GAP COVER SERIES
INDIVIDUAL PAYROLL 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

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	• 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	• PROVIDES A ONCE OFF DREAD DISEASE BENEFIT, LIMITED TO DIAGNOSIS OF CANCER. * SEE DREAD DISEASE EXCLUSIONS - SENIORS (66 YEARS & OLDER) EXCLUDED.
PREMIUM WAIVER BENEFIT	• PROVIDES A LUMP SUM PAYMENT EQUAL TO **6 MONTHS** OF THE MEMBER'S MEDICAL SCHEME CONTRIBUTION. - SENIORS (66 YEARS & OLDER) EXCLUDED.
GUARDIAN*	• 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. * THE GUARDIAN POLICY MAY BE BOUGHT AS A STAND-ALONE PRODUCT.
GAP LPE ADVANCED	• 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
GAP COVER	- GAP COVER 100		R150,000	☐
	- CASUALTY BENEFIT	R10,000		
GAP PLUS	- GAP COVER 100 - CO-PAYMENT COVER		R150,000	☐
	- CASUALTY BENEFIT	R10,000		
GAP SELECT	- GAP COVER 100 - CO-PAYMENT COVER - SUB-LIMIT COVER - CANCER COVER		R150,000	☐
	- 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	☐
	- 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	☐
	- 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	☐
	- 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	☐
	- 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 |

*** 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, N0, M0, 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

PAYROLL DETAILS

EMPLOYER NAME								EMPLOYEE NAME	
EMPLOYEE COST CENTRE								EMPLOYEE SURNAME	
DATE EMPLOYED	D	D	M	M	Y	Y	Y	Y	EMPLOYEE NUMBER	

PLEASE NOTE THAT IF PREMIUMS ARE PAID VIA PAYROLL THEY WILL BE COLLECTED MONTHLY IN ARREARS (UNLESS OTHERWISE SPECIFIED) FOR THE CURRENT MONTH OF COVER.

Having applied for the policy detailed above, and on acceptance of my application by the Insurer, I hereby authorise my salaries/ payroll division to deduct the above premium from my salary and remit to the Insurer on a monthly basis. Such authorisation shall remain in force and effect until cancelled by myself, in writing with 30 days notice or I leave the employ of my current employer. I further authorise the Insurer to increase the amount due in terms of the policy from time to time and authorise my salaries/ payroll division to effect payment on relevant increases.

AGREEMENT OF APPLICANT

DATE D D M M Y Y Y Y

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:

a) 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).

b) 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.

c) 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.

   i. Only one spouse is allowed.

   ii. 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.

   iii. 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   PRINTED NAME OF APPLICANT   DATE D D M M Y Y Y Y

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: premium@ambledown.co.za