



2023 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	COMPI	ETIN	IG TH	HIS F	ORM																				
Client / Applicant	Ye	S	No	F	Please	rea	d and	d initi	al ea	ch de	clarat	ion ເ	under	Client /	/ Applic	ant d	ecla	ration	n and	l cor	ısen	t			
Appointed Broker	Ye	s	No	F	Please	rea	d and	d initi	al ea	ch de	clarat	ion ເ	under	Broker	declara	ation	and	conse	ent						
TELL US ABOUT	YOUR E	MPL	OYE	R																					
Name of employe	r U	NIVI	ERS	ITY	OF S	ΤE	LLE	NBC	SC	Н															
Branch (if applical	ble)																								
Employee no.														Dat	te emp	loyed	d	d	l m	ı r	m	У	У	У	У
TELL US ABOUT	YOU																								
Title						Surn	ame																		
First Name																									
Identity number														Date	of birt	th	d	d	m	m)	/	У	У	У
Medical aid name	!													Plan	n optio	n									
Medical aid no.														Date	e joine	d	d	d	m	m)	/	У	У	У
Please attach medi your gap cover. Ple reflect on your med	ase note	that it	is you	ır res	ponsib	ility	to inf	form (ıs if y	ou are	not o	n a n	nedica	l aid whe	en your	gap c	over	is inc	epted	l. All	dep	ende	ents r		
TELL US HOW T	O CONT	ACT	YOU																						
Postal address											Physical address										٠,			-	
								ı	•	,											r			-	-
		Postal code																Po	stal c	:ode					
Email address:							ı	1																	
Office tel. no.													Мо	bile no.										-	1





TEI	L US WHAT YOU W	OULD LIKE	YOUR CO	OVER OPTION AND	START D	ATE TO BE					
	confirm that you have e receive your applica							ank account		_	
Ple	ase select your cover a	and monthly	premium	option:	Supreme	Gap R320		Primary G	ap R261		
The	monthly premium is inclu	usive of comm	nission and	VAT.			_			_	
		W	/hen do yo	u want your cover to	start?			m m	У	У	У
Cov	er can only start on th	e first day o	of the caler	ndar month following	g applicatio	n. No requests for	backdating	of cover wil	l be consi	idered.	
TEI	L US IF YOU HAD PF	REVIOUS G	AP COVE	R							
Hav	re you previously belor	nged to any	other gap	provider? If yes, ple	ease give us	the details.					
Pre	vious Insurer							1			
Pre	vious cover option					Previous Policy	Number				
Sta	rt date	d d	m m y	у у у		End dat	:e	d d	m m	УУ	УУ
or i	ase attach proof of yo no waiting periods bei of of cover with your	ng applied	to their co								
PR	OVIDE US WITH MO	RE INFORI	MATION A	ABOUT YOUR HEA	LTH						
Imp	Any cancer, birth or p months after cover st Any other physical de months after cover st	tarts; efect, medic									
D	etails of your general o	doctor	Name:				Tel No:				
	ase select a "Y" or "N' here you have selecte						-	-			
1.	Are you currently pre	gnant or try	ying to bec	ome pregnant?				Υ		N	
2.	Have you recently giv	en birth?						Υ		N	
3.	Have you ever been o	diagnosed w	ith any for	m of cancer, malign	ant or pre-ı	nalignant tumours	?	Υ		N	
4.	Have you had any sur during the next 12 mg		dure durin	g the past 12 month	s or are you	planning a surgica	al procedure	Υ		N	
5.	Do you take chronic o	or ongoing r	medication	?				Υ		N	
	re you had or do you o ommended or receive	-	-		ons listed b	elow, for which m	nedical advic	e, diagnosis	, care or	treatm	ent was
6.	Any bone or joint con fibromyalgia or any o						, rheumatisn	n, Y	-	N	
7.	High blood pressure, heartbeat, heart mur lesions or any other h	mur, heart	failure, my	ocardial infarction, a				Υ	4	N	





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





PROVIDE US WITH YOUR BROKER'S DETAILS

INTERN		

Brokerage name	Alexander Forbes Financial Services (Pty) Ltd									
Branch name	Stellenbosch		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.
- 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.
- 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.	
BR	OKER DECLARATION AND CONSENT – only applicable when broker is completing application form on behalf of client	
Ple	ease 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.	
CL	IENT / 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.	.0

