





## 2020 APPLICATION FOR FAMILY COVER

Thank you for deciding to apply for gap insurance cover with MedGap, underwritten by 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: 012 880 2230, Email: info@medgaponline.co.za

### What you must do

1. Fill in the form.

Client / Applicant

- 2. Submit the necessary supporting documents with your completed claim form.
- 3. Submit your application by emailing the form to us at <a href="mailto:new@medgaponline.co.za">new@medgaponline.co.za</a>, with your medical aid membership certificate and proof of previous gap cover (if you are moving your cover from another insurer to us).

### Once you have submitted your application form:

**TELL US WHO IS COMPLETING THIS FORM** 

Yes

No

- 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 012 880 2230 or email new@medgaponline.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.

Please read and initial each declaration under Client / Applicant declaration and consent

Appointed Broker		Yes	5	No		Please	e rea	d and	d initi	al ea	ch de	claration under	Brok	ker declaration	n and	conse	ent					
	VOL.																					
TELL US ABOUT YOU																						
Title							Surn	ame														
First Name																						
Identity number													D	ate of birth	d	d	m	m	У	У	У	У
Medical aid name		Med	dihel	lp									F	Plan option								
Medical aid no.														Date joined	d	d	m	m	У	У	У	У
Please attach an u	ust re nable	eflec e eve	ct on ent.					-			amed	on your cover	with	us and must l	be cov	erec	l on y	our r	nedi	cal ai	d at	
YOUR CONTACT	DET	AILS	5																			
Postal address												Physical addre	ess									
					Ро	stal c	ode									Ро	stal c	ode				
Email address:																						
Office tel. no.												Мс	bile	no.								
SELECT YOUR CO	OVER	OP	TIO	N AN	ND S	TART	DA	ΓE														
You confirm that y	you h	ave	read	and	unde	rstan	d the	ben	efits	that	are co	overed on the s	elect	ed cover optic	on.							
If we receive your	appli	icatio	on at	fter tl	he 15	5 <sup>th</sup> da	y of	the n	nonth	ı, we	may	make a double-	-dedu	uction from yo	our ba	nk ac	coun	t.				
Please select your				M	ledG	ap Fo oer m	r Hea						M	ledGap for He 225 per mont	althPi							
								_														



The monthly premium is inclusive of commission, binder fees of 15% of monthly premium and VAT.

When do you want your cover to start?

100	100	1.7	1.7	1.7	1.7
m	m	У	У	У	У
		-	-		

Cover can only start on the first day of the calendar month following application. No requests for backdating of cover will be considered.

YOUR	R PREVIOUS GAP (	COVER													
Have	you previously belor	nged to any oth	ner gap pro	vider? I	f yes, p	olease give	us the deta	ils.							
Previo	ous Insurer														
Previo	ous cover option						Previ	ous Policy Number							
Start	date	d d m	m y y	У	У			End date	d	d	m	m y	У	У	У
All de deper	e attach proof of yo pendants must reflendants are moving c	ect on this cert cover from a di	ificate in o	urer, ple	ease al	so attach t					o theii	r cover.	f you	r	
PROV	IDE US WITH MO	RE INFORMA	TION ABO	OUT YO	UR HE	EALTH									
- ·	Fail ortant to note: Any cancer, birth or months after cover sharp other physical domanths after cover sharp select a "Y" or "I	pregnancy-relastarts; defect, medical starts.	ated medic	al condi	ition th or injur	nat existed ry that exist	within 12 m	2 months before th	irst day ne first	of co	ver wi	ll be exc			
1.	Are you currently pr	regnant or tryir	ng to becom	ne pregi	nant?					Υ			N		
2.	Have you recently g	iven birth?								Υ			N		
3.	Have you ever been	diagnosed wit	h any form	of canc	er, ma	lignant or p	ore-maligna	nt tumours?		Y			N		
	Have you had any su during the next 12 n		ıre during t	he past	12 mo	nths or are	you planni	ng a surgical proce	dure	Y			N		
5.	Do you take chronic	or ongoing me	edication?							Υ			N		
	e you had or do you mmended or receiv				cal con	ditions list	ed below, f	or which medical a	idvice,	diagn	osis, c	are or tr	eatm	ent v	was
6.	Any bone or joint or rheumatism, fibror										Y		N		
7.	High blood pressur heartbeat, heart m lesions or any other	nurmur, heart f	ailure, myd	ocardial	infarct						Y		N		
8.	Ovarian cysts, horr uterine fibroids or		nent therap	y, endo	metrio	osis, abnorr	nal pap sme	ears or menstrual b	leeding	,	Y		N		
9.	Stroke, spinal cord	l injury or any c	other brain,	spinal o	or nerv	e condition	า				Y		N		
10.	Gastric ulcers, herr	nias, poor dige	stion, gallst	ones, sp	pastic c	colon, GOR	D (heartbur	n), inflammatory b	owel		Y		N		

