

Group GapCover® APPLICATION FORM



Email: admin@gaprisk.co.za / Fax: 087 018 0006

Consultant Reference: Intermediary Code:

Company:

GRP Individual GapCover R 192 GRP Family GapCover R 240 GRP Individual Combined Cover R 276 GRP Family Combined Cover R 344

A POLICY HOLDER DETAILS

This is not a medical scheme and the cover is not the same as that of a medical scheme.
This policy is not a substitute for medical scheme membership.

Effective Date: - - Date of Birth: - -

Title: Initials: Surname:

Full Name: Gender:

ID Number: Passport No:

Telephone (W): Fax No:

Telephone (H): Cell No:

Email Address: Medical Scheme:

Postal Address:

Home Address:

B DEPENDENT DETAILS

Do you have dependents that need to be registered? Yes: No:

Spouse / Life Partner and all children registered as dependents (including full-time students and permanently disabled children) on your medical scheme may be covered on your GapCover policy. Please attach a copy of your medical scheme membership certificate to register dependents on your GapCover policy.

NB: Any changes must be communicated to the Administrator within 30 days of the occurrence and only dependents that are registered on the policy will be covered. (Dependent children are only covered up to their 26th birthday, unless such a child is permanently dependent on the policy holder due to physical or mental disability.)

C PRE-EXISTING CONDITION

Are you aware of any condition or symptom, for which you or your dependents received medical advice, diagnosis, care or treatment in the past 12 months? (Please select)

Yes: No: If yes, please refer to Clause G7 of the Declaration.

Please note: The administrator must be notified if an insured person's state of health changes from the date of signing the application to the date of inception. These conditions will also be excluded as pre-existing conditions.

D BANKING DETAILS (DEBIT ORDER)

Account Holder:	<input type="text"/>	Contact No:	<input type="text"/>		
Name of Bank:	<input type="text"/>	Branch Code:	<input type="text"/>		
Account No:	<input type="text"/>	Account Type:	<input type="checkbox"/> Cheque <input type="checkbox"/> Transmission <input type="checkbox"/>		
			<input type="checkbox"/> Savings <input type="checkbox"/> Current <input type="checkbox"/>		
Debit Order Date:	<input type="text"/> 1st <input type="text"/>	<input type="text"/> 5th <input type="text"/>	<input type="text"/> 10th <input type="text"/>	<input type="text"/> 15th <input type="text"/>	<input type="text"/> 25th <input type="text"/>

I, Hereby authorise Western National Insurance Company Limited to debit my account for the monthly contribution for GapCover. I acknowledge that all such payments from my bank account issued by Western National Insurance Company Limited shall be treated by my bank as if the instructions have been issued by me. I acknowledge that these premiums will be deducted monthly on the selected debit order date from the account above. Your bank statement will reflect the following reference in relation to your GapCover® debit order: GAPCOVERNO (followed by your policy number)

Date: - - Signature of Account Holder:

E DECLARATION BY APPLICANT

Standard Declaration

I warrant that the information provided to the insurer in connection with the policy, whether in my own handwriting or not, is true and correct. I, the undersigned, hereby declare that:

1. All the information that I give, whether telephonic, electronic or written, will form part of the policy.
2. To the best of my knowledge and belief the information provided in connection with this application, whether in my own handwriting or not, is true and I have not withheld any material facts known to me.
3. I understand that this is an accident and health policy with stated benefits in terms of the Short-term Insurance Act 53 of 1998. This is not a medical scheme and the cover is not the same as that of a medical scheme. This policy is not a substitute for medical scheme membership.
4. I acknowledge that the sharing of claims information and underwriting (including credit information) by insurers is essential to enable the insurance industry to underwrite policies and assess risk fairly and reduce the incidence of fraudulent claims, in the public interest and with a view to limiting premiums. I hereby waive any rights to privacy of any claim information supplied by me or on my behalf in respect of any insurance claim made or lodged by me and I consent to such information being disclosed to any other insurance company or its agent. I also waive any rights to privacy and consent to the disclosure of any information relevant to claims concerning me or any person I represent. I also acknowledge that information provided by me may be verified against other legitimate sources or databases.
5. If the insurer accepts this application, it will be on condition that there is no important change to the facts that I disclosed and upon which this application is based and accepted. If there has been such a change, I must inform the insurer within 30 days of the occurrence in order for him to reassess the risk for the insurance cover.
6. Upon receipt of my policy document, I will familiarise myself with all the terms and conditions of the policy and contact my Intermediary or the Administrator for clarification should anything be unclear.
7. This consent is to remain in force after my death.

