2025 APPLICATION UNIVERSITY OF STELLENBOSCH VOLUNTARY GROUP - PAYROLL DEDUCTION

Thank you for deciding to apply for 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: admed@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 admed@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 YOUR EMPLOYER

Name of employer	**UNIVERSITY OF STELLENBOSCH**																		
Branch (if applicable)																			
Employee no.													Date employed	d	d	m	m	y	y	y	y

TELL US ABOUT YOU

Title		Surname																	
First Name																			
Identity number													Date of birth	d	d	m	m	y	y	y	y
Medical aid name													Plan option								
Medical aid no.													Date joined	d	d	m	m	y	y	y	y

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	
	Postal code		Postal code
Email address:			
Office tel. no.		Mobile no.	

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

Please select your cover and monthly premium option: **Supreme Gap R 375** ☐ **Primary Gap R306** ☐

The monthly premium is inclusive of commission and VAT.

When do you want your cover to start? m m y y y y

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 y y y y	End date	d d m m y y y y

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.

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.	Are you currently pregnant or trying to become pregnant?	Y	N
2.	Have you recently given birth?	Y	N
3.	Have you ever been diagnosed with any form of cancer, malignant or pre-malignant tumours?	Y	N
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	N
5.	Do you take chronic or ongoing medication?	Y	N

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?

6.	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	Y	N
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	Y	N

8. Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse	Y	N
9. Stroke, spinal cord injury or any other brain, spinal or nerve condition	Y	N
10. Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition	Y	N
11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Y	N
12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	Y	N
13. Any condition of the mouth, teeth or gums including 3axilla-facial treatment or specialised dentistry	Y	N
14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	Y	N
15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	Y	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	Y	N
17. Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders	Y	N
18. Any condition of the prostate including undescended testes or urinary incontinence	Y	N
19. Any condition of the respiratory system; asthma, tuberculosis, chronic obstructive pulmonary disease (COPD), silicosis, pulmonary or cystic fibrosis or emphysema?	Y	N
20. Any other medical condition not listed above that may require treatment or surgery	Y	N

*Please provide detail where "Y" has been ticked: _____

_____

_____

TELL US ABOUT YOUR BENEFICIARY

In the event of your death while you are covered on the policy, please tell us who to pay any claim amounts to

Title				First Name										Surname						
Identity number														Date of birth	d	d	m	m	y	y	y	y
Mobile number											Physical address:									
Relationship to you																				

YOUR DEPENDENTS' DETAILS

Please complete a separate Dependent 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 Dependent 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 BROKER'S DETAILS

INTERMEDIARY DETAILS

Brokerage name	**Alexander Forbes Financial Services**												
Branch name				FSP No.			**1**	**1**	**7**	**7**			
Advisor name	**Riaan Oosthuizen**	Mobile No.											
E-mail address	**oosthuizenr@alexforbes.com**												

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 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 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. ☐

10. 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 accept that any notice given to my employer is deemed to have been given to me. ☐

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. ☐

17. 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). ☐

18. 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. ☐

21. I declare my understanding that only if a binder holder has been appointed to the group policy, will a payment of a monthly binder fee be made by Guardrisk to the binder holder. This binder fee is calculated as a percentage of the monthly gross premium. The binder fee is paid to the binder holder for the performance of this function, however it is important to note that this does not affect the premium charged to you, as the cost of the fee is carried from our expense reserving. ☐

Date signed:

d	d	m	m	y	y	y	y

_____
Signature of Applicant

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DEPENDENT DECLARATION

Please complete the below for each dependent named on your policy *Dependent declaration no 1 of _____*

Title		First name		Surname	
Identity number				Date of birth	d d m m y y y y
Relationship				Gender	*Male* / *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 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 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.

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 dependent currently pregnant or trying to become pregnant?	Y	N
2.	Has this dependent recently given birth?	Y	N
3.	Has this dependent ever been diagnosed with any form of cancer, malignant or pre-malignant tumours?	Y	N
4.	Has this dependent had any surgical procedure during the past 12 months or planning a surgical procedure during the next 12 months?	Y	N
5.	Does this dependent take chronic or ongoing medication?	Y	N

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?

