

GAP COVER SERIES INDIVIDUAL DEBIT ORDER APPLICATION FORM

Underwritten by Constantia Insurance Company Limited (CICL), Reg. No. 1952/001514/06, FSP No: 31111 (The Insurer)

- THIS IS NOT A MEDICAL SCHEME AND THE COVER IS NOT THE SAME AS THAT OF A MEDICAL SCHEME.
- THIS POLICY IS NOT A SUBSTITUTE FOR MEDICAL SCHEME MEMBERSHIP.
- THE MASTER POLICY ISSUED IS THE SOURCE OF ALL BENEFITS, RIGHTS, AND OBLIGATIONS AND EXCLUSIONS. TO DETERMINE YOUR INDIVIDUAL NEEDS, WE SUGGEST THAT YOU CONTACT YOUR BROKER AND REQUEST ADVICE FROM HIM / HER.

BROKER DETAILS

BROKER / CONSULTANT NAME															
NAME OF BROKERAGE															
FSP NUMBER								BROKER CODE							
BROKER CONTACT NUMBER		AREA CODE								VAT NUMBER					
BROKER E-MAIL ADDRESS								UNIQUE IDENTIFIER (IF NECESSARY)							

PERSONAL PARTICULARS

APPLICANT

TITLE				SURNAME						FIRST NAMES					
ID NUMBER															

EMPLOYER

NAME OF EMPLOYER						DATE EMPLOYED		D	D	M	M	Y	Y	Y	Y
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MEDICAL SCHEME

NAME OF MEDICAL SCHEME						PLAN OPTION									
DATE JOINED		D	D	M	M	Y	Y	Y	Y	MEDICAL SCHEME NUMBER					

DEPENDANTS To see who qualifies as a dependant see DECLARATION c)

FIRST NAME (AND SURNAME IF DIFFERENT)	RELATIONSHIP	I.D. NUMBER																		

CONTACT DETAILS

POSTAL ADDRESS										PHYSICAL ADDRESS (IF DIFFERENT TO POSTAL)										
					POSTAL CODE										POSTAL CODE					
HOME NUMBER	AREA CODE									WORK NUMBER	AREA CODE									
CELL NUMBER	CODE									E-MAIL										

MEDICAL QUESTIONNAIRE

1. DO YOU OR ANY OF YOUR DEPENDANTS SUFFER FROM ANY CHRONIC OR RECURRING ILLNESS OR ANY OTHER SERIOUS AILMENT?										NO		
										YES		
IF "YES" PLEASE SPECIFY												
2. HAVE YOU OR ANY OF YOUR DEPENDANTS RECEIVED TREATMENT OR ADVICE BY A MEDICAL PRACTITIONER IN THE LAST 12 MONTHS?										NO		
										YES		
IF "YES" PLEASE SPECIFY												
NAME OF FAMILY'S GENERAL MEDICAL PRACTITIONER												
CONTACT NUMBER				AREA CODE								
3. HAVE YOU OR ANY OF YOUR DEPENDANTS BEEN HOSPITALISED DURING THE LAST 12 MONTHS?										NO		
										YES		
IF "YES" TO THE ABOVE PLEASE SPECIFY THE CONDITION FOR WHICH HOSPITALISATION WAS NECESSARY												
NAME			DATE HOSPITALISED						REASON FOR HOSPITALISATION			
			D	D	M	M	Y	Y	Y	Y		
			D	D	M	M	Y	Y	Y	Y		
4. DO YOU OR ANY OF YOUR DEPENDANTS EXPECT TO BE HOSPITALISED DURING THE NEXT 12 MONTHS?										NO		
										YES		
IF "YES" TO THE ABOVE PLEASE SPECIFY THE CONDITION FOR WHICH HOSPITALISATION IS NECESSARY												
NAME			EXPECTED DATE OF HOSPITALISATION						REASON FOR HOSPITALISATION			
			D	D	M	M	Y	Y	Y	Y		
			D	D	M	M	Y	Y	Y	Y		

