



2024 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.
- 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

when you sign this	э аррпса	lion,	you	.011111		at ye	o iia	vere	au ai	iu uii	iucis	loou	tile te	ciiiis a	ina cona	ition	3 01 (OVE	anu	agre	- 10 1	iieiii.		
TELL US WHO IS	COMPL	ETIN	IG TH	HIS F	ORM	1																		
Client / Applicant	Ye	S	No	Р	lease	e rea	d and	liniti	al ead	ch de	clara	tion ι	ınder	Client	:/Applic	ant d	lecla	ration	n and	cons	ent			
Appointed Broker	Ye	S	No	Р	lease	e rea	d and	liniti	al ead	ch de	clara	tion ι	ınder	Broke	er declara	ation	and	conse	ent					
TELL US ABOUT	YOUR E	MPL	OYE	R																				
Name of employe	r U	nive	rsity	/ Of	Stel	leni	oos	ch																
Branch (if applicat	ole)																							
Employee no.														D	ate emp	loyed	d	d	n	n m	У	У	У	У
TELL US ABOUT	YOU																							
Title						Surn	ame																	
First Name																								
Identity number														Dat	te of birt	:h	d	d	m	m	У	У	У	У
Medical aid name									•	•		•		Pla	an optio	n				•				
Medical aid no.														Da	ate joine	d	d	d	m	m	У	У	У	У
Please attach medic your gap cover. Plea reflect on your med	ase note t	hat it	is you	ur res	ponsi	bility	to inf	orm u	ıs if yo	ou are	not o	on a n	nedica	l aid w	hen your	gap c	over	is inc	epted	l. All c	lepen	dents		
TELL US HOW TO	O CONT	ACT	YOU																					
Postal address											Phy	/sical	addre	ess						-	9_			•
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				Pos	stal c	ode												Ро	stal c	ode				-0
Email address:		1				ı		1	1	ı	T							ı			ı			
Office tel. no.													Мо	bile n	о.									





TELL US WHAT YOU W	OULD LIKE YOUR COVER	R OPTION AND START D	OATE TO BE	
			on the selected cover option. double deduction from your b	ank account.
Please select your cover	and monthly premium option	on: Suprem	e Gap R344	Primary Gap R281
The monthly premium is inc	lusive of commission and VAT.			
	When do you wa	nt your cover to start?		m m y y y y
Cover can only start on t	he first day of the calendar i	month following applicati	on. No requests for backdating	of cover will be considered.
TELL US IF YOU HAD P	REVIOUS GAP COVER			
Have you previously belo	onged to any other gap prov	rider? If yes, please give u	s the details.	
Previous Insurer				
Previous cover option			Previous Policy Number	
Start date	d d m m y y	УУ	End date	d d m m y y y y
	ing applied to their cover.			e in order to benefit from reduced nsurer, please also attach their
PROVIDE US WITH MO	DRE INFORMATION ABO	UT YOUR HEALTH		
months after cover	starts; efect, medical condition, illr			t day of cover will be excluded for 12 rst day of cover will be excluded for 9
Details of your general	doctor Name:		Tel No:	
	•		onestly, accurately and complete the space below the question	-
1. Are you currently pr	egnant or trying to become	pregnant?		Y
2. Have you recently gi	ven birth?			Y
3. Have you ever been	diagnosed with any form of	cancer, malignant or pre-	malignant tumours?	Y
4. Have you had any su during the next 12 n		past 12 months or are yo	u planning a surgical procedure	Y N
5. Do you take chronic	or ongoing medication?			Y
	currently have, any of the i ed within the last 12 month		below, for which medical advi	ce, diagnosis, care or treatment was
	ndition including ongoing ba other musculoskeletal (back		problems, arthritis, rheumatisr	n, Y
			disease, chest pains, irregular ipheral vascular disease, valve	Y