F FEES AND COMMISSION

I acknowledge and appoint Optivest Health Services (FSP no. 13475) as intermediary to provide ongoing intermediary services to me regarding this policy. I agree that the insurer may pay commission to the intermediary in terms of the Short-term Insurance Act 53 of 1998.

G IMPORTANT TERMS AND CONDITIONS OF THIS POLICY

I understand and agree that:

1. To qualify for benefits under this policy, I must be a member, and my insured family must be dependants of a medical scheme approved in terms of the Medical Schemes Act and my dependents must be registered as dependents on the policy.
2. Cover will commence on the 1st day of the calendar month for which the insurer accepts my application for insurance and receives my first premium.
3. The Policy Premium may be changed annually, after the insurer has given me 30 days' notice. If I do not pay my premiums in full, I will not be covered.
4. In terms of the policy, the insurer will pay the difference between the surgical and consultation fees charged by health professionals for insured events and the benefits payable by my medical scheme. Terms and conditions will apply as stipulated in the policy contract.
5. A maximum benefit of R198 660 will be payable per beneficiary per policy per annum. A sub limit of R17 500 per event is applicable to all CoPay Cover claims and Non-DSP hospital co-payments are limited to one event per policy per annum.
6. Termination of cover will take place if I have given a calendar month's written notice of cancellation, if 3 consecutive premiums are unpaid, or if a dependant does not qualify for cover on my policy.
7. Benefits will not be paid:
If the medical scheme pays the entire claim or pays short due to scheme limits or exclusions.
If I do not submit my claim within 4 months of the date of payment by my medical scheme.
For the first 3 months of cover. (Please refer to full definition and details supplied on the Policy Contract)
For the first 12 months of cover in respect of any pre-existing condition. (Please refer to full definition and details supplied on the Policy Wording).
8. This policy does not cover Prescribed Minimum Benefits (PMB) as defined in the Medical Schemes Act 131 of 1998 with Regulations, which are payable by my medical scheme.
9. The full terms and conditions are provided in the Policy Contract.

H PROTECTION OF PERSONAL INFORMATION ACT (POPIA) NOTICE

1. Collection of your Personal Information

We collect and process your personal information mainly to provide you with access to our services and products, to help us improve our offerings to you and for certain other purposes explained below.

The type of information we collect will depend on the purpose for which it is collected and used. We will only collect information that we need for that purpose.

We collect information directly from you where you provide us with your personal details, for example when you purchase a product or services from us or when you submit enquiries to us or contact us. Where possible, we will inform you what information you are required to provide to us and what information is optional.

2. Use of your Personal Information

GapRisk collects and uses your personal information to deliver the services you have requested. GapRisk may also contact you from time to time via surveys to conduct research about your opinion of current services or of potential new services that may be offered when necessary. GapRisk does not sell, rent or lease its customer lists to third parties.

3. Protection of your Personal Information

GapRisk values the information that you choose to provide and will take appropriate, reasonable technical and organisational steps to protect your personal information from loss, misuse or unauthorised alteration. The information GapRisk has concerning GapRisk clients is stored in databases that have built-in safeguards to ensure the privacy and confidentiality of that information.

4. Correction of Personal Information

You have an obligation to notify us if any of your personal information held by GapRisk changed or is no longer valid. To ensure our records are up to date, you can e-mail us or you can phone our contact centre as supplied on our website, under "contact us".

Additional detail regarding the use of personal information is set out in our Privacy Policy that can be viewed on our website www.gaprisk.co.za/privacy-policy/ or www.gapcover.co.za/privacy-policy/.

Date:

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Signature of Policy Holder: