



GAP COVER SERIES CHANGE OF OPTION APPLICATION FORM

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

FOR OFFICE USE ONLY	
POLICY NUMBER	

BROKER DETAILS

BROKER / CONSULTANT NAME			
NAME OF BROKERAGE			
FSP NUMBER		VAT NUMBER	
BROKER CODE		UNIQUE IDENTIFIER (IF NECESSARY)	
BROKER E-MAIL ADDRESS		BROKER CONTACT NUMBER	

PERSONAL PARTICULARS

APPLICANT

TITLE		SURNAME		FIRST NAMES	
ID NUMBER					
NAME OF EMPLOYER				DATE EMPLOYED	D D M M Y Y Y Y
NAME OF MEDICAL AID SCHEME				PLAN OPTION	
DATE JOINED	D D M M Y Y Y Y	MEDICAL AID NUMBER			

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

FIRST NAME (AND SURNAME IF DIFFERENT)	RELATIONSHIP	I.D. NUMBER

CONTACT DETAILS

POSTAL ADDRESS					PHYSICAL ADDRESS (IF DIFFERENT TO POSTAL)				
		POSTAL CODE					POSTAL CODE		
HOME NUMBER	AREA CODE				WORK NUMBER	AREA CODE			
CELL NUMBER	AREA CODE				E-MAIL				

PRODUCT SUMMARY

GAP 100	- GAP COVER 100. - CASUALTY BENEFIT.	GAP SUPREME	GAP COVER 100. CO-PAYMENT COVER. SUB-LIMIT COVER. CANCER COVER. CASUALTY BENEFIT. PREMIUM WAIVER.
GAP PLUS	- GAP COVER 100. - CO-PAYMENT COVER. - CASUALTY BENEFIT.		
GAP SELECT	- GAP COVER 100. - CO-PAYMENT COVER. - SUB-LIMIT COVER. - CANCER COVER. - CASUALTY BENEFIT.	GAP LPE ADVANCED (LISTED PROCEDURE ENHANCER)	- GAP COVER 100. - MEDICAL EXPENSES RELATED TO NINE DEFINED PROCEDURES.
GAP ELITE	- GAP COVER 100. - SUB-LIMIT COVER. - CANCER COVER. - CASUALTY BENEFIT.	GAP SENIORS*	- GAP COVER 100. - CASUALTY BENEFIT.
	- PREMIUM WAIVER: PROVIDES A LUMP SUM PAYMENT EQUAL TO 6 MONTHS MEMBER'S MEDICAL SCHEME CONTRIBUTION.	GAP PLUS SENIORS*	GAP COVER 100. CO-PAYMENT COVER. CASUALTY BENEFIT.

BENEFITS SUMMARY

GAP COVER 100	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 AND R2 000 000 PER FAMILY PER ANNUM.
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. LIMITED TO R100 000 PER FAMILY PER ANNUM.
SUBLIMITATION COVER	COVERS CHARGES ABOVE THE DEFINED IN-HOSPITAL SUB-LIMITS IMPOSED BY THE MEDICAL SCHEME. LIMITED TO R500 000 PER FAMILY PER ANNUM.
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 OF CANCER WITH BIOLOGICAL DRUGS. LIMITED TO R500 000 PER FAMILY PER ANNUM.
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. LIMITED TO R10 000 PER FAMILY PER ANNUM.
LISTED PROCEDURE ENHANCER	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, LIMITED TO R75 000 PER FAMILY PER ANNUM.
PREMIUM WAIVER	PROVIDES A LUMP SUM PAYMENT EQUAL TO 6 MONTHS OF THE MEMBER'S MEDICAL SCHEME CONTRIBUTION.

PRODUCT SELECTION

GAP 100	R230.00 PER FAMILY PER MONTH	GAP PLUS	R290.00 PER FAMILY PER MONTH
GAP SELECT	R350.00 PER FAMILY PER MONTH	GAP ELITE	R340.00 PER FAMILY PER MONTH
GAP SUPREME	R375.00 PER FAMILY PER MONTH	GAP LPE ADVANCED	R235.00 PER FAMILY PER MONTH
GAP SENIORS	R365.00 PER FAMILY PER MONTH	GAP PLUS SENIORS	R385.00 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

1 st		7 th		15 th		20 th		25 th		28 th		LAST DAY OF THE MONTH	
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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

D	D	M	M	Y	Y	Y	Y
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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. The waiting periods (a, b and c) below will be applied where applicable to the additional benefits obtained when the Option Change relates to an upgrade in cover:

- 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).
- 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.
- 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 unless the insured has been in remission for a period of 3 years and longer.
- 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

D	D	M	M	Y	Y	Y	Y
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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