



2021 APPLICATION FOR 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	СОМР	LETIN	NG TI	IIS FO	ORM	1																	
Client / Applicant	Ye	es	No	Р	lease	e read	d and	l initi	al ea	ch de	clara	tion u	ınder	Client /	/ Applicant	declai	ratior	n and	l cons	ent			
Appointed Broker	Ye	es	No	Р	lease	e read	d and	l initi	al ea	ch de	clara	tion u	ınder	Broker	declaration	and	conse	ent					
TELL US ABOUT	YOUR	EMPL	LOYE	R																			
Name of employe	r I	UNIV	/ERS	SITY	OF	STE	ELLI	ENB	OS	CH													
Branch (if applicab	ole)																						
Employee no.														Dat	te employe	d d	d	n	n m	У	У	У	У
TELL US ABOUT	YOU																						
Title	\top					Surn	name																
First Name									.1														
Identity number														Date	e of birth	d	d	m	m	У	У	У	У
Medical aid name			_1							_1				Plar	n option				.1				
Medical aid no.														Dat	e joined	d	d	m	m	У	У	У	У
Please attach medic note that it is your r aid certificate, be no	responsil	bility t	to info	rm us	if you	u are	not o	n a m	edica	ıl aid w	vhen y	our g	ap cov	ver is inc	cepted. All de	epend	ents n						
TELL US HOW TO	CONT	ACT	YOU																				
																				\mathcal{X}		Y	
Postal address											Phy	/sical	addre	ess							_	_	$\overline{}$
				Pos	tal co	ode											Pos	stal o	code	Y		Y	
Email address:																	l.						
Office tell no					 					1			Ma	hila na	. 1				Y		Y		

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The Marc, Tower 2, 129 Rivonia Road, Sandton, 2196





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 th day of the month, we may make a double deduction from your bank account.												
Please select your cover and monthly premium option: Supreme	Gap R279	Primary Gap R223										
The monthly premium is inclusive of commission, binder fees 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	n. 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										
Please attach proof of your previous gap cover if applicable. All dependents or no waiting periods being applied to their cover. If your dependents are morproof 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 ho * Where you have selected "Y" you must supply us with more information in												
Are you currently pregnant or trying to become pregnant?		Y										
2. Have you recently given birth?		Y										
3. Have you ever been diagnosed with any form of cancer, malignant or pre-r	nalignant tumours?	Y										
4. Have you had any surgical procedure during the past 12 months or are you planning a surgical procedure during the next 12 months?												
5. Do you take chronic or ongoing medication?												
Have you had or do you currently have, any of the medical conditions listed be recommended or received within the last 12 months?	elow, for which medical advice,	diagnosis, care or treatment was										
6. Any bone or joint condition including ongoing back, shoulder, hip or knee properties fibromyalgia or any other musculoskeletal (back, bone and muscle) conditions.		Y										
 High blood pressure, high cholesterol or lipids, ischaemic / coronary heart heartbeat, heart murmur, heart failure, myocardial infarction, angina, peri lesions or any other heart-related medical condition 		Y										

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8.	Ovarian cysts, hormor uterine fibroids or pro		lacem	ent t	:hera _l	ру, є	ndon	netri	osis,	abnoı	mal Į	oap s	mear	s or menstrual bleedi	ng,	Υ	N		
9.	Stroke, spinal cord inj	ury or	any o	ther	brain	ı, spi	nal o	r ner	ve co	onditio	on					Υ	N		
10.	Gastric ulcers, hernias disease, intestinal pol		-		-					n, GO	RD (h	eartl	ourn)	, inflammatory bowel		Υ	N		
11.	Cataracts, glaucoma, s disorder of the eye	quint,	blurry	y visio	on, b	lindr	ness (parti	al or	full),	retina	al det	achm	nent or any other		Υ	N		
12.	Any condition of the e implants, tonsillitis, or				t, inc	ludir	ng he	aring	pro	blems	, sinu	s or i	nasal	problems, cochlear		Υ	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																			
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																			
17.	Any blood condition of leukaemia, lymphoma				-							, ITP	(plate	elet deficiency),		Υ	N		
18	Any condition of the p	orosta	te incl	udin	g und	lesce	ended	d test	es o	r urina	ary in	conti	nenc	e		Υ	N		
19	Any other medical co	nditio	n not li	isted	abov	ve th	at ma	ay re	quire	e treat	ment	t or s	urger	у		Υ	N		
*PI	ease provide detail wh	ere "Y	" has b	been	ticke	ed: _											 		_
																			_
TEI	L US ABOUT YOUR I	BENEI	FICIAF	RY															
In t	he event of your death	while	you a	re co	overe	d on	the _l	policy	, ple	ease te	ell us	who	to pa	y any claim amounts	to				
Titl	е			First	t Nan	ne								Surname					
Identity number Date of birth d d m m y y													У	У					
Мо	bile number										Phy	sical	addr	ess:					
Rel	ationship 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.