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

lesions or any other heart-related medical condition





8.	Ovarian cysts, hor uterine fibroids or				nent	thera	ару, є	endor	metri	osi	is, abno	rma	pap s	mear	s or menstrual bleedir	ng,	Υ		N			
9.	Stroke, spinal core	d inju	iry or	any	othe	brai	in, sp	inal o	r ner	ve	condit	ion					Υ		N			
10.	Gastric ulcers, her disease, intestinal										lon, G0	ORD (heartk	ourn),	inflammatory bowel		Υ		N			
11.	Cataracts, glaucon disorder of the ey		quint,	blur	ry vis	ion, l	blindı	ness (parti	ial d	or full),	retir	nal det	achm	ent or any other		Υ		N			
12.	Any condition of the implants, tonsilliting					at, in	cludi	ng he	aring	g pr	roblem	s, sin	us or r	nasal	problems, cochlear		Υ		N			
13.	Any condition of t	the m	outh	, tee	th or	gum	s incl	uding	3axi	illa-	-facial t	reati	ment c	r spe	cialised dentistry		Υ		N			
14.	Diabetes, thyroid condition	disea	ase (ii	nclud	ing h	уро (or hy	perth	yroid	disn	n), oste	eopo	rosis o	r any	other metabolic-relat	ed	Υ		N			
15.	Cirrhosis, liver dis	rhosis, liver disease or failure, cystic fibrosis or any other liver-related condition ney and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycystic															Υ		N			
16.	•	Iney and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycystic ney disease or any other renal or urinary condition															Υ		N			
17.	·	Iney and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycystic liney disease or any other renal or urinary condition y blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), ukaemia, lymphoma, haemophilia and any other bleeding disorders															Υ		N			
18.	Any condition of t	the p	rosta	te ind	ludir	ng un	desc	ende	d test	tes	or urin	ary i	nconti	nence	2		Υ		N			
19.	Any condition of t (COPD), silicosis, p											nic c	bstru	ctive	oulmonary disease		Υ		N			
20.	Any other medica	l con	ditio	n not	liste	d abo	ove th	nat m	ay re	qu	ire trea	itme	nt or s	urger	у		Υ		N			
*Ple	ease provide detail	l whe	re "Y	" has	beer	n tick	ed: _															
TEL	L US ABOUT YO	UR B	ENEI	FICIA	RY																	
In t	he event of your do	eath	while	you	are c	over	ed or	the	policy	y, p	olease 1	ell u	s who	to pa	y any claim amounts t	0						
Title	е				Firs	st Na	me								Surname							
Idei	ntity number														Date of birth	d d	m	m	У	У	у ,	У
Мо	bile number											Ph	ysical	addre	ess:							
Rela	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.





