ambledown
FINANCIAL SERVICES (PTY) LTD

[GROUP NAME]
ABSA GOLD & SILVER GAP COVER SERIES INDIVIDUAL DEBIT ORDER APPLICATION FORM

Underwritten by Absa Insurance Company Limited (AIC) Reg. No. 1992/001737/06, FSP No: 8030 (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	Absa Consultants and Actuaries (Pty) Ltd		
FSP NUMBER	327	BROKER CODE	
BROKER CONTACT NUMBER	AREA CODE	VAT NUMBER	
BROKER E-MAIL ADDRESS		UNIQUE IDENTIFIER (IF NECESSARY)	

PERSONAL PARTICULARS

APPLICANT

TITLE		SURNAME	
ID NUMBER		FIRST NAMES	
DATE OF BIRTH	D D M M Y Y Y Y		

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	ID OR PASSPORT NUMBER	DATE OF BIRTH
			D D M M Y Y Y Y
			D D M M Y Y Y Y
			D D M M Y Y Y Y
			D D M M Y Y Y Y
			D D M M Y Y Y Y
			D D M M Y Y Y Y

CONTACT DETAILS

POSTAL ADDRESS			PHYSICAL ADDRESS (IF DIFFERENT TO POSTAL)		
	POSTAL CODE			POSTAL CODE	
HOME NUMBER	AREA CODE		WORK NUMBER	AREA CODE	
CELL NUMBER	AREA 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
ABSA 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.

PRODUCT SUMMARY & SELECTION

PRODUCT	LISTED BENEFITS	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**
ABSA SILVER	- GAP COVER 100	**R150,000**	☐ R310.00	☐ R410.00
ABSA GOLD	- GAP COVER 100 - CO-PAYMENT COVER - SUB-LIMIT COVER - CANCER COVER	**R150,000**	☐ R365.00	☐ R490.00

INCEPTION DATE (DATE COVER IS TO COMMENCE) D D M M Y Y Y Y

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

1st	☐	7th	☐	15th	☐	20th	☐	25th	☐	28th	☐	LAST DAY OF THE MONTH	☐

I, the undersigned, hereby request and authorise the Insurer or it's 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 ACCOUNT HOLDER 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 25 (under 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: ACA Employee Benefits (Proprietary) Ltd
Tel Number 0860 100 380
E-mail Address aca.healthcare.gap@sanlam.co.za

Broker details:
ACA Employee Benefits (Proprietary)
FSP number: 327