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





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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:	У
Sign	nature of Applicant	





DEPENDENT DECLARATION

Please complete the below for each dependent named on your policy Title																					
Title				First na	ime								Surname								
Identi	ity number												Date of	birth	d	d	m	m	У	У	У
Relati	ionship												Gender		Male	?			Fer	nale	
THEIR	R PREVIOUS	GAF	CO/	/ER (if i	not co	overe	d on a p	revio	ous g	ар р	olicy o	of yo	ours)								
Previo	ous Insurer																				
Previo	ous cover opt	ion										Р	revious Policy	Number							
Start	date		d	d	m n	у	У	У					End da	te	d	d	m	m	У	У	У
Please	e attach proc	of of t	his pr	evious g	ap cov	er.															
PRO	VIDE US WI	гн м	ORE	INFORI	MATI	ON A	BOUT T	HIS D	EPEI	NDEN	NT'S H	EAL	TH								
- A m - A	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 1 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 months after cover starts. Details of your general doctor Name: Tel No:																				
Deta	ails of your g	enera	al doc	tor	Nam	e:								Tel No:							
							-						ly, accurately pace below t								
1. Is	s this depend	ent c	urren	tly pregi	nant o	r tryir	ng to beco	ome p	oregn	ant?						Υ			N		
2. H	las this depe	ndent	recei	ntly give	n birtl	า?										Υ			N		
3. H	las this depe	ndent	ever	been di	agnos	ed wit	th any fo	rm of	cance	er, ma	alignan	t or	pre-malignar	t tumours	s?	Υ			N		
	las this deper Juring the nex				ical pr	oced	ure durin	g the	past	12 m	onths c	or pl	anning a surg	ical proce	dure	Υ			N		
5. D	oes this dep	ender	nt tak	e chroni	c or o	ngoin	g medica	tion?								Υ			N		
	you had or d nmended or							cal co	nditio	ons li	sted be	elow	, for which m	edical ad	vice, c	liagno	osis, o	are o	r treat	men	t was
	any bone or jo ibromyalgia o												ems, arthritis,	rheumat	ism,	Υ			N		
h		art m	urmui	r, heart	failure	, myc	cardial ir						se, chest pair al vascular dis			Υ			N		
8. Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse																					
9. Si	troke, spinal	cord	injury	or any	other l	brain,	spinal or	nerv	e con	iditio	n					Υ		-	N	4	•
	Gastric ulcers, lisease, intest									GOR	D (hea	rtbu	rn), inflamma	tory bowe	el	Υ	1		N	*	0





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 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 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	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 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 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?	N
condition 15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition 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 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?	N
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19. Any condition of the respiratory system; asthma, tuberculosis, chronic obstructive pulmonary disease (COPD), silicosis, pulmonary or cystic fibrosis or emphysema?	N
(COPD), silicosis, pulmonary or cystic fibrosis or emphysema?	N
20. Any other medical condition not listed above that may require treatment or surgery	N
	N
*Please provide detail where "Y" has been ticked:	