disease, intestinal polyps or any other abdominal condition



11. Cataracts, glaud disorder of the		squi	nt, blur	ry visi	on, bl	indne	ss (pa	rtial or	full)	, re	etinal o	detac	hment o	r any o	ther			Υ			N		
12. Any condition o cochlear impla						uding	heari	ng pro	blem	ıs, s	sinus c	or nas	sal probl	ems,				Υ			N		
13. Any condition of	of the	mou	ıth, tee	th or	gums	includ	ing m	axillo-1	facia	l tre	eatme	nt or	specialis	sed der	ntistry	,		Υ			N		
14. Diabetes, thyrocondition	oid dis	ease	(includ	ding h	/po or	hype	rthyro	oidism)	, ost	eop	oorosi	s or a	any othei	· metak	oolic-ı	relate	ed	Υ			N		
15. Cirrhosis, liver	diseas	e or	failure	, cysti	c fibro	sis or	any c	ther liv	/er-r	elat	ted co	nditi	on					Υ			N		
16. Kidney and/or kidney disease								rinary o	or bla	add	er infe	ectio	ns, dialys	is, poly	cystic	3		Υ			N		
17. Any blood cond leukaemia, lym												ГР (рі	latelet de	eficienc	cy),			Υ			N		
18. Any condition of	of the	pros	tate in	cludin	g und	escen	ded t	estes o	r urii	nary	y inco	ntine	ence					Υ			N		
19. Any other med	ical co	ondit	ion not	t listed	l abov	e that	may	require	e tre	atm	nent o	r sur	gery					Υ			N		
Please provide detail	wher	e "Y'	" has b	een tid	cked:																		
YOUR BENEFICIARY	DETA	AILS																					
In the event of your de	eath w	vhile	you ar	e cove	red o	n the	policy	, pleas	e tel	l us	who	to pa	ıy any cla	im am	ounts	to							
Title				Nan	ne								Su	rname									
Identity number													Date	of birt	h	d	d	m	m	У	У	У	У
Mobile number										Ph	ysical	addr	ess:										
Relationship to you																							
YOUR DEPENDANTS	de DET	TAIL:	S																				
Please complete a s your policy. Any dependant for	-													-			-					су	
and when adding th																					•	•	
PROVIDE US WITH	/OUR	ВА	NKING	DET	AILS F	OR Y	OUR	MON	THĽ	ΥP	REMI	UM	DEDUC	TION A	AND (	CLAI	M P	AYM	ENT				
Your premium is payal application form, we m													that depe	nding (	on wh	en w	e rec	eive a	and pi	oces	s your	•	
Account holder name													Bank na	ame									
Branch name													Branch	code									
Account number																							
		_		Туре	of acc	count	_		_				Cheque			Savir	ngs			Tran	smissi	on	
Please choose your o						i	_	1		_			_						•			L	



completion of this application form.