PROVIDE US WITH YOUR BROKER'S DETAILS

INTERMEDIARY DETAILS

Brokerage name	Alexander Forbes Health (Pty) Ltd				لمر						
Branch name	Stellenbosch		F	SP N	ο.	3	3	4	7	1	
Advisor name	Marie-Louise Du Toit	Mobile No.			Y		Y		Y		
E-mail address	dutoitm@aforbes.com										

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- 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

Ple	ase 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.	
CLI	ENT / APPLICANT DECLARATION AND CONSENT	
Ple	ase 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.	

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(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 their relevant medical information to Guardrisk to assist in the processing of claims under this policy.		
 	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.		
(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.		
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.		
ı	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).		
8	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.		
	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.		
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 a binder holder has been appointed to the group policy and payment of a monthly binder fee is made by Guardrisk, calculated as 3.5% of the monthly gross premium, to such appointed binder holder.		
	Date signed:	У	

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Dependent declaration no 1 of _____

DEPENDENT DECLARATION

Please complete the below for each dependent named on your policy

Title			First na	ime								Surname							
Identity num	ber											Date of I	birth	d	d	m m	У	У	У
Relationship												Gender		Male	•		F	emale	!
THEIR PREV	IOUS G	AP CO	VER (if	not co	vere	d on a	prev	ious g	зар р	olicy	of y	ours)							
Previous Insu	irer																		
Previous cove	er option	1		1							F	Previous Policy	Number						
Start date		C	d	m m	У	У	У					End dat	е	d	d	m n	У	У	У
Please attach	•	•				_		_	_	_		_		_	_	_	_		
PROVIDE U	S WITH I	MORE	INFOR	MATIO	ON AE	BOUT 1	THIS	DEPE	NDEI	NT'S H	IEAL	.TH							
months a	note: cer, birth after cover er physica	or pre er star al defe	egnancy-i ts; ct, medic	elated	l medi	cal con	ditior	n that	exist	ed wit	hin 1	result in liminary in 12 months before 12 months b	ore the fir	rst day	y of co	ver will			
Details of y	our gene	ral do	ctor	Nam	e:								Tel No:						
						•						ly, accurately a	-						
1. Is this de	pendent	currer	ntly pregi	nant o	r tryinį	g to bed	come	pregn	ant?						Υ		N		
2. Has this	depende	nt rece	ently give	n birth	า?										Υ		N		
3. Has this	depende	nt eve	r been di	agnos	ed witl	h any fo	orm o	f canc	er, m	aligna	nt or	pre-malignant	t tumours	;?	Υ		N		
4. Has this during th				ical pr	ocedu	re durii	ng the	e past	12 m	onths	or pl	anning a surgi	cal proced	dure	Υ		N		
5. Does this	depend	ent tal	ke chroni	c or o	ngoing	medica	ation	?							Υ		N		
Have you had	-		-		-		ical c	onditi	ons li	isted b	elov	v, for which m	edical adv	vice, d	liagnos	is, care	or tre	atmei	nt was
6. Any bone fibromya	-			_	_	_						ems, arthritis,	rheumati	sm,	Υ		N		
	it, heart i	murmi	ır, heart	failure	, myo	cardial i	nfarc					ase, chest pains al vascular dise			Υ		N		
8. Ovarian uterine f			•	nent tl	nerapy	, endor	metri	osis, a	bnori	mal pa	ıp sm	nears or menst	rual bleed	ding,	Υ		N	J	
9. Stroke, s	pinal cor	d injur	y or any	other l	orain,	spinal o	r ner	ve cor	nditio	n					Υ		N		
10. Gastric u disease,									, GOF	RD (hea	artbu	ırn), inflammat	tory bowe	el	Υ		N		Ţ

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





Dependent declaration no 2 of _____

DEPENDENT DECLARATION

Please complete the below for each dependent named on your policy

Title	<u> </u>	First name					Surname					
Identity num	ber						Date of	birth	d d	m n	n y y	УУ
Relationship							Gender		Male		Femo	ale
THEIR PREV	IOUS GAP	COVER (if not o	covered on a	previous	gap polic	y of ye	ours)					
Previous Insu	irer											
Previous cove	er option					F	Previous Policy	Number				
Start date		d d m	m y y	У			End dat	te	d	d m	m y y	УУ
Please attach	proof of this	s previous gap co	over.			_						
PROVIDE US	S WITH MO	RE INFORMAT	ION ABOUT	THIS DEPE	ENDENT'S	HEAL	.TH					
months a	note: cer, birth or pafter cover st	efect, medical co	ed medical cor	ndition that	existed w	vithin 1	.2 months bef	ore the fire	st day of	cover wi	ll be exclud	
Details of y	our general (doctor Na	me:					Tel No:				
		" for each of the										
1. Is this de	pendent cur	rently pregnant	or trying to be	come preg	nant?				,	Υ	N	
2. Has this	dependent re	ecently given bir	th?							Υ	N	
3. Has this	dependent e	ver been diagno	sed with any f	orm of can	cer, maligr	nant or	pre-malignan	t tumours?	? ,	Υ	N	
	dependent h ne next 12 m	ad any surgical p onths?	orocedure duri	ng the past	t 12 month	ns or pl	anning a surgi	cal proced	ure	Υ	N	
5. Does this	s dependent	take chronic or	ongoing medic	ation?					,	Υ	N	
	-	currently have, a d within the las	-	lical condit	ions listed	below	, for which m	edical adv	ice, diag	nosis, car	e or treatm	nent was
-	-	idition including ther musculoske					ems, arthritis,	rheumatis	sm,	Y	N	
heartbea	at, heart mur	high cholesterol mur, heart failu neart-related me	e, myocardial	infarction,						Y	N	
	cysts, hormo ibroids or pro	ne replacement olapse	therapy, endo	metriosis, a	abnormal į	oap sm	lears or menst	rual bleedi	ing,	Y	N	
9. Stroke, s	pinal cord inj	jury or any othe	brain, spinal o	or nerve co	ndition					Y	N	
		s, poor digestior lyps or any othe			n, GORD (h	eartbu	ırn), inflamma	tory bowel	<u> </u>	Y	N	