PR	OVIDE US WITH	гн ነ	γοι	JR E	BRC	OKE	R'S	DET	ΓAIL	S																									
INT	ERMEDIARY DET	ETA	ILS																																
Bro	kerage name	1	Ale	xar	ιde	er F	or	bes	Fir	nan	ncia	al S	Ser	rvic	ces	(Pt	ty)	Ltd																	
Bra	nch name	,	Ste	ller	ıbc	osc	h																		F	SP N	lo.		1	1	7		7		
Adv	visor name	I	Ria	an	Oo	stl	hui	zen											٨	Лok	bile I	No.													
E-m	nail address	(Oos	thu	ıize	nR	@a	lexi	orb	es.	CO	m																							
Вуі	initialling this box	ох у	ou (conf	irm	tha	at yo	our f	inan	cial	ad	lvise	er ha	as co	omr	muni	icat	ed t	he l	belo	ow t	о ус	u: [
1.	That he/she has	as m	nade	you	ı av	vare	e of	the	com	mis	sio	n pa	ayal	ble b	by G	Guard	dris	k to	him	n/h	er ir	res	oect	of ·	this	pol	icy.								
2.	That he/she has	as co	ond	ucte	d a	fina	anci	al ne	eds	ana	alys	sis a	and t	this	insu	uran	ce p	orod	uct	is s	suita	ble	o m	eet	yo	ur in	sur	ance	ne	eds.					
3.	That he/she has as well as how to								pro	duct	t to	о уо	ou ar	nd y	you i	unde	erst	and	hov	w th	he p	rodu	ct w	ork	κs, ν	vhat	is c	over	ed	and v	wha	t is	not	cove	red,
4.	That he/she is re of this application				for	r pro	ovid	ling y	ou v	vith	his	s/he	er co	onta	act d	letai	ils a	nd h	e/s	he i	is ac	coui	itabl	e fo	or a	ny a	dvid	e giv	en	to yo	u al	οοι	ıt co	mple	tion
BR	OKER DECLARA	RAT	ION	A۱	ID (COI	NSE	NT ·	– on	ıly a	app	plic	cabl	le w	vhei	n br	oke	er is	СО	mp	oleti	ng a	ppli	ica	tio	n fo	rm	on b	eh	alfo	of cl	ier	nt		
	Please initial each of the following sentences below to confirm that you are in agreement with the statement:																																		
Ple																																			
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	de p	oroc	f of	yoı	ur c	lien	t's al	oove	me	enti	ione	ed a	auth	oris	atio	n tiı	meo	usly	/ or	n red	ques	t by	Gua	ardı	isk.									
3.	You declare tha are signing on the					has	rea	d the	e bel	ow	Clie	ent	:/Ap	oplic	cant	decl	lara	tion	and	d th	nat y	our	clien	t a	cce	pts e	each	dec	ara	ation	tha	t yo	ou		
CLI	ENT / APPLICA	AN ⁻	ΓDI	ECL	AR/	ATI	ON	ANI	D CC	ONS	SEN	NT																							
Ple	ase initial each o	of t	the	ollo	wii	ng s	ent	ence	es be	low	v to	о со	onfir	rm tl	hat	you	are	in a	gre	er	nent	wit	n the	st	ate	men	t:								
1.	I hereby apply f	for	the	Adı	mec	d pr	odu	ıct th	nrou	gh n	ny e	emp	ploy	yer a	and	I agr	ree	to a	bide	e by	y its	rule	5.												
2.	I declare that t membership of the first day of t	of m	y er	nplo	yer	's g	rou	p scł	neme	e wi	ith (Gua	ardr					•																	
3.	I confirm my un	ınde	ersta	ndi	ng t	that	t sho	ould	this	арр	olica	atio	on be	e ind	com	plet	te, n	ny a	ppli	icat	tion	may	not	be	pro	cess	ed	by Gı	ıar	drisk					
4.	I confirm my un Guardrisk may o				_																						ng ti	he ap	pli	catio	n pr	oce	ess,		
5.	I understand the													be s	subj	ect 1	to v	waiti	ng	pei	riod	s an	d tha	at 1	thes	se w	/aiti	ng p	erio	ods ł	nave	b b	een		
6.	I declare my uno or my depender									ce p	oro	duc	ct is	not	a sı	ubsti	itut	e fo	me	edi	cal s	chei	ne co	ove	er ai	nd th	nat i	t do	es r	not re	epla	ce	my,		

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7. I understand that this product does not insure against every shortfall in medical scheme cover and that I am aware of the

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'

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medical scheme membership at any time.

circumstances in which my and my dependents' cover will and will not pay.





	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.	
	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.	
	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).	
	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.	
	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.	•
		уу
Ci~	Date signed:	60
Sigr	nature of Applicant	