DEBIT ORDER IMAI	IDAIL													
By initialling this box y	ou:	]												
1. Authorise Guardri	sk to debit y	our account wit	h the monthly	premium due in	respect of this	policy.								
2. Acknowledge that	this authori	isation will rema	in in force and	d effect until cand	celled by you, in	writin	g with o	ne cale	endar	mon	th's n	otice.		
3. Understand that of when the Mandat					reement that th	ne acco	unt hol	der is n	ot en	titled	to re	fund	for	
4. Acknowledge that	this Author	ity may be assig	ned to a third	party if this agre	ement is also as	signed	to a th	ird part	y.					
5. Understand and a changing legislation to the adjusted pr	n, with one													
6. Undertake to info	m Guardrisl	k of any change	in your bankin	g details and you	ı authorise Guai	rdrisk	o verify	such b	ankin	g det	ails w	vith yo	our	
7. Confirm that Guar change in banking	drisk shall n details	ot be held liable	for incorrect of	claim payments r	made as a result	of you	ır failur	e to inf	orm G	iuard	risk c	of you	r	
8. Accept that Guard	risk may del	bit your account	on a date oth	er than that spec	cified.									
9. Notwithstanding t that premiums are				on to collect pren	niums, you ackn	owled	ge that	t is you	ır resı	oonsi	bility	to en	sure	
10. Acknowledge that	the first pay	yment date will	be the first da	y of the month ir	n which your co	ver sta	rts.							
11. Acknowledge that automatically be t				n a Sunday, or re	cognised South	Africa	n public	holiday	y, the	payn	nent (	day w	ill	
12. Acknowledge that accountholder.	payment in	structions issue	d from this Ma	andate will be tre	eated as paymer	nt instr	uctions	issued	perso	nally	by th	ne		
13. Understand that t been captured.	he agreeme	nt reference nur	nber will be yo	our membership	number which	will on	ly issue	d once	your	applio	cation	form	has	
14. Understand that t	ne debit ord	ler transaction o	n your bank st	atement will ref	ect as 'ADMED'									
													_	
Signature of bank a	count hold	 der		Date	signed:		d	d	m	m	У	У	У	У
olgitatare or same as				Date	31611041			<u> </u>		J	J			
PROVIDE US WITH	OUR BRO	KER'S DETAILS												
INTERMEDIARY DETA	ILS									·				
Brokerage name														
Branch name							FSP I	No.						
Advisor name					Mobile No.									
E-mail address							•					•	•	
By initialling this box y	ou confirm	that your financ	ial adviser has	communicated t	the below to yo	u:								
1. That he/she is ma	ndated by ar	_				to ac	t on hol	alf of t	- hat E	SP as	a rep	resen	tativ	e.
	idated by ai	n authorised Fin	ancial Services	s Provider (FSP), a	as set out above	., to ac	t on bei	iaii Oi t	liat F					
<ol><li>That he/she is an a</li></ol>	-								.iiat F					
<ol> <li>That he/she is an a</li> <li>That he/she accep</li> </ol>	accredited fi	inancial adviser i	in terms of the	FAIS Act at the	date of signing t	his ap	olication	form.						
	accredited fi	inancial adviser i ointment by you	in terms of the	e FAIS Act at the o	date of signing t	his app	olicatior s in resp	form.						
3. That he/she accep	accredited fi ts their appo	inancial adviser i ointment by you rare of the comm	in terms of the to provide ad nission payable	e FAIS Act at the o lvice and ongoing e by Guardrisk to	date of signing t g intermediary s him/her in resp	his appervice	olicatior s in resp this pol	form. ect of t	this po	olicy.				
<ul><li>3. That he/she accep</li><li>4. That he/she has m</li></ul>	accredited fi ts their appo ade you aw onducted a f splained the	inancial adviser i ointment by you rare of the comm financial needs a e insurance prode	in terms of the to provide ad hission payable analysis and thi	e FAIS Act at the of livice and ongoing by Guardrisk to is insurance proc	date of signing t g intermediary s him/her in resp duct is suitable t	his applervice of the original or	olication s in resp this pol t your ir	form. ect of ticy.	this po	olicy. ds.	hat is	s not d	cover	ed,