DEPENDENT DECLARATION

Please	complete	e the b	elov	o for e	ach d	epen	dent n	amed	l on y	our p	oolicy	,	Depend	dent decl	arati	on no	2 of				
Title				First na	ıme								Surname								
Identity	number												Date of	birth	d	d	m	m	У	У	У
Relation	ship												Gender		Mal	e			Fe	male	
THEIR	REVIOU	S GAP	cov	ER (if ı	not co	vere	ed on a	previ	ious g	зар р	olicy	of you	ırs)								
Previou	Insurer																				
Previou	cover op	tion										Pre	evious Policy	y Number							
Start da	te		d	d	m m	у	У	У					End da	te		d d	m	m	У	У	У
Please a	ttach prod	of of thi	s pre	vious g	ap cov	er.															
PROVII	DE US WI	тн мс	RE I	NFORI	MATIO	ON A	BOUT	THIS	DEPE	NDEI	NT'S H	HEALT	Н								
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 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 months after cover starts. Details of your general doctor Name: Tel No:																					
Detail	of your g	general	doct	or	Nam	e:								Tel No:							
* Wher	you have	e select	ed "	/" you	must s	uppl	y us wit	h mor	e info	rmati		-	, accurately ace below t			re.	\neg			7	
1. Is ti	is depend	ient cur	rent	ıy pregi	nant o	r tryli	ng to be	come	pregn	iant?						Υ			N	_	
2. Has	this depe	ndent r	ecen	tly give	n birth	า?										Υ			N		
3. Has	this depe	ndent e	ever l	een di	agnos	ed wi	th any f	orm o	f canc	er, m	alignaı	nt or p	re-malignar	nt tumours	s?	Υ			N		
	this depe ng the ne				ical pr	oced	ure duri	ng the	e past	12 m	onths	or plar	nning a surg	ical proce	dure	Υ			N		
5. Do	s this dep	endent	take	chroni	c or or	ngoin	g medic	ation?	?							Υ			N		
-	u had or o ended or	-		-		-		lical co	onditi	ons li	sted b	elow,	for which m	nedical ad	vice,	diagn	osis,	care o	r trea	tmen	t was
	bone or j omyalgia o				_	_	-						ms, arthritis	, rheumat	ism,	Υ			N		
hea		art mur	mur	heart '	failure	, myc	ocardial	infarc					e, chest pair vascular dis			Υ			N		
	rian cysts ine fibroi				nent tl	herap	y, endo	metrio	osis, a	bnorr	mal pa	ıp smea	ars or mens	trual bleed	ding,	Υ		-	N	A	
9. Stro	ke, spinal	cord in	jury	or any (other l	brain,	, spinal o	or ner	ve cor	nditio	n					Υ		-	N		
	tric ulcers ase, intes									, GOR	D (hea	artburr	n), inflamma	ntory bowe	el	Υ	-		N	*	-0





·Ple	ease provide detail where "Y" has been ticked:		
0.	Any other medical condition not listed above that may require treatment or surgery	Υ	N
9.	Any condition of the respiratory system; asthma, tuberculosis, chronic obstructive pulmonary disease (COPD), silicosis, pulmonary or cystic fibrosis or emphysema?	Υ	N
.8.	Any condition of the prostate including undescended testes or urinary incontinence	Υ	N
7.	Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders	Υ	N
6.	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
	Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	Υ	N
١.	Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	Υ	N
	Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	Υ	N
	Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	Υ	N
L.	Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Υ	N





DE	PENDENT I	DECL	.ARA	TIO	N																	
Ple	ase complete	the b	elow	for e	each c	leper	nder	nt nar	ned	on y	our p	oolicy	/	Depen	dent decl	ara	tion no	o 3 of				
Title	е		F	irst n	name									Surname								
Idei	ntity number													Date of	birth	C	d d	m	m	У	У	У
Rela	ationship													Gender		М	ale			Fem	ale	
THE	EIR PREVIOUS	GAP	COVE	R (if	not c	over	ed o	n a p	revio	ous g	зар р	olicy	of yo	ours)								
Pre	vious Insurer																					
Pre	vious cover opt	ion								1			P	revious Polic	y Number							
Star	rt date		d	d	m r	n y	У	У	У					End da	te		d d	l m	m	У	У	У
Plea	ase attach prod	of of thi	is prev	⁄ious	gap co	ver.																
PRO	OVIDE US WIT	гн мс	DRE II	NFOF	RMATI	ON A	ABO	UT TH	IIS D	EPE	NDEI	NT'S	HEAL	тн								
Imp	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 1 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 months after cover starts. Details of your general doctor Name: Tel No:																					
De	etails of your g	eneral	docto	r	Nan	ne:									Tel No:							
	ase select a "Y here you have						-							-	-		-					
1.	Is this depend	ent cur	rrently	/ pre{	gnant o	r tryi	ng to	beco	me p	oregn	ant?						Υ			N		
2.	Has this deper	ndent r	ecent	ly giv	en birt	h?											Υ			N		
3.	Has this deper	ndent e	ever b	een d	diagnos	ed w	ith a	ny for	m of	canc	er, m	aligna	ant or	pre-malignar	nt tumours	s?	Υ			N		
4.	Has this deper during the nex				rgical p	roced	lure	during	the	past	12 m	onths	or pl	anning a surg	ical proced	dure	Y			N		
5.	Does this depe	endent	take	chror	nic or c	ngoir	ng m	edicat	ion?								Υ			N		
	re you had or dommended or								al co	nditi	ons li	sted l	below	, for which n	nedical adv	vice	, diagn	osis, (care o	r treatr	nent v	was
6.	Any bone or jo				_	_	_							ems, arthritis	, rheumati	ism,	Y			N		
7.	High blood pre heartbeat, hea lesions or any	art mur	rmur,	heart	t failur	e, my	ocar	dial in							_		Y			N		
8.	Ovarian cysts, uterine fibroic				ement 1	hera	ру, е	ndom	etrio	sis, a	bnorr	nal pa	ap sm	ears or mens	trual bleed	ding	" Y			N	A	
9.	Stroke, spinal	cord in	ijury o	r any	other	brain	, spi	nal or	nerv	e cor	nditio	n					Y		-	N	1	

