



Patient details

First names:										Male <input type="checkbox"/>		Female <input type="checkbox"/>									
Surname:					Relationship to principal member:					Self <input type="checkbox"/>		Spouse <input type="checkbox"/>		Child <input type="checkbox"/>		Other <input type="checkbox"/>					
ID/passport number:																					
Date of birth:				D	D	M	M	Y	Y	Y	Y	Medical scheme name:									
Medical scheme options:										Scheme number:											
Type of cancer:										Is the claim in respect of a dependent child over 21 years of age?				Yes <input type="checkbox"/>		No <input type="checkbox"/>					
										Date of diagnosis of cancer:				D	D	M	M	Y	Y	Y	Y



Providers/Doctors details

Name	Practice number	Date of service								Telephone number									
		D	D	M	M	Y	Y	Y	Y	Area code									
		D	D	M	M	Y	Y	Y	Y	Area code									
		D	D	M	M	Y	Y	Y	Y	Area code									
		D	D	M	M	Y	Y	Y	Y	Area code									



Payment instructions

Should benefits be paid into the bank account from which your policy premiums are collected? Yes No

If 'yes' the remainder of this section need not be completed.

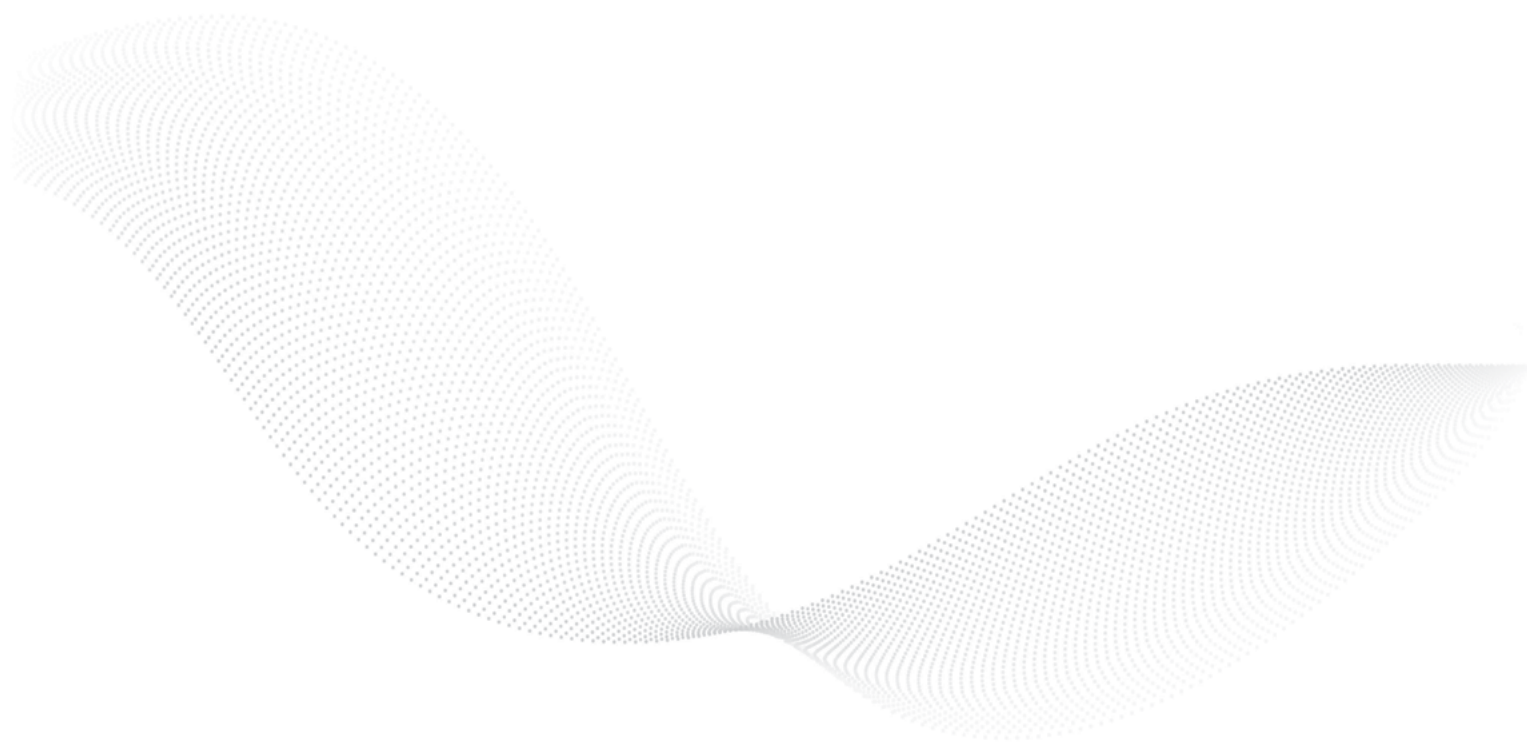
Benefits to be paid into the following bank account by means of electronic fund transfer:

Account holder's name:				Bank / building society:			
Account number:				Branch:			
Branch code:				Account type:		Current	
Source of funds:						Transmission	
						Savings	

Are the benefits being paid into the bank account of a person/entity that is not an insured person on the policy? Yes No

If yes, state the relationship:

The company will not be liable for the loss of funds due to the provision of incorrect bank details by the member.





Declaration

I declare that the above particulars are true in every respect and I attach or will forward as soon as possible copies of all hospital, medical accounts and relevant medical aid statements. I hereby authorise any hospital, physician, medical aid or other person who has attended to or examined me or my dependants, to furnish to the company or its authorised representative any information with respect to any illness or injury, medical history, consultations, prescriptions or treatment and copies of all hospital or medical records.

You hereby authorise and mandate us to obtain all necessary information from your Medical Scheme, including but not limited to biographical information, benefit and claim information, and medical information.

You hereby authorise us to negotiate with and request your Medical Scheme to re-assess your claims, negotiate any discount with the relevant Service Providers on your behalf, pay the benefit payable in terms of the Gap Cover Policy directly to the Service Provider, should a discount be negotiated.

I consent to Ambledown or any authorised 3rd party from obtaining and processing my (or my dependents) personal information and I understand why my /their personal information is required and the purpose it will be used.

This consent and mandate will remain in force until withdrawn in writing. I acknowledge I have the right request from Ambledown details of any of my personal information Ambledown holds on my behalf and details of how my personal information has been processed and to lodge a complaint with the Information Regulator.

If the benefit available to the Insured Person is greater than the fee charged by the Service Provider, then we will pay the balance of the benefit payable in terms of the Gap Cover Policy to the Insured Person once the Service Provider is paid.

This consent and mandate will remain in force until withdrawn in writing.

Except to the extent that we acted with gross negligence or fraudulent intent, you hereby indemnify us and undertake to hold us harmless against any loss, damage, legal liability, legal costs (including costs on an attorney and client scale) or expenses of whatever nature we may suffer or become liable for alleged to arise or arising from the consent and mandate you provided to us in accordance with this Agreement.

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SIGNATURE OF THE PRINCIPAL INSURED PERSON

SIGNATURE OF THE INSURED PERSON

DATE

D	D	M	M	Y	Y	Y	Y
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(if different from the principal insured)

(If the Insured Person is a minor, the form must be signed by the Principal Insured Person, who confirms that they are the competent and authorised person to sign on behalf of the minor)

In case of minor:

Name of the competent and authorised person:

Relationship to the minor Insured Person:

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: premium@ambledown.co.za