

Admed
The heartbeat of Gap

Admed Gap Cover Retail Application Form

2027

Important notes:

- Thank you for your application to join Admed Gap Cover, underwritten by Guardrisk Insurance Company Limited (Reg. 1992/001639/06, FSP No. 75).
- You can only apply for Admed Gap Cover via an accredited financial adviser.
- If you are applying for Under 42 Gap Cover or Pensioner Gap Cover, you may not include dependants.
- Please email the completed and signed form to us at **admedapplications@guardrisk.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.

Tell us who is completing this form	Client/applicant	Yes ☐	No ☐	Please read and initial each declaration under client/applicant declaration and consent.
	Appointed financial adviser	Yes ☐	No ☐	Please read and initial each declaration under financial adviser declaration and consent.

1: Contract details

Family Cover (Main member age 18-64)	Admed Supreme – family	– **R699** ☐
Single member only (Main member age 18-64)	Admed Supreme – single	– **R599** ☐
Family Cover (Main member age 18-64)	Admed Primary – family	– **R589** ☐
Single member only (Main member age 18-64)	Admed Primary – single	– **R455** ☐
<42 Cover (Standard family member age 18-42)	Admed Standard <42	– **R293** ☐
<42 Cover (Standard single member age 18-42)	Admed Standard <42	– **R495** ☐
>65 Cover (Single member age 65+)	Admed Supreme Pensioner	– **R970** ☐
>65 Cover (Single member age 65+)	Admed Primary Pensioner	– **R685** ☐

The monthly premium is inclusive of commission and VAT.

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

When do you want your cover to start? 0 1 M M Y Y Y Y

2: Personal details

2.1 Policy holder

Title ☐☐☐☐ Initials ☐☐☐☐ First name

Surname

ID/Passport number ☐☐☐☐☐☐☐☐☐☐☐☐☐ Date of birth D D M M Y Y Y Y

Country in which passport was issued

Home address

Postal code ☐☐☐☐

Postal address (if different)

Postal code ☐☐☐☐

Telephone - work ☐☐☐☐☐☐☐☐☐☐ Cellphone number ☐☐☐☐☐☐☐☐☐☐

Email address

Medical Scheme membership number ☐☐☐☐☐☐☐☐☐☐ Option

Date joined D D M M Y Y Y Y

Please attach medical aid membership certificate (not older than 1 month) or medical aid application form if you are a taking medical aid at the same time as your gap cover. Please note that it is your responsibility to inform us if you are not on a medical aid when your gap cover is incepted. All dependents must reflect on your medical aid certificate, be named on your cover with us and must be covered on your medical aid at the time of a claimable event.

Spouse or partner (If spouse or partner is also applying for membership)

If you are applying for Under 42 Gap Cover or Pensioner Gap Cover, you may not include dependants.

All dependants must reflect on your Admed Gap Cover Certificate of Cover and must be covered on your medical aid at the time of a claimable event.

First name

Surname

ID/Passport number | Gender Male | Female

Country in which passport was issued | Date of birth D D M M Y Y Y Y

Dependants

Dependants, including your spouse, children and adult dependants.

You do not need to list your dependents on this application form, as we cover all your dependents, that includes your spouse, your adult dependants, and your children, as long as they're registered on your medical scheme option.

3: Previous gap cover details

Have you or any of your dependants previously belonged to any other gap cover? If yes, please give us the details. Yes | No

Name	Previous insurer	Cover option	Cover start date	Cover end date
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y

Please give us proof in the form of a membership certificate.

Please note that only a membership certificate from your current/previous gap cover provider listing all your dependants and their start date of cover will be accepted as proof of cover.

If you answered "yes" and have attached proof of previous gap cover (with a break in cover no more than 90 days), you do not need to complete Section 4.

4: Underwriting

We will apply underwriting to you and your dependants covered on your medical scheme as follows:

Pre-existing conditions exclusions

1. **General rule**

   You and your dependants covered on your medical scheme will not be entitled to claim for a period of **12 months** from the start date of your policy for **any** medical condition where, in the 12 months before your policy start date, you:

   - received medical advice, diagnosis, care, or treatment, or
   - could reasonably have been expected to receive such advice, diagnosis, care, or treatment.