BENEFITS SUMMARY

BENEFIT	DESCRIPTION
GAP SERIES	<ul style="list-style-type: none"> GAP COVER 100 BENEFIT COVERS CHARGES ABOVE THE MEDICAL SCHEME TARIFF FOR ASSOCIATED SERVICES IN-HOSPITAL, LISTED OUT-PATIENT PROCEDURES, CHEMOTHERAPY OR RADIOTHERAPY FOR THE TREATMENT OF CANCER AND KIDNEY DIALYSIS. LIMITED TO 5 TIMES THE SCHEME TARIFF CO-PAYMENT BENEFIT COVERS CO-PAYMENTS OR DEDUCTIBLES LEVIED BY THE MEDICAL SCHEME FOR IN-HOSPITAL ADMISSIONS, LISTED OUTPATIENT PROCEDURES AND MRI AND CT SCANS. SUBLIMITATION BENEFIT COVERS CHARGES ABOVE THE DEFINED IN-HOSPITAL SUB-LIMITS IMPOSED BY THE MEDICAL SCHEME. CANCER BENEFIT COVERS THE SHORTFALL, EITHER THE CO-PAYMENT AFTER THE SUB-LIMITATION OR THE SUB-LIMITATION FOR CANCER TREATMENT FOR TRADITIONAL METHODS OR FOR EITHER THE CO-PAYMENT OR SUB-LIMITATION FOR TREATMENT OF CANCER WITH BIOLOGICAL DRUGS. CASUALTY WARD BENEFIT COVERS THE COST OF A MEDICAL OR A SURGICAL PROCEDURE FOLLOWING AN EMERGENCY INCURRED IN A HOSPITAL CASUALTY UNIT OF A HOSPITAL WHERE SUCH COSTS WERE NOT MET BY THE MEDICAL SCHEME.
DREAD DISEASE (SEVERE ILLNESS) BENEFIT	<ul style="list-style-type: none"> PROVIDES A ONCE OFF DREAD DISEASE BENEFIT, LIMITED TO DIAGNOSIS OF CANCER. ★ SEE DREAD DISEASE EXCLUSIONS - SENIORS (66 YEARS & OLDER) EXCLUDED.
PREMIUM WAIVER BENEFIT	<ul style="list-style-type: none"> PROVIDES A LUMP SUM PAYMENT EQUAL TO 6 MONTHS OF THE MEMBER'S MEDICAL SCHEME CONTRIBUTION. - SENIORS (66 YEARS & OLDER) EXCLUDED.
GUARDIAN*	<ul style="list-style-type: none"> PROVIDES BENEFITS FOR MEDICAL SCHEME SHORTFALLS BUT EXCLUDE GAP COVER; BENEFITS INCLUDE: CO-PAYMENTS OR DEDUCTABLES, IN-HOSPITAL SUB-LIMITS, CANCER COVER AND THE CASUALTY WARD BENEFIT. DREAD DISEASE BENEFIT: PROVIDES A ONCE OFF DREAD DISEASE BENEFIT, LIMITED TO DIAGNOSIS OF CANCER. ★ SEE DREAD DISEASE EXCLUSIONS. - SENIORS (66 YEARS & OLDER) EXCLUDED. PREMIUM WAIVER: PROVIDES A LUMP SUM PAYMENT EQUAL TO 6 MONTHS OF THE MEMBER'S MEDICAL SCHEME CONTRIBUTION - SENIORS (66 YEARS & OLDER) EXCLUDED. <p>* THE GUARDIAN POLICY MAY BE BOUGHT AS A STAND-ALONE PRODUCT.</p>
GAP LPE ADVANCED	<ul style="list-style-type: none"> GAP COVER 100 BENEFIT; PLUS PROVIDES A BENEFIT EQUAL TO THE COST OF IN-HOSPITALISATION AND ASSOCIATED MEDICAL EXPENSES (AS DEFINED) RELATING TO ONE OF THE LISTED PROCEDURES LESS THE COVER PROVIDED BY THE MEDICAL SCHEME OPTION.