Ple	ase complete	e the	y	Depen	dent decl	ara	tion	no .	1 of _													
Title	e			First na	ime								Surname									
Idei	ntity number												Date of	birth	(d	d	m	m	У	У	У
Rela	ationship												Gender		М	ale				Fer	nale	
THI	EIR PREVIOU	S GAI	Р СО	VER (if r	not co	overe	d on	a previ	ous ¿	дар р	olicy	of ye	ours)									
Pre	vious Insurer																					
Pre	vious cover op	tion										F	revious Policy	/ Number								
Sta	rt date		d	l d	m n	у	У	У					End da	te		d	d	m	m	У	У	У
Plea	ase attach prod	of of t	his p	revious g	ap co	ver.											_					
PRO	OVIDE US WI	TH M	IORE	INFORI	MATI	ON A	BOUT	THIS [DEPE	NDEI	NT'S	HEAL	тн									
lmp - -	Any cancer, b months after Any other phy months after	oirth o cover ysical	stari defe	ts; ct, medic																		
De	etails of your g	genera	al do	ctor	Nam	e:								Tel No:								
	ease select a "Y Vhere you have						-							-		-						
1.	Is this depend	lent c	urrer	ntly pregr	nant o	r tryir	ng to b	ecome	pregr	nant?							Υ			N		
2.	Has this depe	ndent	rece	ently give	n birtl	h?											Υ			N		
3.	Has this depe	ndent	t eve	r been dia	agnos	ed wi	th any	form of	canc	er, m	aligna	ant or	pre-malignar	nt tumour	s?		Υ			N		
4.	Has this depe during the ne				ical pr	roced	ure du	iring the	past	12 m	onths	or pl	anning a surg	ical proce	dure	e [Υ			N		
5.	Does this dep	ender	nt tal	ke chroni	c or o	ngoin	g med	lication?									Υ			N		
	ve you had or o ommended or								nditi	ons li	sted l	below	, for which m	nedical ad	vice	, dia	gnos	sis, c	are o	r treat	men	t was
6.	Any bone or j												ems, arthritis	, rheumat	ism,		Υ			N		
7.	High blood pr heartbeat, he lesions or any	art m	urmu	ır, heart i	failure	e, myc	cardia	al infarct									Υ			N		
8.	Ovarian cysts, uterine fibroid				nent t	herap	y, end	lometric	sis, a	ibnori	mal p	ap sm	ears or mens	trual blee	ding	;, <u> </u>	Υ	-		N		٠
9.	Stroke, spinal	cord	injur	y or any o	other	brain,	spina	l or nerv	e cor	nditio	n						Υ		,	N	٠	0
10.	Gastric ulcers disease, intes			_		_				, GOR	D (he	artbu	ırn), inflamma	ntory bow	el		Υ	100		N	•	.0





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:		





Ple	ase complete	e the	belo	w for e	ach d	epen	ident	named	on y	our	policy	D	epend	ent decl	arati	on no	o 2 oj	f			
Title	e			First na	ıme							Surna	ame								
Idei	ntity number											Da	ate of I	oirth	d	d	m	m	У	У	У
Rela	ationship			•								Gen	der		Ма	le			Fe	male	
THI	EIR PREVIOU	S GAF	P CO	VER (if	not co	overe	ed on	a previ	ous g	дар р	olicy o	of yours)									
Pre	vious Insurer		Т																		
Pre	vious cover op	tion										Previous	Policy	Number							
Sta	rt date		d	d	m n	n y	У	УУ				E	nd dat	e		d d	l m	n m	У	У	У
Plea	ase attach pro	of of t	his pr	evious g	ap co	ver.											-				
PRO	OVIDE US WI	тн м	IORE	INFORI	MATI	ON A	ABOU	T THIS I	DEPE	NDE	NT'S H	EALTH									
lmp - -	Any cancer, be months after Any other pho months after	e: oirth o cover ysical	r preg start defec	gnancy-ı s; t, medic	elate	d med	dical c	condition	that	exist	ed with		:hs befo	ore the fi	irst da	ay of	cover	will b			
De	Details of your general doctor Name: Tel No:																				
	ease select a "\ Vhere you have						•					•	-		•	-					
1.	Is this depend	dent c	urren	tly pregi	nant o	r tryii	ng to l	become	pregr	nant?						Υ			N		
2.	Has this depe	ndent	rece	ntly give	n birt	h?										Υ			N		
3.	Has this depe	ndent	ever	been di	agnos	ed wi	th an	y form o	f cand	er, m	alignar	nt or pre-ma	alignan	t tumour	s?	Υ			N		
4.	Has this depe				ical pı	roced	ure di	uring the	past	12 m	onths (or planning a	a surgi	cal proce	dure	Υ			N		
5.	Does this dep	ender	nt tak	e chroni	c or o	ngoin	ig med	dication?	•							Υ			N		
	ve you had or o	-		-		-			onditi	ions li	sted be	elow, for wh	hich m	edical ad	vice,	diagn	osis,	care o	r trea	tmen	ıt was
6.	Any bone or j fibromyalgia												thritis,	rheumat	ism,	Υ			N		
7.	High blood pr heartbeat, he lesions or any	art m	urmu	r, heart	failure	e, myd	ocardi	ial infarc								Υ			N		
8.	Ovarian cysts uterine fibroi				nent t	herap	oy, en	dometrio	osis, a	bnor	mal pa	o smears or	menst	rual blee	ding,	Υ	,		N	*	
9.	Stroke, spinal	cord	injury	or any	other	brain,	, spina	al or ner	ve coi	nditio	n					Υ		,	N	•	•
10.	Gastric ulcers									, GOF	RD (hea	rtburn), infl	ammat	tory bow	el	Y	100		N	•	.0





