



GAP SHIELD - 2022 APPLICATION VOLUNTARY GROUP - PAYROLL 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 C	OMPL	ETIN.	IG TI	HIS F	ORN	Л																			
Client / Applicant	Ye	S	No	P	leas	e rea	d and	d initi	al ea	ch de	clara	tion (under	· Clier	nt / App	licant	decl	ara	tion	and	cons	ent			
Appointed Broker	Ye	S	No	P	leas	e rea	d and	d initi	al ea	ch de	clara	tion	under	Brok	er decla	aratio	n and	d cc	onse	nt					
TELL US ABOUT Y	OUR E	MPL	OYE	R																					
Name of employer																									
Branch (if applicable	e)																								
Employee no.														l	Date en	nploye	ed	d	d	m	m	У	У	У	У
TELL US ABOUT YOU Title Surname																									
Title						Surr	ame	<u>:</u>																	
First Name																									
Identity number														D	ate of b	irth	d		d	m	m	У	У	У	У
Medical aid name														F	Plan opt	ion									
Medical aid no.														[Date joir	ned	d		d	m	m	У	У	У	У
Please attach medica your gap cover. Plea reflect on your	se note	N mber that	Rume ledim ship o it is y	d - <u>me</u> ed - <u>m</u> ertific our re	embe nemb cate (espor	rship(ership (not o sibilit	@rum @me lder t	edime than 1 inform	d.co.: mon us if	<mark>za</mark> ith) or f you a	Siso Sure medi o re no	onke med cal aid t on a	- <u>mem</u> - <u>mem</u> d appl i medi	bersh bersh icatio ical aid	d when y	nkehea medhe you a our ga	ealth.c ealth. re a t ap cov	o.za co.z akir ver i	- <u>2a</u> ng m is inc	epte	d. All	depe	nden	ts mu	
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Postal address											Phy	/sical	addr	ess								_		•	
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Email address:		ı	ı	1	ı	1					1								ı						
Office tel. no.													Mo	obile	no.										

Underwritten by Guardrisk Insurance Company Limited. Guardrisk is part of Momentum Metropolitan Holdings Limited. An Authorised Financial Services Provider and Licensed Non-Life Insurer (FSP No 75)

The Marc, Tower 2, 129 Rivonia Road, Sandton, 2196





														_
TELL US	WHAT YOU W	OULD LIKE	YOUR CO	OVER OPTI	ON AND ST	TART D	ATE TO BE							
	-						on the selected co			accour	nt.			
Please sel	ect your cover a	and monthly	premium	option:		Gap Sh	nield R120							
The month	ly premium is incl	usive of comn	nission and	VAT.										
				When do	you want y	our cove	er to start?	d d ı	m	m	У	У	У	
Cover can	only start on th	ne first day c	of the caler	ndar month	following ap	oplicatio	n. No requests fo	or backdatin	ng of (cover w	vill be co	onsidere	d.	
TELL US I	IF YOU HAD P	REVIOUS G	AP COVE	R										
Have you	previously belo	nged to any	other gap	provider? I	If yes, please	e give us	the details.							
Previous I	nsurer													
Previous o	cover option						Previous Polic	y Number						
Start date	!	d d	m m y	УУ	У		End da	ate	d	d	m m	У	У	У
or no wai		ing applied	to their co				must reflect on the coving cover from							
PROVIDE	US WITH MC	RE INFORI	MATION A	ABOUT YO	UR HEALTH	Н								
mont	t to note: cancer, birth or hs after cover s	pregnancy-r tarts; efect, medic	elated me	dical condit	tion that exi	sted wit	nay result in lin	efore the fir	rst da	y of co	over will			
Details o	of your general	doctor	Name:					Tel No:						
				-			nestly, accuratel the space below			-				
1. Are ye	ou currently pre	egnant or try	ing to bec	ome pregna	ant?					Υ		N		
2. Have	you recently giv	ven birth?								Υ]	N		
3. Have	you ever been	diagnosed w	vith any for	m of cance	r, malignant	or pre-n	nalignant tumou	rs?		Υ		N		
	you had any su g the next 12 m		dure durin _i	g the past 1	2 months or	r are you	planning a surgion	cal procedui	re	Υ		N		
5. Do yo	ou take chronic	or ongoing r	nedication	?						Υ]	N		
-	had or do you on the name of t		-		al conditions	s listed b	elow, for which	medical adv	ice, c	diagnos	sis, care	or treat	ment wa	IS
-	oone or joint com myalgia or any c			-			oroblems, arthriti on	s, rheumati	sm,	Υ	1	N		
heart		rmur, heart	failure, my	ocardial infa			disease, chest pa oheral vascular d	_		Υ		N		