# BROKER DECLARATION AND CONSENT – only applicable when broker is completing application form on behalf of client

Ple	ase 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.	
ΥO	UR DECLARATION AND CONSENT	
Ple	ase initial each of the following sentences below to confirm that you are in agreement with the statement:	
1.	1. I hereby apply for the MedGap product 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 the contract of insurance between Guardrisk and me, 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 dependants' 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 dependants' 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 dependants' cover will and will not pay.	
8.	I further declare my understanding that my and my dependants' eligibility for cover is dependant on my, and my dependants remaining active members of a registered medical scheme and I undertake to advise Guardrisk if I terminate my, or my dependants' medical scheme membership at any time.	
9.	I confirm that I have appointed the above named financial advisor as intermediary to my policy.	
10.	I authorise Guardrisk to make payment of the monthly commission, calculated according to a scale of 20% of the first R299, and 15% of the remaining monthly premium, to the appointed intermediary for services rendered in respect of this policy.	
11.	I understand that in terms of the Financial Advisory and Intermediary Services Act, 2002 ("FAIS"), the financial advisor must be mandated by a licensed Financial Services Provider ("FSP") as a representative with the necessary FAIS sub-categories to act on my behalf and that it is my responsibility to determine whether my financial advisor has the necessary authorisation.	
12.	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 dependants') diagnosis, treatment and medical history. I further confirm that my dependants and/or beneficiaries have also provided the necessary authority for their medical scheme to disclose their relevant medical information to Guardrisk to assist in the processing of claims under this policy.	



Date signed:  Signature of Applicant	
19. I authorise Guardrisk to disclose all relevant information to the appointed broker on my papplication form, for the purpose of administering cover and processing of all future clair include my (or one of my dependents') medical diagnosis, treatment and history as well at that my dependents and/or beneficiaries have also provided the necessary authority to dappointed broker to assist in the processing of this application form, administrating of the Guardrisk on this policy.	ms under this policy. This information could as personal information. I further confirm disclose their relevant information to the
18. I undertake to notify Guardrisk of any change in my personal details within a reasonable against any liability for any loss that may result from my failure to notify Guardrisk of suc	ch change in a timeous manner.
17. I authorise Guardrisk to negotiate discounts on my behalf with medical service providers my cover. If successful, I acknowledge that payment will be made directly to the service payment will be due to me.	
16. I authorise Guardrisk, or its appointed service provider, to negotiate on my behalf with m claims that may have arisen from medical events which my medical scheme is legally obli	
15. I confirm that I am aware of my right to request a copy of my and my dependants' person have the right to request that such personal information is updated, corrected or deleted object to the processing of my personal information by lodging a complaint with the Info	d by Guardrisk and that I have the right to
14. I authorise Guardrisk to use, review and process any of my or my dependents' persor course of this application and for the purpose of administering cover and processing confirm that my dependents and/or beneficiaries have also provided me with the authorous Guardrisk.	of future claims under this policy. I further
13. I authorise Guardrisk to obtain from any person, medical practitioner or institution, any is purposes of claims arising from this policy. I authorise such person(s) to give the said information other insurers and medical schemes any information in this application or in any related through a database operated by or for insurers as a group, at any time (even after my decoded form as Guardrisk or the operators of such database may decide from time to time authorisation and that it will endure after my death.	prmation to Guardrisk, and to share with policy or other document, either directly or eath) and in such detailed, abbreviated or