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10. Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel

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

disease, intestinal polyps or any other abdominal condition





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	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	Y	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 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:		





DEPENDENT DECLARATION

Ple	ease com	plete	the b	elow	tor e	ach d	epen	ident r	ame	d o	n y	our p	olicy		Depend	dent decl	arati	ion no	4 of				
Titl	le			F	First na	ame									Surname								
Ide	ntity numl	ber													Date of	birth	d	d	m	m	У	У	У
Rel	ationship														Gender		Mai	le			Fem	ale	
ТН	EIR PREV	IOUS	GAP	COVE	ER (if	not co	overe	ed on a	pre	viou	us g	ар р	olicy c	of your	rs)								
Pre	evious Insu	rer																					
Pre	evious cove	er opt	ion											Pre	evious Poli	cy Numbe	r						
Start date d d m m y y y y End date									d d m m y y y														
Ple	ase attach	proo	f of thi	is prev	vious g	gap co	ver.																
PR	OVIDE US	s WIT	тн мс	DRE II	NFOR	MATI	ON A	BOUT	THIS	DE	PEN	NDEI	NT'S H	EALTH									
 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 y	our ge	eneral	docto	or	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 de	pende	ent cur	rently	y preg	nant o	r tryir	ng to be	com	e pr	egna	ant?						Υ			N		
2.	Has this o	deper	ndent r	ecent	tly give	en birt	h?											Υ			N		
3.	Has this o	deper	ndent e	ever b	een di	iagnos	ed wi	th any	orm	of ca	ance	er, m	alignan	t or pr	e-malignar	t tumours	s?	Υ			N		
4.	Has this during th					gical pr	oced	ure dur	ing th	ne pa	ast 1	12 m	onths o	or planı	ning a surg	ical proced	dure	Υ			N		
5.	Does this	depe	endent	take	chron	ic or o	ngoin	g medi	cation	1?								Υ			N		
	ve you had commende		•		-		-		dical	con	ditio	ons li	sted be	elow, fo	or which m	edical ad	vice,	diagn	osis, (care oi	rtreati	ment	was
6.	Any bone fibromya														s, arthritis,	rheumati	ism,	Υ			N		
7.		it, hea	art mur	rmur,	heart	failure	e, myc	ocardial	infar						, chest pair rascular dis			Υ			N		
8.	Ovarian outerine fi					ment t	herap	oy, endo	metr	iosi	s, al	onorr	nal pap	smea	rs or mens	trual bleed	ding,	Υ			N		
9.	Stroke, s	pinal	cord in	jury c	or any	other	brain,	, spinal	or ne	rve	con	ditio	n					Υ			N	4	
10.	Gastric u disease, i										lon,	GOR	D (hea	rtburn)	, inflamma	tory bowe	el	Υ	-		N		





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 condition of the respiratory system; asthma, tuberculosis, chronic obstructive pulmonary disease (COPD), silicosis, pulmonary or cystic fibrosis or emphysema?	Υ	N
20. Any other medical condition not listed above that may require treatment or surgery	Υ	N
*Please provide detail where "Y" has been ticked:		