



## 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 COI	MPLETI	NG TH	IS FC	ORM																			
Client / Applicant	Yes	No	PI	ease	read	and	initia	al ead	ch de	clara	tion ι	under	Client /	/ Applic	ant de	eclar	ation	and	cons	ent			
Appointed Broker	Yes	No	Pl	ease	read	and	initia	al ead	ch de	clara	tion ι	under	Broker	declara	ation a	and c	onse	nt					
TELL US ABOUT YOU	JR EMP	LOYER	ł																				
Name of employer	UNIV	ERSI	тү с	DF S	TEL	LE	NBC	osc	Η														
Branch (if applicable)																							
Employee no.													Da	te empl	loyed	d	d	m	m	У	У	У	У
TELL US ABOUT YOU	J																						
Title				S	Surna	ame																	
First Name																							
Identity number													Date	e of birt	:h	d	d	m	m	У	У	У	У
Medical aid name													Plai	n optior	n								
Medical aid no.													Dat	e joine	d	d	d	m	m	У	У	У	У
Please attach medical ai your gap cover. Please n reflect on your medical a	ote that i	it is you	r resp	onsibi	ility t	o info	orm u	ıs if yo	ou are	e not	on a n	nedica	al aid wh	en your	gap co	over i	s ince	pted.	All d	epen	dents		as
TELL US HOW TO CO	ONTACT	YOU																					
Postal address										Phy	ysical	addr	ess							-			
					.					-									-			•	•
			Post	al co	de												Pos	tal co	ode				
Email address:		<u>т</u> т								1				- T - T									
Office tel. no.												Mo	obile no									- -	
Underwritten by Guardris An Authorised Financial The Marc. Tower 2, 129	Services	Provid	ler an	d Lic	ense								etropolit	an Hold	lings L	.imite	ed.	1		-	•		





## 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 15<sup>th</sup> 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?

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	У	У	у	У
Please attach proof of vo	our previous gap cover if applicable. All dependents	must reflect on this certificate	in or	der t	o be	nefit	fron	n red	uced	

prease 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:	
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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?	Υ		Ν	
2.	Have you recently given birth?	Y		Ν	
3.	Have you ever been diagnosed with any form of cancer, malignant or pre-malignant tumours?	Y		Ν	
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		Ν	
5.	Do you take chronic or ongoing medication?	Y		Ν	
	ve you had or do you currently have, any of the medical conditions listed below, for which medical advice, di ommended or received within the last 12 months?	iagnos	is, care or t	reatme	ent was
c	Any hone or joint condition including angoing back, chouldon bin or know problems, arthritic, rhoumaticm	1			

- 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
- 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

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

\*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
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Title		Fire	st Na	me						Surname								
Identity number										Date of birth	d	d	m	m	У	У	У	У
Mobile number							Phy	sical	addro	ess:								
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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Admed The heartbeat of Gap



## PROVIDE US WITH YOUR BROKER'S DETAILS

#### **INTERMEDIARY DETAILS**

Brokerage name	Alexander Forbes Financial Services								
Branch name			F	SP 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.

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## The heartbeat of Gap

- 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:

Signature of Applicant

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## **DEPENDENT DECLARATION**

Plea	ase complete the b	elow for	each d	epende	nt nan	ned o	on yo	ur polic	с <b>у</b>	Depen	dent decl	aratic	on no 1	of				
Title	2		Surname															
Ider	ntity number									Date of	birth	d	dı	m m	У	/ У	У	
Rela	ationship									Gender		Male	2		Fen	nale		
THE	EIR PREVIOUS GAP	COVER (if	not co	overed o	on a pr	reviou	us ga	p policy	y of ye	ours)								
Prev	vious Insurer																	
Previous cover option										Previous Polic	y Number							
Start date         d         d         m         y         y         y         y         End date         d         d         m         m         y											У	/ У	У					
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:																		
<ul> <li>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;</li> <li>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.</li> </ul>																		
De	etails of your general	doctor	Nam	e:							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 cur	rently pre	gnant o	r trying to	o beco	me pr	egna	nt?					Y		Ν			
2.	Has this dependent r	ecently giv	en birtl	n?									Y		Ν			
3.	Has this dependent e	ver been d	liagnos	ed with a	iny fori	m of ca	ancei	r, malign	ant or	pre-maligna	nt tumour	s?	Y		Ν			
4.	Has this dependent h during the next 12 m		gical pr	ocedure	during	the p	ast 1	2 month	s or pl	anning a surg	ical proce	dure	Y		Ν			
5.	Does this dependent	take chror	nic or o	ngoing m	edicati	ion?							Y		Ν			
	e you had or do you o ommended or receive	-		-		al con	ditio	ns listed	below	v, for which n	nedical ad	vice, d	liagnosi	is, care o	or treat	ment	was	
6.	Any bone or joint cor fibromyalgia or any o		-							ems, arthritis	, rheumat	ism,	Y		Ν			
7.	High blood pressure, heartbeat, heart mur lesions or any other h	mur, hear	: failure	, myocar	dial inf								Y		Ν			
8.	Ovarian cysts, hormo uterine fibroids or pro		ment t	herapy, e	endome	etriosi	is, abı	normal p	oap sm	lears or mens	trual blee	ding,	Y	•	N	•	•	
9.	Stroke, spinal cord in	jury or any	other	brain, spi	nal or	nerve	cond	lition					Y	*	N		. 1	
10.	Gastric ulcers, hernia disease, intestinal po						lon, (	GORD (h	eartbu	ırn), inflamma	atory bow	el	Y		Ν			
Unde An A	erwritten by Guardrisk I uthorised Financial Se	nsurance ( rvices Prov	Compar vider an	ny Limiteo d License	d. Guar ed Non	rdrisk i: -Life Ir	s pari nsure	t of Mom r (FSP N	ientum lo 75)	Metropolitan	Holdings I	_imited			. •		•	

