ambledown FINANCIAL SERVICES (PTY) LTD

CompliMed™ ... for the GAP in your medical aid

For office use only:

POLICY NUMBER:	

GAP COVER SERIES
EMPLOYER GROUP 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

Representative:		Name of Brokerage:	
FSP No.:		Vat No.:	
Broker Code:		Agent :	
Broker e-mail address:		Broker Contact No.:	

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

PRODUCT SELECTION

PRODUCTS AVAILABLE	PLEASE SELECT √	MONTHLY PREMIUM
GAP		
GAP PLUS		
GAP PLUS &EXTEND		
GAP SHIELD		
GAP SHIELD &CO-PAY		
GAP SELECT		

INCEPTION DATE (DATE COVER IS TO COMMENCE)

D	D	M	M	Y	Y	Y	Y

EMPLOYER GROUP DETAILS

Company Name:		
Registration Number:		
VAT Number:		
Payment Method (Please Tick)	(A.) Electronic Funds Transfer (EFT)	
	(B.) Individual Debit Orders	

CONTACT DETAILS

POSTAL ADDRESS					
	POSTAL CODE:				

PHYSICAL ADDRESS (IF DIFFERENT TO POSTAL)					
	POSTAL CODE:				

Contact Name:		Designation:	
Tel Number:	( )	Fax:	( )
E-mail address:		Cell:	

Inception Date:	D	D	M	M	Y	Y	Y	Y

Number of Employees to be Covered:				
Basis of Participation:	Voluntary		Compulsory	
Category of employees covered on a compulsory participation basis:				

PREMIUM PAYMENT DETAILS

The employer must provide Ambledown with a monthly membership listing upon payment of premium when payment is made by way of EFT or Debit Order.

Day in each month on which Premium EFT will be paid over to The Insurer i.e. 1st:				
Will Premium be paid in arrears? (Please tick)	Yes		No	

Premiums are to be transferred to the following account:
IOM (Pty) Ltd
FNB Corporate Banking
Account Number: 62206927850
Branch Code: 255005
Reference: Prefix AMBLE, followed by a 10-character description

Debit Order Details

It is a compulsory requirement that the below debit order details are verified by attaching a letter of confirmation either on the company letterhead or from the relevant bank:

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 the application by the Insurer, the authorised signatory, acting on behalf of the Employer, hereby authorise the Insurer or its representative to debit the above 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 ourselves, in writing with one calendar months' notice. We further authorise the Insurer to increase the amount due in terms of the policy from time to time and authorise our bank to effect payment on relevant increases. Notwithstanding the fact that we grant the Insurer permission to collect premiums, we acknowledge that we need to ensure that premiums are collected for cover to remain in force.

Signature of Authorised Signatory **Date**

DECLARATION

I declare that I am an authorised signatory on behalf of the above mentioned Employer Group and that I have not withheld any material information and I accept that this application and declaration shall be the basis of the contract of insurance with 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 our financial needs may not be properly addressed.

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Signed Date

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Name of authorised signatory

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