Ν



### **DEPENDANT DECLARATION**

Please complete the below for each dependant named on your policy Dependant declaration no 1 of Title First name Surname Identity number Date of birth Relationship Gender Male Female THEIR PREVIOUS GAP COVER (if not covered on a previous gap policy of yours) **Previous Insurer Previous Policy Number** Previous cover option Start date End date Please attach proof of this previous gap cover. PROVIDE US WITH MORE INFORMATION ABOUT YOUR DEPENDANT'S HEALTH 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 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. Please select a "Y" or "N" for each of the below questions. Please answer honestly, accurately and completely. 1. Is this dependant currently pregnant or trying to become pregnant? Ν 2. Has this dependant recently given birth? Ν Ν 3. Has this dependant ever been diagnosed with any form of cancer, malignant or pre-malignant tumours? 4. Has this dependant had any surgical procedure during the past 12 months or planning a surgical procedure Ν during the next 12 months? 5. Does this dependant take chronic or ongoing medication? Ν Have you had or do you currently have, any of the medical conditions listed below, for which medical advice, diagnosis, care or treatment was recommended or received within the last 12 months? 6. Any bone or joint condition including ongoing back, shoulder, hip or knee problems, arthritis, rheumatism, Ν fibromyalgia or any other musculoskeletal (back, bone and muscle) condition 7. High blood pressure, high cholesterol or lipids, ischaemic / coronary heart disease, chest pains, irregular Ν heartbeat, heart murmur, heart failure, myocardial infarction, angina, peripheral vascular disease, valve lesions or any other heart-related medical condition Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, Ν uterine fibroids or prolapse Stroke, spinal cord injury or any other brain, spinal or nerve condition Ν 10. Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel Ν disease, intestinal polyps or any other abdominal condition 11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other Ν disorder of the eye

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	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 other medical condition not listed above that may require treatment or surgery	Υ	N
Please provide detail where "Y" has been ticked:		



# **DEPENDANT DECLARATION**

PIG	ease com	piete	tne b	elow t	or ea	acn ae	epen	aaı	nt nai	mea	on y	ou	ır po	olicy		Depena	ant aecid	aratio	on no	)					
Tit	tle			Fi	rst na	ıme										Surname									
Ide	entity num	ber														Date of b	irth	d	d	m	m	У	У	У	У
Re	elationship	١														Gender		Male	?			F	emale	?	
TH	HEIR PRE	/IOUS	GAP	COVE	R (if	not co	overe	ed (	on a <sub>l</sub>	previ	ous	ga	ррс	olicy	of y	yours)									
Pro	evious Ins	urer																							
Pro	evious cov	er opt	ion												ı	Previous Policy N	lumber								
Sta	art date			d	d	m n	у	1	У	У						End date		d	d	m	m	У	У	У	У
Ple	ease attacl	h proo	f of th	is previ	ous g	gap cov	ver.																		
PR	ROVIDE U	S WIT	НМ	ORE IN	FOR	MATI	ON A	ABC	OUT Y	OUR	DEF	EI	NDA	NT'S	HE	ALTH									
lm -	months	cer, bii after c	th or s	pregnai tarts;	ncy-r	elated	med	ical	cond	ition 1	that (	exi	sted	withi	in 1	result in limit 2 months before	e the first	day o	of cov	er wi	ll be e				
-	Any other				nedic	al con	ditior	n, ill	lness (	or inju	ury th	nat	exis	sted w	/ith	in 12 months be	fore the f	first d	ay of	cove	r will	be e	kclude	ed fo	r 9
Ple	ease selec	t a "Y"	or "N	" for ea	ich of	the b	elow	que	estion	s. Ple	ase a	ans	wer	hone	stly	, accurately and	complete	ely.							
1	. Is this de	ependa	ant cui	rently	pregr	nant o	r tryir	ng t	o bec	ome į	oregr	nar	nt?						Υ			N			
2	. Has this	depen	dant r	ecently	give /	n birth	າ?												Υ			N			
3	. Has this	depen	dant e	ever be	en dia	agnose	ed wit	th a	any fo	rm of	cano	cer,	, ma	lignar	nt o	r pre-malignant	tumours?	?	Υ			N			
4	. Has this during th				_	ical pr	oced	ure	durin	g the	past	12	2 mo	nths (	or p	olanning a surgic	al proced	ure	Υ			N			
5	. Does thi	s depe	ndant	take cl	hroni	c or or	ngoin	g m	nedica	tion?									Υ			N			
	ive you ha as recomm		-		-		•				ndit	ior	ıs lis	ted b	elo	w, for which me	dical adv	ice, d	liagno	osis, o	are o	r tre	atme	nt	
6.	Any bon fibromya															olems, arthritis, r	heumatis	sm,	Υ			N			
7.		at, hea	rt mu	rmur, h	eart	failure	, myc	ocai	rdial i							ease, chest pains ral vascular dise			Υ			N			
8.	Ovarian uterine f					nent tl	nerap	у, е	endon	netrio	sis, a	abn	norm	nal pa	p sr	mears or menstr	ual bleedi	ing,	Y			N			
9.	Stroke, s	pinal o	cord in	jury or	any o	other I	orain,	, sp	inal oı	r nerv	e co	ndi	ition						Υ			N			
10	. Gastric u disease,											ı, G	ORE	) (hea	ırtb	urn), inflammato	ory bowel	I	Υ			N			
11	. Cataracts disorder			squint,	blurr	y visio	n, bli	indı	ness (Į	partia	l or f	full	), re	tinal o	deta	achment or any o	other		Υ			N			
12	. Any cond implants						incl	udi	ng hea	aring	prob	len	ns, s	inus d	or n	asal problems, c	ochlear		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 other medical condition not listed above that may require treatment or surgery	Υ	N
Please provide detail where "Y" has been ticked:		