2. **Pregnancy**

   If you or your dependants covered on your medical scheme fall pregnant **before the start date of your policy**, this will be regarded as a pre-existing condition. All pregnancy and birth-related claims will therefore be excluded for **12 months** from the start date of your policy.

3. **Continuation of cover**

   If, immediately before the start date of this policy, you were insured under another gap cover policy with similar benefits:

   - the pre-existing condition waiting period will only apply to the **unexpired portion** of the waiting period from your previous policy, and
   - the full 12-month waiting period will still apply to any benefit not covered under your previous policy.

5: Your beneficiary details

Your Admed Gap Cover policy has two benefits that will pay your nominated beneficiary an amount of money should you die as a result of a violent crime or an accident. In the event of your death while you are covered on the policy, the payout will be paid to a nominated beneficiary only if you have nominated a beneficiary at the time of joining cover. If you have not nominated a beneficiary, the payout will be made to your estate.

Title | Initials | First name

Surname

ID/Passport number | Cellphone number

Physical address

Postal code

Date of birth D D M M Y Y Y Y | Relationship to you

6: Banking details for collection of premiums and claim refunds payable

Name of account holder	
Account holder ID/passport number	
Country in which passport was issued	
Company registration number, if a company account is used	
Name of bank	
Account number	
Account type	Current/Cheque ☐ Savings ☐ Transmission ☐
Branch code	Branch name
Please choose your debit order date	1st ☐ 7th ☐ 10th ☐ 15th ☐ 20th ☐ 25th ☐

☐ Tick this box if we may use the same bank account details provided for your premium payments for claim refunds payable

If not, please complete the bank details below.
If a third party's account details are used, please provide a copy of their ID.

Name of account holder	
Account holder ID/passport number	
Country in which passport was issued	
Company registration number, if a company account is used	
Name of bank	
Account number	
Account type	Current/Cheque ☐ Savings ☐ Transmission ☐
Branch code	Branch name

7: Debit order mandate

By initialling this box you:

1. Authorise Guardrisk to debit your account with the monthly premium due in respect of this policy.
2. Acknowledge that this authorisation will remain in force and effect until cancelled by you, in writing with one calendar month's notice.
3. Understand that cancelling the Mandate does not cancel the Agreement. Agreement that the account holder is not entitled to refund for when the Mandate was still active, if such amounts were owed to them.
4. Acknowledge that this Authority may be assigned to a third party if this agreement is also assigned to a third party.
5. Understand and accept that should your premium be adjusted annually on renewal and in the case of benefit restructuring necessitated by changing legislation, with one month's notice and subject to your right of cancellation of cover, the aforementioned authorisation will extend to the adjusted premium.
6. Undertake to inform Guardrisk of any change in your banking details and you authorise Guardrisk to verify such banking details with your bank.
7. Confirm that Guardrisk shall not be held liable for incorrect claim payments made as a result of your failure to inform Guardrisk of your change in banking details.
8. Accept that Guardrisk may debit your account on a date other than that specified.
9. Notwithstanding the fact that you grant Guardrisk permission to collect premiums, you acknowledge that it is your responsibility to ensure that premiums are collected for cover to remain in force.
10. Acknowledge that the first payment date will be the first day of the month in which your cover starts.
11. Acknowledge that in the event that the payment day falls on a Sunday, or recognised South African public holiday, the payment day will automatically be the very next ordinary business day.
12. Acknowledge that payment instructions issued from this Mandate will be treated as payment instructions issued personally by the accountholder.
13. Understand that the agreement reference number will be your membership number which will only be issued once your application form has been captured.
14. Understand that the debit order transaction on your bank statement will reflect as 'ADMED'.

Signature of bank account holder **Date signed** D D M M Y Y Y Y

8: Financial adviser

You can only apply for Admed Gap Cover via an accredited financial adviser.