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																		-	-			
8.	Ovarian cysts, houterine fibroids				nent the	rapy,	endo	metric	sis, abno	rmal pa	ap sme	ears (or mer	nstrua	l bleedi	ing,	Υ			N		
9.	Stroke, spinal co	rd inj	ury o	any o	other br	ain, sp	oinal (or nerv	e conditi	on							Υ			N		
10.	Gastric ulcers, he disease, intestin									RD (he	artbu	n), iı	nflamr	matory	y bowel	I	Υ			N		
11.	Cataracts, glauco disorder of the e		quint	, blurr	y vision	, blinc	Iness	(partia	l or full),	retinal	detac	hme	nt or a	iny otl	her		Υ			N		
12.	Any condition of implants, tonsilli					nclud	ing h	earing	problems	, sinus	or nas	sal pr	oblem	ns, coc	hlear		Υ			N		
13.	Any condition of	the n	nouth	ı, teet	h or gur	ns inc	ludin	g maxi	llo-facial t	reatm	ent or	spec	cialised	d dent	istry		Υ			N		
14.	Diabetes, thyroic	d dise	ase (i	ncludi	ing hypo	or hy	ypertl	nyroidi	sm), oste	oporos	is or a	ny o	ther m	netabo	olic-rela	ited	Υ			N		
15.	Cirrhosis, liver d	sease	or fa	ilure,	cystic fi	brosis	or ar	ny othe	er liver-re	ated c	onditio	on					Υ			N		
16	Kidney and/or re kidney disease o				•				ry or blac	lder in	fectior	ıs, di	alysis,	polyc	ystic		Υ			N		
17		y blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), kaemia, lymphoma, haemophilia and any other bleeding disorders y condition of the prostate including undescended testes or urinary incontinence															Υ			N		
18	Any condition of	ny condition of the prostate including undescended testes or urinary incontinence															Υ			N		
19	Any other medical condition not listed above that may require treatment or surgery																Υ			N		
*PI	Any other medical condition not listed above that may require treatment or surgery asse provide detail where "Y" has been ticked:																					_
																						_
TE	L US ABOUT YO	IIID E	PENIE	EICIA	DV																	_
	he event of your					rod o	n tho	policy	nloaco t	all us v	tha ta	nave	any di	aim an	nounts	to						
	· ·	Jeatii	WIIII	you			iii tiie	policy	, piease t	en us v	viio to	рау				ιο						
Titl					First N	ame								rname		-1						
	ntity number					+				Phys	ical ad	dres		of bir	rtn	d	d I	n n	1 /	У	У	У
	bile number									1 1113	icai au	uics	J.									
Rel	ationship to you																					
YO	UR DEPENDENT	S' DE	TAIL	.S																		
Ple	ase complete a se	para	te De	pende	ent Decl	aratio	on (la	st page	of this f	orm) fo	or eacl	n dep	ende	nt tha	t you w	vish t	o add	to you	ır pol	icy.		
	dependent for with the														be cov	/ered	on th	e poli	cy and	d whe	n add	ding
PR	OVIDE US WITH	YOU	IR BR	OKER	R'S DET	AILS																
INT	ERMEDIARY DET	AILS																				
Bro	kerage name																		-			. 1
Bra	nch name														FS	P No.		,				6
Adv	visor name										N	Лobil	le No.									•
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E-n	nail address																				0	

