ambledown
FINANCIAL SERVICES (PTY) LTD

CompliMed
... for the GAP in your medical aid

For office use only:

POLICY NUMBER:	

GAP COVER SERIES
INDIVIDUAL DEBIT ORDER APPLICATION FORM
Underwritten by Hollard Group Risk (HGR), a division of The Hollard Insurance Company Limited, Reg. No. 1952/003004/06, FSP No: 17698 (The Insurer)
Administered by Ambledown Financial Services (Pty) Ltd

BROKER DETAILS

Broker/ Consultant Name:	NELDA CELLIERS	Name of Brokerage:	MEDICAL BENEFIT ADVISORS
FSP No.:	42939	Vat No.:	
Broker Code:		Unique Identifier (if necessary) :	
Broker e-mail address:	nelda@medicalbenefits.co.za	Broker Contact No.:	(021) 975 8324

PRODUCT SUMMARY

GAP*	GAP COVER: COVERS CHARGES ABOVE THE MEDICAL SCHEME TARIFF FOR ASSOCIATED SERVICES IN-HOSPITAL, LISTED OUT-PATIENT PROCEDURES, CHEMOTHERAPY OR RADIOTHERAPY FOR THE TREATMENT OF CANCER AND KIDNEY DIALYSIS
GAP PLUS*	GAP COVER; PLUS CO-PAYMENT COVER: COVERS CO-PAYMENTS OR DEDUCTIBLES LEVIED BY THE MEDICAL SCHEME FOR IN-HOSPITAL ADMISSIONS, LISTED OUTPATIENT PROCEDURES AND MRI AND CT SCANS
GAP PLUS & EXTEND	GAP COVER; PLUS CO-PAYMENT COVER; PLUS SUB-LIMIT COVER: COVERS CHARGES ABOVE DEFINED IN-HOSPITAL SUB-LIMITS IMPOSED BY THE MEDICAL SCHEME
GAP SHIELD	GAP COVER; PLUS CANCER COVER; COVERS THE SHORTFALL, EITHER OF THE CO-PAYMENT AFTER THE SUB-LIMITATION OR THE AMOUNT ABOVE THE SUB-LIMITATION FOR CANCER TREATMENT USING TRADITIONAL METHODS OR USING BIOLOGICAL CANCER DRUGS
GAP SHIELD & CO-PAY	GAP COVER; PLUS CANCER COVER: PLUS CO-PAYMENT COVER
GAP SELECT	GAP COVER; PLUS CO-PAYMENT COVER; PLUS CANCER COVER; PLUS SUB-LIMIT COVER

* - These packages are available in the Seniors Range (i.e. actual age at date of joining 71 and above)

PRODUCT SELECTION

PRODUCTS AVAILABLE	√	PLEASE SELECT MONTHLY PREMIUM
GAP		R130.00 PER FAMILY PER MONTH
GAP SENIORS		R185.00 PER FAMILY PER MONTH
GAP PLUS		R150.00 PER FAMILY PER MONTH
GAP PLUS SENIORS		R225.00 PER FAMILY PER MONTH
GAP PLUS & EXTEND		R165.00 PER FAMILY PER MONTH
GAP SHIELD		R180.00 PER FAMILY PER MONTH
GAP SHIELD & CO-PAY		R200.00 PER FAMILY PER MONTH
GAP SELECT		R220.00 PER FAMILY PER MONTH

INCEPTION DATE (DATE COVER IS TO COMMENCE)

D	D	M	M	Y	Y	Y	Y

PERSONAL PARTICULARS

Applicant

TITLE:		SURNAME:					FIRST NAMES:						
ID NO:													
NAME OF EMPLOYER:													
DATE EMPLOYED:													

NAME OF MEDICAL AID SCHEME:		PLAN OPTION:	
DATE JOINED:		MEDICAL AID NUMBER;	

Dependants (IF ADDITIONAL SPACE IS REQUIRED GIVE DETAILS ON SEPARATE SHEET)

FIRST NAME (AND SURNAME IF DIFFERENT)	RELATIONSHIP	I.D. NUMBER
1.		
2.		
3.		
4.		
5.		
6.		
7.		