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





## **DEPENDENT DECLARATION**

Plea	ise complete the b	elow for e	ach d	epender	nt nam	ned on	י yo	our polic	y	Depend	lent decl	aratio	n no 2	? of				
Title		First n	ame							Surname								
Iden	tity number									Date of	birth	d	d	m m	у у	У	У	
Relat	tionship					·				Gender		Male	,		Fem	ale		
THE	IR PREVIOUS GAP	COVER (if	not co	overed o	n a pr	evious	s ga	p policy	of yo	ours)								
Prev	ious Insurer																	
Previous cover option									Р	revious Policy	v Number							
Start date         d         d         m         m         y         y         y         y         End date										te	d	d	m m	у у	y y	У		
Please attach proof of this previous gap cover.																		
PRO	VIDE US WITH MO	RE INFOR	MATI		UT TH	IS DEP	PEN	DENT'S	HEAL	тн								
<ul> <li>Failure to disclose pre-existing medical conditions may result in limited or excluded benefits.</li> <li>Important to note: <ul> <li>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;</li> <li>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.</li> </ul> </li> </ul>																		
Det	tails of your general	doctor	Nam	e:							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																		
	Has this dependent e Has this dependent h		-		-			-					Y		N			
	during the next 12 m	onths?											Y		N			
5.	Does this dependent	take chron	ic or oi	ngoing me	edicati	on?							Y		Ν			
	e you had or do you o mmended or receive	-		-		l cond	litio	ns listed	below	, for which m	edical ad	vice, d	iagnos	is, care	or treatr	nent v	was	
	Any bone or joint cor fibromyalgia or any o									ems, arthritis,	rheumat	ism,	Y					
l	High blood pressure, heartbeat, heart mur lesions or any other h	mur, heart	failure	, myocaro	dial inf			-			-		Y		Ν			
	Ovarian cysts, hormo uterine fibroids or pr	•	ment tl	herapy, e	ndome	etriosis,	, ab	normal p	ap sm	ears or menst	rual blee	ding,	Y		N	•	• •	
9.	Stroke, spinal cord in	jury or any	other l	orain, spii	nal or r	nerve c	cond	lition					Υ		N	•	. /	
	Gastric ulcers, hernia disease, intestinal po						on, (	GORD (he	eartbu	rn), inflamma	tory bow	el	Y	-	Ν	•	•	
	rwritten by Guardrisk I uthorised Financial Se									Metropolitan I	Holdings L	imited			5		• _	