PRODUCT SUMMARY & SELECTION

PRODUCT	LISTED BENEFITS	SPECIFIC LIMITATION PER INSURED PERSON PER ANNUM	OVERALL LIMITATION PER INSURED PERSON PER ANNUM	PREMIUM PER FAMILY PER MONTH (incl. VAT) 18-65 YEARS OLD	PREMIUM PER FAMILY PER MONTH (incl. VAT) 66 YEARS & OLDER	
GAP COVER	- GAP COVER 100		R150,000	<input type="checkbox"/>	<input type="checkbox"/>	
	- CASUALTY BENEFIT	R10,000				
GAP PLUS	- GAP COVER 100 - CO-PAYMENT COVER		R150,000	<input type="checkbox"/>	<input type="checkbox"/>	
	- CASUALTY BENEFIT	R10,000				
GAP SELECT	- GAP COVER 100 - CO-PAYMENT COVER - SUB-LIMIT COVER - CANCER COVER		R150,000	<input type="checkbox"/>	<input type="checkbox"/>	
	- CASUALTY BENEFIT	R10,000				
	- DREAD DISEASE BENEFIT	ONCE OFF R50,000 ON DIAGNOSIS				* See dread disease exclusions
GAP ELITE	- GAP COVER 100 - SUB-LIMIT COVER - CANCER COVER		R150,000	<input type="checkbox"/>	<input type="checkbox"/>	
	- CASUALTY BENEFIT	R10,000				
	- DREAD DISEASE BENEFIT	ONCE OFF R50,000 ON DIAGNOSIS				* See dread disease exclusions
	- PREMIUM WAIVER BENEFIT	LIMITED TO 6 MONTHS MEDICAL AID CONTRIBUTIONS				** See premium waiver exclusion
GAP SUPREME	- GAP COVER 100 - CO-PAYMENT COVER - SUB-LIMIT COVER - CANCER COVER		R150,000	<input type="checkbox"/>	product not available	
	- CASUALTY BENEFIT	R10,000				
	- DREAD DISEASE BENEFIT	ONCE OFF R50,000 ON DIAGNOSIS				* See dread disease exclusions
	- PREMIUM WAIVER BENEFIT	LIMITED TO 6 MONTHS MEDICAL AID CONTRIBUTIONS				** See premium waiver exclusion
GUARDIAN (Excludes Gap Cover 100 benefit)	- CO-PAYMENT COVER - SUB-LIMIT COVER - CANCER COVER		R150,000	<input type="checkbox"/>	<input type="checkbox"/>	
	- CASUALTY BENEFIT	R10,000				
	- DREAD DISEASE BENEFIT	ONCE OFF R50,000 ON DIAGNOSIS				* See dread disease exclusions
	- PREMIUM WAIVER BENEFIT	LIMITED TO 6 MONTHS MEDICAL AID CONTRIBUTIONS				** See premium waiver exclusion
GAP LPE ADVANCED	- GAP COVER 100		R150,000	<input type="checkbox"/>	<input type="checkbox"/>	
	- MEDICAL EXPENSES RELATED TO 10 DEFINED PROCEDURES	A R75,000 LIMITATION APPLIES TO ANY ONE OF THE 10 DEFINED PROCEDURES				

INCEPTION DATE (DATE COVER IS TO COMMENCE)

D	D	M	M	Y	Y	Y	Y
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* Dread disease exclusions:

- All tumours, which are histologically described as pre-malignant, as non-invasive or as cancer in situ.
- All forms of lymphoma in the presence of any Human Immunodeficiency Virus.
- Kaposi's sarcoma in the presence of any Human Immunodeficiency Virus.
- Any skin cancer other than malignant melanoma.
- Cancerous cells that have not invaded the surrounding or underlying tissue.
- Early cancer of the prostate gland or breast. (Stage1 described as T1a, NO, MO, G1)
- Seniors (66 years & older) excluded.