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





Dependent declaration no 3 of _

Surname

DEPENDENT DECLARATION

Please complete the below for each dependent named on your policy

First name

Ide	ntity number											Date of	birth	d	d	m	m	У	У	У
Rel	ationship											Gender		Male				Femo	ale	
TH	EIR PREVIOUS GAP C	OVER (if not	cover	ed o	n a p	revio	ous g	ар ро	olicy	of ye	ours)								
Pre	vious Insurer																			
Pre	vious cover option										F	revious Policy	Number							
Sta	rt date	d d	m	m y	У	У	У					End da	te	d	d	m	m	У	У	У
Ple	ase attach proof of this	previou	ıs gap (cover.																
PR	OVIDE US WITH MOI	RE INFO	DRMA	TION	ABO	UT TH	lIS D	EPEN	NDEN	IT'S F	IEAL	тн								
m - -	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.																			
D	etails of your general d	loctor	Na	ame:									Tel No:							
	ease select a "Y" or "N" Where you have selecte Is this dependent curr	ed "Y" yo	ou mus	st supp	ly us	with I	more	info	rmatio				-	-		_	ſ	N		
2.	Has this dependent re	ecently g	iven bi	irth?											Υ]	[N		
3.	Has this dependent ev	ver been	ı diagn	osed w	ith aı	ny for	m of	cance	er, ma	aligna	nt or	pre-malignan	t tumours	s?	Υ			N		
4.	Has this dependent had during the next 12 mg	•	urgical	proced	dure (during	the	past :	12 mc	onths	or pl	anning a surgi	ical proced	dure	Υ			N		
5.	Does this dependent t	take chro	onic or	ongoi	ng me	edicat	ion?								Υ			N		
	ve you had or do you co	-		-			al coi	nditio	ons lis	ted b	elow	, for which m	edical adv	vice, d	iagno	sis, c	are or	treatn	nent v	vas
6.	Any bone or joint cond fibromyalgia or any ot				_							ems, arthritis,	rheumati	sm,	Υ			N		
7.	High blood pressure, heartbeat, heart murr lesions or any other he	nur, hea	art failu	ure, my	ocard	dial in									Υ		4	N		
8.	Ovarian cysts, hormor uterine fibroids or pro		cemen	t thera	py, eı	ndom	etrios	sis, al	onorn	nal pa	p sm	ears or menst	trual bleed	ding,	Υ			N		
9.	Stroke, spinal cord inju	ury or a	ny othe	er brair	ı, spir	nal or	nerve	e con	dition	1					Υ		1	N		
10.	Gastric ulcers, hernias disease, intestinal pol								GORI	D (hea	artbu	ırn), inflamma	tory bowe	el	Y	_		N		

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11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Υ	N
12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	Υ	N
13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	Υ	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	Υ	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	Υ	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	Υ	N
19. Any other medical condition not listed above that may require treatment or surgery	Υ	N
*Please provide detail where "Y" has been ticked:		





Dependent declaration no 4 of

Surname

DEPENDENT DECLARATION

Please complete the below for each dependent named on your policy

First name

Idei	ntity number														Date of	birth	d	d	m	m	У	У	У	У
Rela	ationship	nship Gender								Male				Female										
THI	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					У	у у у у								End date				d	m	m y	/ У	У	У	
Plea	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.																								
De	etails of your g	eneral o	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?										Υ			N	ı									
2.	2. Has this dependent recently given birth?											Υ			N	ı								
3.	3. Has this dependent ever been diagnosed with any form of cancer, malignant or pre-malignant tumours?										?	Υ			N	ı								
4.	Has this deper during the nex			_	ical pro	cedu	ıre d	uring	g the	past	12	2 moi	nths	or p	lanning a surgi	cal proced	lure	Υ			N	ı		
5.	5. Does this dependent take chronic or ongoing medication?											Υ			N	ı								
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									sm,	Υ			N	1									
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									Υ			N	1										
8.		Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleed uterine fibroids or prolapse										ing,	Υ			N								
9.	Stroke, spinal cord injury or any other brain, spinal or nerve condition										Y	4		N	1		7							
10.	. Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition										Y					_								

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