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

- 1. That he/she has made you aware of the commission payable by Guardrisk to him/her in respect of this policy.
- 2. That he/she has conducted a financial needs analysis and this insurance product is suitable to meet your insurance needs.
- 3. 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.		•
4.	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 co of this application form.	mpletio	'n
BR	ROKER DECLARATION AND CONSENT – only applicable when broker is completing application form on behalf of client		
Ple	ease 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.		
CL	IENT / APPLICANT DECLARATION AND CONSENT		
Ple	ease initial each of the following sentences below to confirm that you are in agreement with the statement:		
1.	I hereby apply for the Admed 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 dependents' 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 dependents' 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.		
8.	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.	٠	
10	0. I hereby provide authority for my employer to deduct my monthly premium from my salary and to pay this across to Guardrisk on my behalf.		-
11	I. I accept that any notice given to my employer is deemed to have been given to me.	.0	(

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12.	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.	
13.	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 medical scheme membership at any time.	
14.	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.	
15.	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.	
16.	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.	
L 7 .	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).	
L 8 .	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.	
19.	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.	
20.	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 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 and any claims processed by Guardrisk on this policy.	
	Date signed:	у у

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

Signature of Applicant





DEPENDENT DECLARATION

Ple	ase complete	e the	belo	w for ea	ch de	epen	dent	t named	l on y	our p	oolicy	/	Depen	dent decl	ara	tion	no :	1 of _.				
Title	e			First na	me								Surname									
Ide	ntity number												Date of	birth	(d	d	m	m	У	У	У
Rela	ationship												Gender		М	ale				Fer	nale	
THI	EIR PREVIOU	S GAI	Р СО	VER (if n	ot co	vere	d on	a previ	ious {	дар р	olicy	of ye	ours)									
Pre	vious Insurer																					
Pre	vious cover op	tion										P	revious Policy	y Number								
Sta	rt date		d	d r	n m	у	У	УУ					End da	te		d	d	m	m	У	У	У
Plea	ase attach prod	of of t	his p	revious ga	ap cov	er.			_													
PR	OVIDE US WI	тн м	IORE	INFORM	ЛАТІС	ON A	BOU	T THIS	DEPE	NDEI	NT'S	HEAL	TH									
lmp - -	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 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 months after cover starts. Details of your general doctor Name: Tel No:																					
De	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 depend	lent c	urrer	ntly pregn	ant o	r tryir	ng to	become	pregr	ant?							Υ			N		
2.	Has this depe	ndent	rece	ently giver	n birth	า?											Υ			N		
3.	Has this depe	ndent	evei	r been dia	gnose	ed wi	th an	y form o	f canc	er, m	aligna	ant or	pre-malignar	nt tumour	s?		Υ			N		
4.	Has this depe during the ne				cal pr	oced	ure d	uring the	e past	12 m	onths	or pl	anning a surg	ical proce	dure	e	Υ			N		
5.	Does this dep	ender	nt tak	ke chronic	or or	ngoin	g me	dication	?								Υ			N		
	ve you had or o ommended or	-		-		-			onditi	ons li	sted l	below	, for which n	nedical ad	lvice	, dia	gnos	sis, c	are o	r treat	men	t was
6.	Any bone or j fibromyalgia												ems, arthritis	, rheumat	ism,	, [Υ			N		
7.	High blood pr heartbeat, he lesions or any	art m	urmu	ir, heart f	ailure	, myc	card	ial infarc									Υ			N		
8.	Ovarian cysts, uterine fibroid				ent th	herap	y, en	dometri	osis, a	bnorr	mal p	ap sm	ears or mens	trual blee	ding	5,	Υ	-		N		٠
9.	Stroke, spinal	cord	injur	y or any o	ther l	brain,	, spin	al or ner	ve cor	nditio	n						Υ		,	N	٠	•
10.	Gastric ulcers disease, intes			_		_				, GOR	D (he	artbu	rn), inflamma	atory bow	el		Υ			N		.0