Specific condition

- The Dread Disease Benefit terminates at the member reaching the benefit expiry age, or age 65.

** Premium waiver exclusion:

- Seniors (66 years & older) excluded.

Specific condition

- The Premium Waiver Benefit terminates at the member reaching the benefit expiry age, or age 65.

PREMIUM PAYMENT

DEBIT ORDER DETAILS

ACCOUNT HOLDERS NAME		BANK / BUILDING SOCIETY	
ACCOUNT NUMBER		BRANCH	
BRANCH CODE		ACCOUNT TYPE	CURRENT
			TRANSMISSION
			SAVINGS

PLEASE SELECT PREFERRED DEBIT ORDER COLLECTION DATE

1 st		7 th		15 th		20 th		25 th		28 th		LAST DAY OF THE MONTH	
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I, the undersigned, hereby request and authorise the Insurer or its representative to deduct the premium payable under the above plan against my bank account or institution (or any other bank or institution or branch where my account is kept or transferred to) on the preferred debit order collection date.

Should the collection date selected fall on a weekend or public holiday, I understand that a debit will be processed against my account on the first working day following the weekend or public holiday.

I further declare that:

- I authorise my bank or institution (as stated) to debit my account with all debits which may be presented by the company as if I personally signed for each one.
- I also understand that the details of each debit order will be printed on my bank statement as a separate line as proof thereof.
- I declare that all bank costs related to this debit order system and approval, will be for my own account.
- I understand and accept that I or the company can change this arrangement at any time in writing (by giving the other party 30 days' notice) or cancel this arrangement, given that it won't have any effect on the deductions of the company which was already agreed and authorised herein.
- I understand and accept that all payments in terms of this agreement will be made without any prejudice.
- I understand and accept that if any payment in terms of this agreement is not received, the relevant policy/ies will be cancelled effective from the last day of the uninterrupted period for which payment(s) were received.
- I accept that this request and authorisation will be applicable for all amounts payable from inception and monthly thereafter.
- I acknowledge that I need to ensure that premiums are collected for cover to remain in force.

SIGNATURE OF APPLICANT													DATE	D	D	M	M	Y	Y	Y	Y
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DECLARATION

I declare that I have not withheld any information and I accept that this application and declaration shall be the basis of the contract of insurance between me and the Insurer, which will become effective on the first day of the month for which premiums are received. I also acknowledge that should this application not be considered as part of a full financial needs analysis and I have instructed the broker not to proceed with a full financial needs analysis, this could have the effect that all my financial needs may not be properly addressed.

I further confirm that the following notable conditions have been explained to me:

- No benefits will be payable during a general 3 month waiting period for all treatment received unless the treatment was required as a result of an accident (external violent physical means).
- No benefits will be payable for treatment during the first 12 months of the policy if treatment or advice was received 12 months prior to inception of the policy that related to the subsequent treatment.
- Not all your dependants on your medical scheme are automatically covered under this policy, only your eligible spouse and your eligible children are covered as per the policy definitions.
 - Only one spouse is allowed.
 - The maximum age for a child dependant is under 21. This age may be extended to 26 in respect of an unmarried child who is a dependant on the Principal Insured Person's Medical Scheme and is financially dependent on the Principal Insured Person.
 - No cover is provided for extended family members.

I confirm that although I have completed this application form, it does not constitute an insurance contract until a membership number is assigned, policy issued and premium is successfully paid.

SIGNATURE OF APPLICANT													DATE	D	D	M	M	Y	Y	Y	Y
PRINTED NAME OF APPLICANT																					

Please return to your broker or alternatively: Ambledown Financial Services (Pty) Ltd
 PO Box 1862, Cramerview, 2060
 Tel Number 0861 262533, Fax Number 011 463 1600
 E-mail Address: admin@ambledown.co.za