6.	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	Y	N
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	Y	N
8.	Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse	Y	N
9.	Stroke, spinal cord injury or any other brain, spinal or nerve condition	Y	N
10.	Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition	Y	N

11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Y	N
12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	Y	N
13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	Y	N
14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	Y	N
15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	Y	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	Y	N
17. Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders	Y	N
18. Any condition of the prostate including undescended testes or urinary incontinence	Y	N
19. Any condition of the respiratory system; asthma, tuberculosis, chronic obstructive pulmonary disease (COPD), silicosis, pulmonary or cystic fibrosis or emphysema?	Y	N
20. Any other medical condition not listed above that may require treatment or surgery	Y	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 policy *Dependent declaration no 2 of _____*

Title		First name		Surname	
Identity number				Date of birth	d d m m y y y y
Relationship				Gender	*Male* / *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 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 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.

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 dependent currently pregnant or trying to become pregnant?	Y	N
2.	Has this dependent recently given birth?	Y	N
3.	Has this dependent ever been diagnosed with any form of cancer, malignant or pre-malignant tumours?	Y	N
4.	Has this dependent had any surgical procedure during the past 12 months or planning a surgical procedure during the next 12 months?	Y	N
5.	Does this dependent take chronic or ongoing medication?	Y	N

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?

6.	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	Y	N
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	Y	N
8.	Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse	Y	N
9.	Stroke, spinal cord injury or any other brain, spinal or nerve condition	Y	N
10.	Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition	Y	N

11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Y	N
12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	Y	N
13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	Y	N
14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	Y	N
15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	Y	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	Y	N
17. Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders	Y	N
18. Any condition of the prostate including undescended testes or urinary incontinence	Y	N
19. Any condition of the respiratory system; asthma, tuberculosis, chronic obstructive pulmonary disease (COPD), silicosis, pulmonary or cystic fibrosis or emphysema?	Y	N
20. Any other medical condition not listed above that may require treatment or surgery	Y	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 policy *Dependent declaration no 3 of _____*

Title		First name		Surname	
Identity number				Date of birth	d d m m y y y y
Relationship				Gender	*Male* / *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 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 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.

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 dependent currently pregnant or trying to become pregnant?	Y	N
2.	Has this dependent recently given birth?	Y	N
3.	Has this dependent ever been diagnosed with any form of cancer, malignant or pre-malignant tumours?	Y	N
4.	Has this dependent had any surgical procedure during the past 12 months or planning a surgical procedure during the next 12 months?	Y	N
5.	Does this dependent take chronic or ongoing medication?	Y	N

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?

6.	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	Y	N
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	Y	N
8.	Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse	Y	N
9.	Stroke, spinal cord injury or any other brain, spinal or nerve condition	Y	N
10.	Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition	Y	N

11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Y	N
12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	Y	N
13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	Y	N
14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	Y	N
15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	Y	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	Y	N
17. Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders	Y	N
18. Any condition of the prostate including undescended testes or urinary incontinence	Y	N
19. Any condition of the respiratory system; asthma, tuberculosis, chronic obstructive pulmonary disease (COPD), silicosis, pulmonary or cystic fibrosis or emphysema?	Y	N
20. Any other medical condition not listed above that may require treatment or surgery	Y	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 policy *Dependent declaration no 4 of _____*

Title		First name		Surname	
Identity number				Date of birth	d d m m y y y y
Relationship				Gender	*Male* / *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 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 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.

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 dependent currently pregnant or trying to become pregnant?	Y	N
2.	Has this dependent recently given birth?	Y	N
3.	Has this dependent ever been diagnosed with any form of cancer, malignant or pre-malignant tumours?	Y	N
4.	Has this dependent had any surgical procedure during the past 12 months or planning a surgical procedure during the next 12 months?	Y	N
5.	Does this dependent take chronic or ongoing medication?	Y	N

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?

6.	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	Y	N
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	Y	N
8.	Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse	Y	N
9.	Stroke, spinal cord injury or any other brain, spinal or nerve condition	Y	N
10.	Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition	Y	N

11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Y	N
12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	Y	N
13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	Y	N
14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	Y	N
15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	Y	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	Y	N
17. Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders	Y	N
18. Any condition of the prostate including undescended testes or urinary incontinence	Y	N
19. Any condition of the respiratory system; asthma, tuberculosis, chronic obstructive pulmonary disease (COPD), silicosis, pulmonary or cystic fibrosis or emphysema?	Y	N
20. Any other medical condition not listed above that may require treatment or surgery	Y	N

*Please provide detail where "Y" has been ticked: _____

_____

_____