Gap Cover General *Frequently asked Questions*

General	Comment
Will the Ambledown Gap Cover Series cover me if I only have a hospital cash plan and do not belong to a registered Medical Scheme?	No, the Ambledown Gap Cover Range augments (assists, increases) the benefit offered by a Medical Scheme. Regrettably without a recognised registered Medical Scheme Plan in place as the Principal member or dependant you cannot have gap cover.
Can I obtain Cover for my parents or relatives?	No, this product only covers immediate family which includes the spouse of the main member and children. Your parents may however take out their own policy.
Can I continue with Cover for my 26 year old child who is still financially dependent on me?	Yes, an adult child will however need to take out his/her own gap cover policy, even if they are registered as a dependent on your Medical Scheme. Please note that there is no age limit for mentally or physically handicapped children who are wholly dependent on the principal insured and such child is covered by a registered Medical Aid scheme. Proof of disability will be required.
My grandchild is covered by my medical aid. Will he/she also be covered by my Gap Cover?	Cover for the grandchild is subject to the child being legally adopted or fostered. Then the eligible child conditions will be applicable.
I have been on Gap cover with another company. If I join Ambledown, will I be subjected to waiting periods?	The 3 month general waiting period will apply unless the claim is as a result of an accident. If the benefits on the previous policy are the same as the Ambledown policy, the policy has been active for longer than 12 months, and there has been no break in cover, the 12 months pre-existing condition waiting period will not apply. The full 12 months will apply if there has been a break in cover, or on any new benefits not included in your previous policy. If the benefits are the same and there has been no break in cover, but the previous policy was not active for 12 months, the balance of the 12 month waiting period will apply. For example, if the previous policy was active for 6 months, then 6 months of the 12 month waiting period will remain on the new policy. A certificate of insurance from your previous insurer will be required to verify the benefits provided, inception date and cancellation date of your policy.
Will the policy premium be adjusted, and how frequently will it be adjusted.	The Gap Cover Series premiums are generally reviewed annually with adjustments taking effect on 1 January every year. The Insurer reserves the right to adjust the premium at any time by providing the member with 31 days written notice.

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What are the notable exclusions of the policy?	The most notable exclusions include 1. Any procedure not covered or declined by the Medical Scheme. 2. Pre-existing conditions (for a maximum of 12 months). 3. Depression, Insanity or mental stress or psychotic/psychoneurotic disorders. 4. Obesity, cosmetic surgery, drug addiction and self-inflected injuries. Please refer to your policy document for the full list.
Should I wish to buy-up in the Gap Cover Series, will new waiting periods and pre-existing conditions apply?	Yes, should you buy-up in the range of products, new Waiting periods and pre-existing conditions will apply. The waiting periods and pre-existing conditions will apply to additional benefits.
Are my Gap Cover premium payments paid to Ambledown Income Tax deductible?	No. Section 18 (1) of the Income Tax Act allows a deduction for contributions to a Medical Scheme registered in terms of the Medical Schemes Act of 1998. The Gap Cover Series is defined as Accident and Health products in the Short-Term Insurance Act.
Gap Cover premium payments paid to Ambledown for my employees, can I claim them back for VAT?	That will depend on who the policyholder is and your company's VAT registration conditions, kindly refer the query to your company Accountant or Tax Consultant.
What happens if I don't pay my premium on time?	It is your responsibility to ensure that your debit order is successfully collected. Should your debit order not be successfully collected, your cover will be suspended on the last day of the month for which an unsuccessful debit was submitted. An automatic second debit order will be run the following month and will include the arrears and the new month's premium. Should the second debit order not be successfully met, the policy will lapse with immediate effect and the cancellation date backdated to the month in which the last debit order was successfully received. Should a debit order be rejected where Ambledown has no prospect of collecting future premiums, for example "No Authority to Debit" or "No such Account", the policy will lapse with immediate effect and the cancellation date backdated to the month in which the last debit order was successfully received.
How do I cancel my Gap Cover?	31 days written notice must be given to Ambledown via email to admin@ambledown.co.za or fax to (011) 463 1600. However, we do advise that you contact your broker to determine the necessity of the Ambledown Gap Cover product and submit the cancellation through the broker after proper consultation.