Brokerage name	Financial adviser's name	Cellphone number	Email address

Signature of financial adviser **Date** D D M M Y Y Y Y

9: Financial adviser declaration and consent – only applicable when a financial adviser is completing an application form on behalf of the client

Please 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.

10: Declaration

☐ By ticking this box you confirm that your financial adviser has communicated the below to you:

1. That he/she is mandated by an authorised Financial Services Provider (FSP), as set out above, to act on behalf of that FSP as a representative.
2. That he/she is an accredited financial adviser in terms of the FAIS Act at the date of signing this application form.
3. That he/she accepts their appointment by you to provide advice and ongoing intermediary services in respect of this policy.
4. That he/she has made you aware of the commission payable by Guardrisk to him/her in respect of this policy.
5. That he/she has conducted a financial needs analysis and this insurance product is suitable to meet your insurance needs.
6. That he/she has explained the insurance product to you and you understand how the product works, what is covered and what is not covered, as well as how to claim from the policy.
7. That he/she is responsible for providing you with his/her contact details and he/she is accountable for any advice given to you about completion of this application form.

Your declaration and consent

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

1. I hereby apply for Admed Gap Cover 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 cover will and will not pay. ☐
8. I further declare my understanding that my eligibility for cover is dependent on me and my dependants remaining active members of 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 adviser as intermediary to my policy. ☐
10. I authorise Guardrisk to make payment of the monthly commission, calculated as per the legislated sliding scale in the Demarcation Act of 2017 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 adviser 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 adviser has the necessary authorisation. ☐

10: Declaration (continued)

Your declaration and consent (continued)

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 processing of claims under this policy. ☐
13. 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 this authorisation will endure for a maximum of five years after my death. ☐
14. I authorise Guardrisk to use, review and process any of my or my dependants' 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 dependants and/or beneficiaries have also provided me with the authority to disclose their personal information to Guardrisk.dependants ☐
15. I authorise Guardrisk, or its appointed service provider, to negotiate on my behalf with my medical scheme in respect of shortfall claims that may have arisen from medical events which my medical scheme is legally obliged to cover in full. ☐
16. I authorise Guardrisk to negotiate discounts on my behalf with medical service providers in order to maintain a good risk profile for my cover. If successful, I acknowledge that payment will be made directly to the service provider's bank account and no further payment will be due to me. ☐
17. I undertake to notify Guardrisk of any change in my personal details within a reasonable time period and I indemnify Guardrisk against any liability for any loss that may result from my failure to notify Guardrisk of such change in a timeous manner. ☐
18. I authorise Guardrisk to collect, process and store my and my dependants' personal information for the purpose of administering cover under this policy. I further confirm that my dependants and/or beneficiaries have also provided me with the authority to disclose their personal information to Guardrisk as well as for their medical scheme to disclose such personal information to assist in the processing of claims under this policy. ☐
19. I confirm that I am aware of my right to request a copy of my and my dependants' 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 who can be contacted on **010 023 5200** or via email at **POPIAComplaints@inforegulator.org.za** or **PAIAComplaints@inforegulator.org.za**. ☐
20. I authorise Guardrisk to disclose all relevant information to the appointed financial adviser 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 dependants') medical diagnosis, treatment and history as well as personal information. I further confirm that my dependants and/or beneficiaries have also provided the necessary authority to disclose their relevant information to the appointed financial adviser to assist in the processing of this application form, administrating of this policy and any claims processed by Guardrisk on this policy. ☐
21. If I am applying for the Under 42 product, I further declare my understanding that my eligibility for cover on this product is dependent on my being between 18-42 years old and that once I reach 42 years old, my cover will be transferred to a Supreme or Primary product at the required premium from 1 January of the next year. ☐
22. If I am applying for Supreme or Primary single rate product, I declare my understanding that this cover applies only to me and that if I want to add a spouse, adult or child dependant to my cover, I will have to transfer to the Supreme or Primary family rate product at the required premium, from the first of the month during which I add my dependant/s. ☐

Signed at

*Remember to inform us should any information provided on this form change between the date of signing the form and the start date.

Signature of policy holder **Date** D D M M Y Y Y Y