GapCover
medical shortfall solutions

Fax to: 0866 764 947

APPLICATION FORM

LRO / SS

SACU | Region: | Date

☐ **Combined Cover:** R150 per month

☐ **GapCover:** R90 per month (maximum benefit per year R 1000 000 - 5 x Scheme Tariff)

A. Principal Member Details

Joining Date				
Title		Initial	Surname	
First Names			Date of Birth	
ID Number			Gender	
Telephone (W)			Fax	
Telephone (H)			Cellular	
E-mail Address				
Postal Address				
Residential Address				

B. Spouse Details

Title		Initial/s	Surname	
First Names			Date of Birth	
ID No.			Gender	☐ Male ☐ Female

C. Children's Details (Children 21yrs and older cannot be added as dependents)

Title		Initial/s	Surname	
First Names			Date of Birth	
ID No.			Gender	☐ Male ☐ Female
Title		Initial/s	Surname	
First Names			Date of Birth	
ID No.			Gender	☐ Male ☐ Female
Title		Initial/s	Surname	
First Names			Date of Birth	
ID No.			Gender	☐ Male ☐ Female
Title		Initial/s	Surname	
First Names			Date of Birth	
ID No.			Gender	☐ Male ☐ Female
Title		Initial/s	Surname	
First Names			Date of Birth	
ID No.			Gender	☐ Male ☐ Female

Please attached a copy of the Medical Aid Membership Certificate as proof of membership

Please turn over

D. Health Declaration

I, _____(first name and surname) declare on behalf of myself and my dependants:

1: Current conditions / illnesses that would need treatment in the next 12 months

Name of member	Condition & date diagnosed	Name of Medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

2: Procedures planned in the next 6 months

Name of member	Condition & date diagnosed	Name of Medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

Signed at (town or city) _____ on this date _____

Signature of applicant: _____

E. Banking Details (Debit Order)

Name of account holder

Name of Bank

Branch Name _____ Branch Code _____

Account Number

Type of Account

Debit Order date 1st ☐ 5th ☐ 10th ☐ 15th ☐ 25th ☐

I, (full name) _____ hereby give authority for the deduction of my monthly contribution for GapCover.
I acknowledge that these premiums will be deducted monthly in advance from the following account:

Signature of applicant: _____ Date: _____

DECLARATION BY APPLICANT
I, the undersigned, hereby declare:
1. that to the best of my knowledge and belief the information provided in connection with this application whether in my own hand writing or not, is true and I have not withheld any material fact which are known to me. NB: A material fact is likely to influence the assessment of this application by underwriters. (If you are in any doubt as to whether a fact is material or not, you should disclose it.)
2. that I understand that any relevant material fact omitted in this proposal form may lead to Underwriters not meeting claims, should the omitted fact have been of such importance that the risk may not have been accepted in the first instance, in terms of the policy. This may lead to cancellation of this policy or rejecting claims, without refund of premiums if applicable.
3. that I understand that this is an accident and health policy with stated benefits in terms of the Short Term Insurance Act 53 of 1998 and not a Medical Scheme product.
4. that 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 a view to limiting premiums. I hereby waive any rights to privacy in any claims 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 of 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. I specifically consent to Optivest Heath Services contacting my current Medical Scheme and/or medical practitioner to verify any medical details as provided in my application form. I further consent to such information being disclosed to Optivest Health Services for purposes of verifying the disclosure as provided on my application form.

Applicant: _____ Date: _____