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





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

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





DEPENDENT DECLARATION

Please co	mplete	e the l	belov	w for e	ach d	eper	ndent	nar	ned	on y	our	policy	•	Depend	dent decl	ara	tion	no 2	of_				
Title				First na	me									Surname									
Identity nu	ımber													Date of	birth	(d	d	m	m	У	У	У
Relationsh	ip													Gender		М	ale				Fen	nale	
THEIR PR	EVIOU	S GAP	CO/	/ER (if	not c	overe	ed on	арі	revic	ous g	дар р	olicy	of y	ours)									
Previous Ir	surer																						
Previous c	over op	tion											F	Previous Policy	Number								
Start date			d	d	m n	n y	У	У	У					End da	te		d	d	m	m	У	У	/
Please atta	ch prod	of of th	nis pr	evious g	gap co	ver.																	
PROVIDE	US WI	TH M	ORE	INFOR	MATI	ON A	ABOU	T TH	IIS D	EPE	NDE	NT'S F	IEAL	TH									
month - Any of	ancer, b ns after	e: iirth oi cover ysical o	r preg starts	gnancy-l s; t, medic	relate	d me	dical c	condi	ition	that	exist	ed wit	hin 1	result in limi	ore the fi	irst (day d	of cov	ver v	vill be			
Details o	f your g	enera	l doc	tor	Nam	ne:									Tel No:								
														ly, accurately space below t								1	
1. Is this	depend	lent cu	urrent	tly preg	nant o	r tryi	ng to	beco	me p	regr	nant?							Υ			N		
2. Has th	is depe	ndent	recer	ntly give	n birt	h?												Υ			N]	
3. Has th	is depe	ndent	ever	been di	agnos	ed w	ith an	y for	m of	cano	er, m	aligna	nt or	r pre-malignan	t tumour	s?		Υ			N		
	is depe the ne				gical p	roced	ure d	uring	g the	past	12 m	onths	or p	lanning a surg	ical proce	dure	e	Υ			N		
5. Does t	his dep	enden	ıt take	e chroni	c or o	ngoin	ig med	dicat	ion?									Υ			N		
Have you l		-		-		-			al co	nditi	ions li	isted b	elov	v, for which m	edical ad	vice	, dia	gnos	is, ca	are o	r treat	men	t wa
				on inclu r muscu										lems, arthritis,	rheumat	ism,	,	Υ			N		
heartk	eat, he	art mu	ırmuı		failure	e, my	ocardi	ial in						ase, chest pair al vascular dis	_			Υ			N		
	ın cysts e fibroi				nent t	herap	oy, en	dom	etrio	sis, a	bnor	mal pa	ıp sm	nears or mens	trual blee	ding	<u>,</u>	Υ	•	4	N		•
9. Stroke	, spinal	cord i	njury	or any	other	brain	, spina	al or	nerv	e coi	nditio	n						Υ		,	N	•	0
				oor dige or any		_					, GOF	RD (hea	artbu	urn), inflamma	tory bow	el		Υ			N	•	.0

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

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DEPENDENT DECLARATION		
Please complete the below for each dependent named on your polic	1	:ion no 3 of
Title First name	Surname	
Identity number	Date of birth	
Relationship	Gender <i>Ma</i>	ale 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
Please attach proof of this previous gap cover.		
PROVIDE US WITH MORE INFORMATION ABOUT THIS DEPENDENT'S	HEALTH	
Failure to disclose pre-existing medical conditions	may result in limited or eyelu	ded henefits
Important to note:	may result in inniced of excid	ded belieffes.
- Any cancer, birth or pregnancy-related medical condition that existed wi	ithin 12 months before the first c	lay of cover will be excluded for 1
months after cover starts;Any other physical defect, medical condition, illness or injury that existed	within 12 months hefore the first	t day of cover will be excluded for
months after cover starts.	within 12 months before the ms	t day of cover will be excluded for
	1	
Details of your general doctor Name:	Tel No:	
Please select a "Y" or "N" for each of the below questions. Please answer h		
* Where you have selected "Y" you must supply us with more information in	n the space below the questionna	ire.
1. Is this dependent currently pregnant or trying to become pregnant?		Y
2. Has this dependent recently given birth?		Y
3. Has this dependent ever been diagnosed with any form of cancer, malignation	ant or pre-malignant tumours?	Y
4. Has this dependent had any surgical procedure during the past 12 months	c or planning a curgical procedure	
during the next 12 months?	s or planning a surgical procedure	Y
5. Does this dependent take chronic or ongoing medication?		Y
Have you had or do you currently have, any of the medical conditions listed recommended or received within the last 12 months?	below, for which medical advice,	, diagnosis, care or treatment was
Any bone or joint condition including ongoing back, shoulder, hip or knee	problems, arthritis, rheumatism.	
fibromyalgia or any other musculoskeletal (back, bone and muscle) condi	•	Y
7. High blood pressure, high cholesterol or lipids, ischaemic / coronary heart		Y
heartbeat, heart murmur, heart failure, myocardial infarction, angina, per lesions or any other heart-related medical condition	ripheral vascular disease, valve	
Ovarian cysts, hormone replacement therapy, endometriosis, abnormal p	pap smears or menstrual bleeding	, , ,
uterine fibroids or prolapse	, 22 22 20 20 20 20 20 20 20 20 20 20 20	Y
9. Stroke, spinal cord injury or any other brain, spinal or nerve condition		Y
10. Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (he	earthurn) inflammatory howel	
To. Gastric dicers, Herrias, poor digestion, galistones, spastic colon, GORD (ne	cartburn, minamiliatory bower	