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





# **DEPENDENT DECLARATION**

Please complete the b	elow for ea	ch dep	pendent	t name	ed on y	our policy	y	Depend	ent decla	aratic	on no	3 of _					
Title	First name Surname																
Identity number								Date of b	oirth	d	d	m	m y	У	у у		
elationship Gender Ma											?			Female			
THEIR PREVIOUS GAP	COVER (if n	ot cove	ered on	a pre	vious g	ap policy	of y	ours)									
Previous Insurer																	
Previous cover option Previous Policy Number																	
Start date         d         d         m         m         y         y         y         g         End date										d	d	m	m y	У	у у		
Please attach proof of this previous gap cover.																	
PROVIDE US WITH MORE INFORMATION ABOUT THIS DEPENDENT'S HEALTH																	
<ul> <li>Failure to disclose pre-existing medical conditions may result in limited or excluded benefits.</li> <li>Important to note: <ul> <li>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;</li> <li>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.</li> </ul> </li> </ul>																	
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 cur	rently pregn	ant or t	rying to	becom	e pregn	ant?					Y			N			
2. Has this dependent r	ecently giver	n birth?									Y						
3. Has this dependent e	ver been dia	gnosed	l with an	y form	of canc	er, maligna	ant o	r pre-malignant	t tumours	?	Y		I	N			
<ol> <li>Has this dependent h during the next 12 m</li> </ol>		cal proc	cedure d	uring tł	ne past	12 months	s or p	lanning a surgio	cal procec	dure	Y		1	Ν			
5. Does this dependent	take chronic	or ong	oing me	dicatior	n?						YN						
Have you had or do you o recommended or receive	-				conditi	ons listed	belov	w, for which me	edical adv	/ice, d	liagno	osis, ca	re or tr	eatmer	nt was		
<ol> <li>Any bone or joint cor fibromyalgia or any o</li> </ol>								lems, arthritis,	rheumati	sm,	Y		I	Ν			
<ol> <li>High blood pressure, heartbeat, heart mur lesions or any other h</li> </ol>	mur, heart f	ailure, n	nyocard	ial infar							Y		I	Ν			
<ol> <li>Ovarian cysts, hormo uterine fibroids or pr</li> </ol>		ent the	erapy, en	dometi	riosis, al	bnormal p	ap sn	nears or mensti	rual bleed	ling,	Y	-		N .	1		
9. Stroke, spinal cord in	jury or any o	ther bra	ain, spin	al or ne	erve con	dition					Y		-	N	. /		
10. Gastric ulcers, hernia disease, intestinal po		-				GORD (he	artb	urn), inflammat	tory bowe	el.	Y	]	ľ	N			
Underwritten by Guardrisk An Authorised Financial Se The Marc, Tower 2, 129 Riv	rvices Provid	er and I	Licensed						Holdings Li	imited	l.		-				





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





# **DEPENDENT DECLARATION**

Please	e comple	te the b	elow fo	or each d	lepender	nt nam	ed on	your poli	icy	Depend	dent decl	aratio	n no 4	of			
Title			Firs	t name						Surname				<i>,</i>			
Identity	y number									Date of	birth	d	d m	n m	уу	У	У
Relatio	nship		•							Gender		Male			Fem	ale	
THEIR PREVIOUS GAP COVER (if not covered on a previous gap policy of yours)																	
Previou	us Insurer																
Previou	us cover o	ption								Previous Poli	cy Numbe	r					
Start date         d         d         m         m         y         y         y         y         End date         d         d         m         m											n y	у у	У				
Please attach proof of this previous gap cover.																	
PROVIDE US WITH MORE INFORMATION ABOUT THIS DEPENDENT'S HEALTH																	
<ul> <li>Failure to disclose pre-existing medical conditions may result in limited or excluded benefits.</li> <li>Important to note: <ul> <li>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;</li> <li>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.</li> </ul> </li> </ul>																	
Detai	ls of your	general	doctor	Nam	ne:						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 t	this deper	ident cur	rently p	regnant c	or trying to	becor	ne preg	nant?					Y		Ν		
2. Ha	is this dep	endent ro	ecently	given birt	h?								Y		Ν		
3. Ha	is this dep	endent e	ver bee	n diagnos	ed with a	ny forn	n of can	cer, maligi	nant o	or pre-malignar	nt tumour:	s?	Y		Ν		
	is this dep ring the n			surgical p	rocedure	during	the pas	t 12 montl	hs or p	blanning a surg	ical proce	dure	Y		Ν		
5. Do	es this de	pendent	take chi	ronic or o	ngoing m	edicatio	on?						Y		Ν		
-	ou had or mended o	-		-	-		l condit	tions listed	d belo	w, for which m	nedical ad	vice, d	iagnosis	s, care o	r treatr	nent wa	as
	•	-		-				hip or kne Iscle) cond	•	olems, arthritis,	, rheumat	ism,	Y		Ν		
hea		eart mur	mur, he	art failure	e, myocar	dial infa				ease, chest pair ral vascular dis	-		Y		Ν		
	varian cyst erine fibro			icement t	herapy, e	ndome	triosis,	abnormal	pap si	mears or mens	trual blee	ding,	Υ	٠.	Ν		
9. Str	oke, spina	al cord inj	ury or a	iny other	brain, spi	nal or r	ierve co	ondition					Υ	*	N		. 6
	istric ulcei sease, inte			-	-			n, GORD (ł	neartb	urn), inflamma	atory bow	el	Υ		Ν	• •	
An Autho		ancial Se	rvices P	rovider <sup>`</sup> ar	nd License			oart of Mon urer (FSP I		m Metropolitan	Holdings L	_imited	1	. 1		2	5



Υ

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

\*Please provide detail where "Y" has been ticked: \_\_\_\_\_

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