# 2024 MEDGAP OPTION CHANGE FORM

You can **downgrade** from Supreme Gap to Primary Gap at any time of the year by completing and submitting this form to us at least one calendar month before the date of change.

When you do this, we will change your cover option with us at the end of the month in which you let us know.

Your new premium will be applicable from the date on which your new benefits begin.

You may only **upgrade** from Primary Gap to Supreme Gap once per year, on your renewal date.

## TELL US ABOUT YOU

| | | | |
|---|---|---|---|
| Title | | Surname | |
| First Names | | | |
| Employer | | Member no | |
| Identity number | | Date of birth | d d m m y y y y |
| Medical aid | | Option | |
| Medical aid no. | | | |

## YOUR CONTACT DETAILS

| | | | |
|---|---|---|---|
| Mobile number | | Work number | |
| Email address | | | |
| Postal address | | | |

## YOUR OPTION CHANGE

**I want to UPGRADE from Primary Gap to Supreme Gap** ☐
*(you may only upgrade on your policy renewal date)*
Please complete section "A" below

**I want to DOWNGRADE from Supreme Gap to Primary Gap** ☐
*(you may downgrade at any time, subject to a calendar month's written notice)*
Please complete section "B" below

## SECTION C - MEMBER DECLARATION

Please initial each of the following sentences below to confirm that you are in agreement with the statement:

1. I declare that the information that I have supplied is true and correct and that I have not withheld anything which may be material to or likely to affect the assessment of my risk. I understand that in the event of any material non-disclosure or misrepresentation my policy may be rendered null and void, that I will forfeit any and all contributions and that Guardrisk may decline to indemnify or compensate me for any claims under any section of cover. ☐
2. I understand that any new dependent added may be subject to waiting periods and that these waiting periods have been communicated to me. ☐
3. 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' medical scheme membership at any time. ☐
4. 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 their relevant medical information to Guardrisk to assist in the processing of claims under this policy. ☐

5. 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. ☐

6. 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. ☐

7. 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. ☐

8. I undertake to notify Guardrisk of any change in my personal details within a reasonable time period and you indemnify Guardrisk against any liability for any loss that may result from your failure to notify Guardrisk of such change in a timeous manner. ☐

9. I authorise Guardrisk to disclose all relevant information to the appointed broker on my policy to assist in the processing of this application form, for the purpose of administering cover and processing of all future claims under this policy. 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, administrating of this policy and any claims processed by Guardrisk on this policy. ☐

Signature of Member _____ Date signed | d | d | m | m | y | y | y | y |