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disease, intestinal polyps or any other abdominal condition





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





DEPENDENT DECLARATION

Pleas															dent decl	larati	ion r	10 4 0	f			
Title				Firs	st nar	ne								Surname								
Identi	ity number													Date of	birth	d	d	m	m	У	У	У
Relati	ionship													Gender		Ма	le			F	emale	?
THEI	R PREVIOUS	S GAI	Р СО	VER	(if n	ot co	vere	d on	a prev	ious	gap p	oolicy	of y	ours)								
Previo	ous Insurer																					
Previo	ous cover op	tion												Previous Poli	cy Numbe	er						
Start	date		C	d	d r	m r	n y	У	У	У				End d	ate		d	d	m	m y	У	У
Please	e attach prod	of of t	his p	revio	us ga	p cov	er.															
PRO\	VIDE US WI	TH M	IORE	INF	ORN	IATIO	ON A	BOUT	THIS	DEPE	NDE	NT'S	HEAI	LTH								
- A m - A	nonths after	e: irth o cover /sical	r pre start	egnar ts; ct, m	ncy-re	elated	d med	lical co	onditio	n that	t exist	ed wi	thin :	result in lim 12 months bei	ore the f	irst d	ay of	f cove	r will l			
Deta	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	s this depend	lent c	urrer	ntly p	regna	ant o	r tryir	ng to b	ecome	preg	nant?						,	Υ		N		
2. H	las this depe	ndent	rece	ently	given	n birtl	า?											Υ		N		
3. H	las this depe	ndent	evei	r bee	n dia	gnos	ed wi	th any	form o	of can	cer, m	naligna	ant oi	r pre-malignar	it tumour	s?	,	Υ		N		
	las this depe luring the ne				surgio	cal pr	oced	ure du	ring th	e pas	t 12 m	nonths	or p	lanning a surg	ical proce	dure	,	Υ		N		
5. D	oes this dep	ender	nt tak	ke ch	ronic	or or	ngoin	g med	ication	?							,	Υ		N		
	you had or on mended or									ondit	ions l	isted	belov	v, for which m	edical ad	lvice,	diag	nosis,	care	or tre	atmeı	nt was
	Any bone or jo ibromyalgia o					_	_	-						lems, arthritis	rheumat	ism,	,	Y		N		
h		art m	urmu	ır, he	art fa	ailure	, myc	cardia	al infar					ase, chest pair al vascular dis			,	Υ		N		
	Ovarian cysts, Iterine fibroid				acem	ent t	herap	y, end	lometr	iosis,	abnor	mal p	ap sn	nears or mens	trual blee	ding,	,	Y	•	N		
9. S	itroke, spinal	cord	injur	y or a	any o	ther l	brain,	spina	l or ne	rve co	nditio	on					,	Υ	*	N		
	Gastric ulcers, lisease, intes										n, GO	RD (he	eartbu	urn), inflamma	tory bow	el	,	Y		N	•	.0

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