CONTACT DETAILS

POSTAL ADDRESS	PHYSICAL ADDRESS (IF DIFFERENT TO POSTAL)
POSTAL CODE:	POSTAL CODE:

HOME NO:	AREA CODE		WORK NO:	AREA CODE	
CELL NO:			E-MAIL:		

MEDICAL QUESTIONNAIRE

1. DO YOU OR ANY OF YOUR DEPENDANTS SUFFER FROM ANY CHRONIC OR RECURRING ILLNESS OR ANY OTHER SERIOUS AILMENT? Y/N	
IF "YES" PLEASE SPECIFY:	
2. HAVE YOU OR ANY OF YOUR DEPENDANTS RECEIVED TREATMENT OR ADVICE BY A MEDICAL PRACTITIONER IN THE LAST 12 MONTHS? Y/N	
IF '"YES" PLEASE SPECIFY:	
NAME OF FAMILY'S GENERAL MEDICAL PRACTITIONER / CONTACT NO.:	
3. HAVE YOU OR ANY OF YOUR DEPENDANTS BEEN HOSPITALISED DURING THE PRECEDING 12 MONTHS? Y/N	
IF '"YES" TO THE ABOVE PLEASE SPECIFY THE CONDITION FOR WHICH HOSPITALISATION WAS NECESSARY	

NAME	DATE HOSPITALISED	REASON FOR HOSPITALISATION

4. HAVE YOU OR ANY OF YOUR DEPENDANTS BEEN DIAGNOSED WITH CANCER? Y/N	
IF '"YES" TO THE ABOVE PLEASE SPECIFY THE NAMES OF DEPENDANTS DIAGNOSED WITH CANCER	
5. DO YOU OR ANY OF YOUR DEPENDANTS EXPECT TO BE HOSPITALISED DURING THE NEXT 12 MONTHS? Y/N	
IF '"YES" TO THE ABOVE PLEASE SPECIFY THE CONDITION FOR WHICH HOSPITALISATION IS NECESSARY	

NAME	EXPECTED DATE OF HOSPITILISATION	REASON FOR HOSPITALISATION

6. ARE YOU OR ANY OF YOUR DEPENDANTS CURRENTLY PREGNANT? Y/N	

PREMIUM PAYMENT

Debit Order Details

ACCOUNT HOLDERS NAME		BANK / BUILDING SOCIETY			
ACCOUNT NUMBER		BRANCH			
BRANCH CODE		ACCOUNT TYPE	CURRENT	TRANSMISSION	SAVINGS

PLEASE SELECT PREFERRED DEBIT ORDER COLLECTION DATE:

1ST		7TH		15TH		20TH		25TH		28TH		LAST DAY OF THE MONTH	

Having applied for the above mentioned insurance products and on acceptance of my application by the Insurer, I hereby authorise the Insurer or its representative to debit my account the premiums payable under the above plan on the preferred debit order collection date. Such authorisation shall remain in force and effect until cancelled by myself, in writing with one calendar months' notice. I further authorise the Insurer to increase the amount due in terms of the policy from time to time and authorise my bank to effect payment on relevant increases. Notwithstanding the fact that I grant the Insurer permission to collect premiums, I acknowledge that I need to ensure that premiums are collected for cover to remain in force.

Signature of Account Holder **Date**

DECLARATION

I declare that I have not withheld any information and I accept that this application and declaration shall be the basis of the contract of insurance between me and the Insurer, which will become effective on the first day of the month for which premiums are received. I also acknowledge that I have requested and instructed the broker not to complete a financial needs analysis. Furthermore, I understand and accept that this instruction not to proceed with a full financial needs analysis could have the effect that all my financial needs may not be properly addressed.

I further confirm that the following notable conditions have been explained to me:

a) No benefits will be payable during a general 3-month waiting period for all treatment received unless the treatment was required as a result of an accident (external violent physical means)
b) No benefits will be payable for treatment during the first 12 months of the policy if treatment or advice was received 12 months prior to inception of the policy that related to the subsequent treatment
c) No benefit shall be payable under the Cancer Cover for any pre-existing condition (meaning any form of cancer) occurring or manifesting prior to the Commencement Date of the Cancer Cover

I confirm that although I have completed this application form, it does not constitute an insurance contract until a membership number is assigned, policy issued and premium is successfully paid.

Signature of Applicant **Printed Name of Applicant** **Date**

Please return to your broker or alternatively:

Ambledown Financial Services (Pty) Ltd, PO Box 1862, Cramerview, 2060
Tel Number 0861 262533, Fax Number (011) 463 1600
E-mail Address: admin@ambledown.co.za