Gap Cover Claims *Frequently asked Questions*

Claims	Comment
I am due for an operation, how do I get the pre-authorisation number?	Regrettably we do not provide pre-authorisations on claims. Please consult with you Medical Scheme for such. Kindly refer to your gap cover policy document regarding your available benefits and applicable exclusions. Alternatively contact your broker to provide clarity where needed.
I am due for an operation, I was informed that there will be a co-payment. Will this be paid by my gap cover policy?	The claim will be considered if you have a Co-payment benefit on your policy. However where the Co-payment is as a result of penalty imposed by your Medical Scheme, Gap cover will not reimburse you. Where the Medical Scheme informs you of a Co-payment free option and you opt not to take it, such a "Co-payment" will be considered to be a penalty and such a claim will be rejected. The Co-payment benefit includes a once-off payment per family, per annum for the penalty imposed by a medical scheme for the use of a non-network hospital. The benefit is limited to R13 000.
Why will my claim not be paid if I want a surgical procedure to be carried out by my preferred Specialist?	When the procedure is not authorised by your Medical Scheme or when you have made use of a provider outside your network and your Medical Scheme rejects your claim or charges a Co-payment, these costs may not be covered under your gap cover policy. The only exception is when a penalty has been imposed by the Medical Scheme for the use of a non-network provider, the Co-payment benefit allows for a once-off payment per family per year for such a Co-payment/penalty.
My medical aid savings are depleted. How do I go about claiming from my Gap Cover?	Gap cover is not intended to cover you for the normal day to day benefits payable by your Medical Scheme, e.g. doctor consultations, medication, consumables. Generally (but not limited to) claims for procedures and treatment paid by your Medical Scheme out of your hospital risk benefits will be considered.
How and when do I submit a claim?	A claim form can be obtained from your broker or our website. It must be completed in full and emailed to claims@ambledown.co.za with all supporting documentation within 6 months of the first day of treatment/hospitalisation.
To whom will the benefit be paid?	The principal member needs to provide his her own banking details for payment to be made. We will pay the service provider when a discount is negotiated.

Claims	Comment
How long will the claims process take?	The claim is assessed within a reasonable time frame from receipt of all supporting documentation. Where a claim requires the input of a medical specialist and our SLA cannot be met, the claimant will be advised accordingly with an expected timeline of finalising the claim.
If I wish to dispute the claims assessment, what procedures do I need to follow and within what time frame?	Once a claim has been finalised you will be emailed a statement reflecting the amount to be paid and/or any claims rejected. A reason will be provided where a claim has been rejected or a portion of the claim has been paid. The document will also include details of the dispute process should you not agree with the decision.
I received treatment in a Casualty Ward, can I submit the account to Gap for payment?	The account will be considered if the treatment received was a result of an emergency or classified as an emergency treatment by the attending Medical Practitioner, as per the ICD codes on the invoices. Classification will not be limited to your interpretation of the symptoms presented.
I was hospitalised and upon recovery discharged, however I need to receive daily treatment in the Casualty Ward. A facility folder with my Medical Scheme for daily authorisations has been approved. Will the Casualty accounts be settled under my Gap cover?	The facility fee claims will NOT be covered as these are out-patient related claims. It is not related to an emergency to be considered for payment from the casualty benefit. Most of the charged items will relate to material expenditure, which is an exclusion on the policy.
What is a PMB?	Prescribed Minimum Benefits (PMB's) are minimum benefits which by law must be provided to all Medical Scheme members by Medical Schemes and include the provision of diagnosis, treatment and care costs for: i. any emergency medical condition. ii. a range of conditions are specified in Annexure A of the Regulations to the Medical Schemes Act (No 131 of 1998), subject to limitations specified in Annexure A. Included in this list of conditions is the list of chronic conditions.
I would like to claim for a fee the Doctor has charged me over and above the tariff that was submitted to my Medical Scheme.	This is what we refer to as "Split Billing". Regrettably any amount charged by a Medical Practitioner or Hospital which is a separately identifiable fee, in excess of the Medical Scheme Tariff and not considered refundable by a Medical Scheme will not be considered under your gap cover. For a gap claim to be assessed all items must reflect on the invoice and assessed by the Medical Scheme.