# **DEPENDANT DECLARATION**

PI	ease coi	mpiete	tne	beio	w to	or ea	ich a	epen	uar	it na	amec	on	yo	our p	olicy		Depend	iant aecia	ratic	on no	3 0]					
Tit	tle				Firs	st na	me										Surname									
Id	entity nu	mber															Date of I	oirth	d	d	m	m	У	У	У	У
Re	elationshi	ip															Gender		Male	ı			F	emale	?	
TH	HEIR PRI	EVIOU	S GA	Р СО	VER	(if r	not c	overe	ed o	on a	prev	/iou:	s g	ар р	olicy	of	yours)									
	evious In																									
Pr	evious co	over op	tion														Previous Policy	Number								
St	art date			d	(	d	m n	n y	)	У	У	/					End dat	e	d	d	m	m	У	У	У	У
Ple	ease atta	ch prod	of of t	his p	revio	us g	ap co	ver.																		
PF	ROVIDE	US WI	TH M	IORE	INF	ORI	MATI	ON A	ABO	UT	YOU	R DE	EPI	END/	ANT'S	S H	IEALTH									
lm	nportant		:														y result in liming						ovelu	dod f	or 12	
-		s after			-	су-ге	elateu	meu	icai	COIII	uitioi	ı ula	t e	xistet	ı Witi	1111	12 months befor	e the mst	uay u	ii cov	ei wi	ii be e	exciu	ueu i	01 12	
-	Any ot					edica	al con	ditior	n, ill	ness	or in	jury	tha	at exi	sted v	wit	hin 12 months be	efore the fi	irst da	ay of	cove	r will	be e	xclud	ed for	9
Pl	ease sele	ct a "Y'	" or "l	N" fo	r eac	h of	the b	elow	que	estio	ns. Pl	ease	e ar	nswer	hone	estl	ly, accurately and	d complete	ly.							
1	l. Is this o	depend	ant c	urren	ıtly p	regn	ant o	r tryir	ng te	o be	come	pre	gna	ant?						Υ			N			
2	2. Has thi	s depei	ndant	rece	ntly	give	n birtl	า?												Υ			N			
3	3. Has thi	s depei	ndant	ever	bee	n dia	gnos	ed wi	th a	iny fo	orm c	of cai	nce	er, ma	aligna	nt	or pre-malignant	tumours?		Υ			N			
4		s depei the nex				surgi	ical pr	oced	ure	duri	ng th	e pa	st 1	12 m	onths	or	planning a surgion	cal procedu	ıre	Υ			N			
5	5. Does tl	nis dep	endar	nt tak	ce ch	ronio	or o	ngoin	g m	edic	ation	?								Υ			N			
	ave you h as recom											ond	litic	ons li	sted b	el	ow, for which m	edical advi	ice, d	iagno	osis, o	care o	or tre	atme	nt	
6.	Any bo fibrom																blems, arthritis,	rheumatisı	m,	Υ			N			
7.		eat, he	art m	urmu	ır, he	art f	ailure	, myc	ocar	dial	infar						sease, chest pain eral vascular dise			Υ			N			
8.		n cysts, e fibroic				acem	nent t	herap	у, ∈	endo	metri	osis,	, ak	onorn	nal pa	p s	smears or menst	rual bleedi	ng,	Υ			N			
9.	Stroke,	spinal	cord	injury	y or a	any c	other	brain,	, spi	inal d	or ner	ve c	on	ditior	า					Υ			N			
10		ulcers, e, intest											on,	GOR	D (he	art	burn), inflammat	ory bowel		Υ			N			
11		ts, glau er of the			iint, k	olurr	y visio	on, bli	indr	ness	(parti	ial or	r fu	ıll), re	etinal	de <sup>.</sup>	tachment or any	other		Υ			N			
12	. Any cor implan							t, incl	udir	ng he	earing	g pro	ble	ems,	sinus	or	nasal problems,	cochlear		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 other medical condition not listed above that may require treatment or surgery	Υ	N
Please provide detail where "Y" has been ticked:		



