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FINANCIAL SERVICES (PTY) LTD

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 835 272

FOR OFFICE USE ONLY	
POLICY NO.:	

GAP COVER SERIES
INDIVIDUAL CHANGE OF OPTION APPLICATION FORM

Underwritten by Constantia Insurance Company Limited (CICL),
Reg. No. 1952/001514/06, FSP No: 31111 (The Insurer)

BROKER DETAILS

Broker/ Consultant Name:		Name of Brokerage:	Aon South Africa (Pty) Ltd
FSP No.:	20555	Vat No.:	4320101498
Broker Code:		Unique Identifier (if necessary) :	
Broker e-mail address:	apps@aon.co.za	Broker Contact No.:	0860 835 272

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 (One spouse allowed. Maximum child dependant age limit 26yrs old. No cover is provided for extended family members.)

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

PRODUCT SUMMARY

GAP COVER	GAP COVER CASUALTY BENEFIT. RAF EXPERT.
GAP SELECT	GAP COVER. CO-PAYMENT COVER. SUB-LIMIT COVER. CANCER COVER. CASUALTY BENEFIT. RAF EXPERT.
GAP SUPREME	GAP COVER CO-PAYMENT COVER. SUB-LIMIT COVER. CANCER COVER. CASUALTY BENEFIT. RAF EXPERT. PREMIUM WAIVER.
LISTED PROCEDURE ENHANCER **ADVANCED**	GAP COVER; plus A BENEFIT EQUAL TO THE COST OF IN-HOSPITALISATION AND ASSOCIATED MEDICAL EXPENSES (AS DEFINED) RELATING TO ONE OF THE LISTED PROCEDURES LESS THE COVER PROVIDED BY THE MEDICAL SCHEME OPTION: **NINE DEFINED PROCEDURES**.
GAP PLUS SENIORS*	GAP COVER CO-PAYMENT COVER. CASUALTY BENEFIT. RAF EXPERT.

BENEFITS SUMMARY

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 LIMITED TO 5 TIMES THE SCHEME TARRIF.
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.
SUBLIMITATION COVER	COVER: CHARGES ABOVE DEFINED IN-HOSPITAL SUB-LIMITS IMPOSED BY THE MEDICAL SCHEME.
CANCER COVER	COVERS THE SHORTFALL, EITHER THE CO-PAYMENT AFTER THE SUB-LIMITATION OR THE SUB-LIMITATION FOR CANCER TREATMENT FOR TRADITIONAL METHODS OR FOR EITHER THE CO-PAYMENT OR SUB-LIMITATION FOR TREATMENT O**F** CANCER WITH BIOLOGICAL DRUGS**.**
CASUALTY BENEFIT	THE COST OF A MEDICAL OR A SURGICAL PROCEDURE FOLLOWING AN EMERGENCY INCURRED IN A HOSPITAL CASUALTY UNIT OF A HOSPITAL WHERE SUCH COSTS WERE NOT MET BY THE MEDICAL SCHEME.
RAF EXPERT	COVERS THE COSTS ASSOCIATED WITH THE PRESENTATION OF A "BONA FIDE" ROAD ACCIDENT FUND CLAIM.
PREMIUM WAIVER	PROVIDES A LUMP SUM PAYMENT EQUAL TO **6 MONTHS** MEMBER'S MEDICAL SCHEME CONTRIBUTION

PRODUCT SELECTION (Please Select √)

GAP COVER		**R200.00 PER FAMILY PER MONTH**
GAP SELECT		**R300.00 PER FAMILY PER MONTH**
GAP SUPREME		**R320.00 PER FAMILY PER MONTH**

LPE ADVANCED		**R210.00 PER FAMILY PER MONTH**
GAP PLUS SENIORS		**R350.00 PER FAMILY PER MONTH**

INCEPTION DATE (DATE COVER IS TO COMMENCE)

D	**D**	**M**	**M**	**Y**	**Y**	**Y**	**Y**

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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 benefits will be payable for biological cancer drugs under the Gap Cover cancer benefits for a member already diagnosed with cancer at inception of this policy.
d) Not all your dependants on your medical scheme are automatically covered under this policy, only your eligible spouse and your eligible children are covered as per the policy definitions.

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

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