any o</li> </ol>	-				, rheumatis	m, Y	Ν
<ol> <li>High blood pressure, heartbeat, heart mur lesions or any other h</li> </ol>	nur, heart failure	, myocardial inf					Ν
8. Ovarian cysts, hormo uterine fibroids or pro		herapy, endome	etriosis, abnormal pa	p smears or mens	trual bleedi	ng, Y	N
9. Stroke, spinal cord inj	ury or any other	brain, spinal or r	nerve condition			Y	N
10. Gastric ulcers, hernia disease, intestinal pol				artburn), inflamm	atory bowel	Y	N
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11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Y	Ν	
12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	Υ	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	Υ	Ν	
17. 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	Y	Ν	
*Please provide detail where "Y" has been ticked:			

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14