## **DEPENDANT DECLARATION**

implants, tonsillitis, or adenoiditis

Please complete the b	elow for each o	lependan	nt named o	on you	ır policy	Dependant de	clarat	tion no	o 4 of				
Title	Surname	Surname											
Identity number						Date of birth	d	d	m	m	У	У	У
Relationship						Gender	Ма	1ale Female			ale		
THEIR PREVIOUS GAP	COVER (if not o	overed o	on a previ	ous ga	p policy	of yours)							
Previous Insurer							'					' '	
Previous cover option						Previous Policy Number							
Start date	d d m	m y y	у у			End date		d d	m	m	У	У	У
Please attach proof of th	nis previous gap co	over.		_									
PROVIDE US WITH MO	ORE INFORMAT	ION ABO	UT YOUR	DEPE	NDANT'S	HEALTH							
<ul> <li>Important to note:</li> <li>Any cancer, birth or months after cover s</li> <li>Any other physical d months after cover s</li> </ul>	pregnancy-related starts; efect, medical col starts.	d medical	condition t	hat exi	sted withi	nay result in limited or on a second or the fire of th	rst day e first	of cov	ver wi	ll be e			
ricase select a ri or iv	Tor each of the	ociow que	.3(10113. 1 100	130 0113	Wei none	stry, accurately and comple	ciciy.						
1. Is this dependant currently pregnant or trying to become pregnant?								Υ			N		
2. Has this dependant recently given birth?							Υ			N			
3. Has this dependant ever been diagnosed with any form of cancer, malignant					nt or pre-malignant tumou	rs?	Υ			N			
4. Has this dependant had any surgical procedure during the past 12 months of during the next 12 months?					or planning a surgical proce	edure	Υ			N			
5. Does this dependant take chronic or ongoing medication?							Υ			N			
Have you had or do you was recommended or re				ndition	ns listed b	elow, for which medical a	dvice,	diagn	osis, d	are o	r treatr	nent	
6. Any bone or joint condition including ongoing back, shoulder, hip or knee properties fibromyalgia or any other musculoskeletal (back, bone and muscle) conditions.							tism,	Υ			N		
	rmur, heart failur	e, myocar	dial infarct			disease, chest pains, irregu pheral vascular disease, va		Υ			N		
Ovarian cysts, hormouterine fibroids or process.		therapy, e	ndometrio	sis, abn	normal pa	o smears or menstrual blee	eding,	Y			N		
9. Stroke, spinal cord in	njury or any other	brain, spi	nal or nerv	e condi	ition			Υ			N		
10. Gastric ulcers, hernia disease, intestinal po					GORD (hea	rtburn), inflammatory bov	vel	Υ			N		
11. Cataracts, glaucoma, disorder of the eye	squint, blurry visi	on, blindr	ness (partia	l or full	l), retinal o	detachment or any other		Y			N		
12. Any condition of the	ear, nose or throa	nt, includir	ng hearing ¡	orobler	ms, sinus o	or nasal problems, cochlea	r	V			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 other medical condition not listed above that may require treatment or surgery	Υ	N
Please provide detail where "Y" has been ticked:		