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:		





Please complet	_		_	ch de	oen	dent	name	d on	you	r polic	,	Depend	lent decl	arati	on no	3 of				
Title		Fi	rst nan	ne								Surname								
Identity number												Date of	birth	d	d	m	m	У	, ,	У
Relationship							•	•				Gender		Mal	e			Fem	ale	
THEIR PREVIOU	S GAP (COVE	R (if no	ot cov	ere	ed on	a prev	vious	gap	policy	of y	ours)								
Previous Insurer																				
Previous cover of	otion										ı	Previous Policy	Number			•				
Start date		d	d m	n m	У	У	У	/				End dat	е		d d	m	m	У	/ }	/
Please attach pro	of of this	s previ	ious ga	p cove	r.															
PROVIDE US W	тн мо	RE IN	FORM	IATIO	N A	BOU ⁻	T THIS	DEPI	END	ENT'S	HEAI	LTH								
	Failu	ıre to	disclo	se pre	e-ex	xistin	g med	ical c	ond	itions	may	result in limi	ted or ex	kclud	led be	enefit	ts.			
mportant to not	e:																			
Any cancer, l	oirth or p	pregna	ancy-re	lated r	nec	dical c	onditio	n tha	t exis	sted wi	thin :	12 months bef	ore the fi	rst da	ay of c	over	will b	e exclu	ded	for 1
months after		,		ا موندا	+: - ·	- ساائی			ha+	oviete d	ا ما هازر ر	in 12 manuth - I-	ofore +b -	finat	dav af			ho avel	- حاميدا	۳ t
 Any other ph months after 			nedica	ı condi	tior	n, illne	ss or ir	ıjury t	nat	existed	withi	in 12 months b	etore the	tirst	day of	cove	r will	pe exc	uded	a tor
months area	cover se	.ur cs.																		
Details of your	general o	doctor	r	Name:									Tel No:							
Please select a "	Y" or "N'	" for e	ach of	the be	low	v ques	tions.	Pleas	e an	swer h	onest	lly, accurately	and comp	oletel	у.					
* Where you hav	e selecte	ed "Y"	you m	ust su	pply	y us w	ith mo	re inf	orma	ation in	the	space below th	ne questio	onnai	re.					
1. Is this depen	dent curi	rently	pregna	ant or t	tryir	ng to b	ecome	preg	nant	?					Υ			N		
																<u> </u>				
2. Has this depe	endent re	ecently	y given	birth?)										Υ			N		
3. Has this depe	endent e	ver be	en dia	gnosed	l wi	th any	form (of can	cer,	maligna	ant o	r pre-malignan	t tumours	s?	Υ			N		
1 Has this don	ndont h	ad any	, curaic	cal pro	cod	uro di	ırina th	o nac	· 12	months	orn	lanning a surgi	cal proces	duro		_ 				
4. Has this depo during the no				ai proi	ceu	ure ac	iring tr	e pas	ι 12	monuns	or p	ianning a surgi	cai procei	uure	Υ			N		
5. Does this dep	endent	take cl	hronic	or ong	oin	g med	lication	?							Υ			N		
·						_			•	11-4-41						_ •			.	
Have you had or recommended o								conan	ions	listea	oeiov	v, for which m	edicai ad	vice,	aiagno	osis, c	are o	r treati	ment	ı was
				_	_	_						lems, arthritis,	rheumati	ism,	Y	1		N		
fibromyalgia	or any o	ther m	nusculc	skelet	al (l	back, k	one a	nd mu	scle) condit	ion				Ŀ					
7. High blood p		_											_		Υ			N		
lesions or an								ctiOff,	angl	na, per	ihiiel	al vascular dis	ease, VdIV	c						
8. Ovarian cysts	, hormo	ne rep	laceme	ent the	erap	y, end	lometr	iosis,	abno	rmal p	ap sn	nears or menst	rual bleed	ding,	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			N.		
uterine fibro					•										Υ		3-	N		
9. Stroke, spina	l cord inj	jury or	any ot	ther br	ain,	, spina	l or ne	rve co	ndit	ion					Υ		P	N	•	
			r digas	tion a	allet	tonos	cnactio	colo		NDD /ha	arthi	urn), inflamma	tony howy	o.l		-				.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

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	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:		





Please complet	te the	bel	ow	tor e	each (deper	ndent	na	amed	d on	your	polic	У	Depend	lent decl	larati	ion no	o 4 oj	f			
Title			F	irst n	name									Surname								
Identity number														Date of	birth	d	d	m	m	У	У	У
Relationship														Gender		Ма	le			Fer	nale	
THEIR PREVIOU	JS GA	P CC	OVE	R (if	not c	over	ed on	а	prev	ious	gap	oolicy	of y	ours)								
Previous Insurer																						
Previous cover o	ption													Previous Polic	y Numbe	er						
Start date			d	d	m	m y	У	,	У	У				End da	ate		d	d	m r	n y	У	У
Please attach pro	of of	this p	prev	ious	gap co	over.																
PROVIDE US W	ITH N	/IOR	E IN	IFOR	RMAT	ION A	ABOU'	ΤT	THIS	DEP	ENDE	NT'S	HEA	LTH								
months afte	te: birth o r cove nysical	or pr r stai defe	egn rts; ect,	ancy-	-relate	ed me	dical c	on	ditio	n tha	t exist	ed wi	thin :	result in limi 12 months bef n 12 months b	ore the f	irst da	ay of	cover	will b			
Details of your general doctor Name: Tel No:																						
Please select a " * Where you have							-							-			-					
1. Is this deper	ident d	curre	ently	preg	gnant	or tryi	ng to l	bec	come	preg	;nant?						Υ			N		
2. Has this dep	enden	t rec	entl	ly giv	en bir	th?											Υ			N		
3. Has this dep	enden	t eve	er be	een d	diagno	sed w	ith any	y fo	orm o	of can	icer, n	naligna	ant o	r pre-malignan	t tumour	s?	Υ			N		
4. Has this dep during the n					gical p	roced	lure dı	urir	ng the	e pas	t 12 m	nonths	or p	lanning a surgi	cal proce	dure	Υ			N		
5. Does this de	pende	nt ta	ake d	chror	nic or o	ongoir	ng med	dica	ation	?							Υ			N		
Have you had or recommended o	-			-		-			ical c	ondi	tions l	isted	belov	v, for which m	edical ad	vice,	diagn	osis,	care o	or treat	men	t was
6. Any bone or fibromyalgia														lems, arthritis,	rheumat	ism,	Υ			N		
7. High blood p heartbeat, h lesions or an	eart m	nurm	iur, l	heart	t failur	e, my	ocardi	al i	nfarc					ase, chest pain al vascular dis			Υ			N		
8. Ovarian cyst uterine fibro					ement	therap	oy, end	dor	metri	osis,	abnor	mal p	ap sn	nears or menst	rual blee	ding,	Υ		•	N		٠
9. Stroke, spina	al cord	inju	ry o	r any	other	brain	, spina	al o	r ner	ve co	onditio	on					Υ		-	N	0	•
10. Gastric ulcer disease, inte											n, GO	RD (he	artbı	urn), inflamma	tory bow	el	Y	-		N	•	.0





11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Υ	N
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*Please provide detail where "Y" has been ticked:		