

2024 APPLICATION FOR AON SMART GAP VOLUNTARY GROUP – DEBIT ORDER DEDUCTION

Thank you for deciding to apply for gap insurance cover with Admed, a division of Guardrisk Insurance Company Limited (Reg. 1992/001639/06, FSP No. 75). This document is an application form for cover. Please complete the form accurately and completely in order that we may process your application.

Contact us

Tel: 0860 102 936, Email: admed@guardrisk.co.za

Who we are

Admed, a division of Guardrisk Insurance Company Limited – Registration number 1992/001639/06, Financial Service Provider No. 75

What you must do

1. Fill in the form.
2. Submit the necessary supporting documents with your completed claim form.
3. Submit your application by emailing the form to us, with your medical aid membership certificate.

Once you have submitted your application form:

- If any details are missing or we need more information, we will contact you.
- We will activate your membership and we will email you a confirmation of cover, along with your policy wording.
- **If you do not hear from us 2 weeks after sending us your application, please contact us on 0860 102 936 or email admed@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 Broker	Yes	No	Please read and initial each declaration under Broker declaration and consent

TELL US ABOUT YOUR EMPLOYER	
Name of employer	AON Smart Gap
Branch (if applicable)	
Employee no.	Date employed

TELL US ABOUT YOU			
Title	Surname		
First Name			
Identity number	Date of birth		
Medical aid name	Plan option		
Medical aid no.	Date joined		

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.

TELL US HOW TO CONTACT YOU			
Postal address	Physical address		
Postal code	Postal code		
Email address:			
Office tel. no.	Mobile no.		

TELL US WHAT YOU WOULD LIKE YOUR COVER OPTION AND START DATE TO BE

You confirm that you have read and understand the benefits that are covered on the selected cover option.

If we receive your application after the 15th day of the month, we may make a double deduction from your bank account.

Please select your cover and monthly premium option:

Supreme Gap R 235

The monthly premium is inclusive of commission and VAT.

When do you want your cover to start?

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

TELL US IF YOU HAD PREVIOUS GAP COVER

Have you previously belonged to any other gap provider? If yes, please give us the details.

Previous Insurer																	
Previous cover option							Previous Policy Number										
Start date	d	d	m	m	y	y	y	y	End date	d	d	m	m	y	y	y	y

Please attach proof of your previous gap cover if applicable.
All dependents must reflect on this certificate in order to benefit from reduced or no waiting periods being applied to their cover. If your dependents are moving cover from a different insurer, please also attach their proof of cover with your application.

PROVIDE US WITH MORE INFORMATION ABOUT YOUR HEALTH

Failure to disclose pre-existing medical conditions may result in limited or excluded benefits.

Important to note:

- Any cancer, birth or pregnancy-related medical condition that existed within 12 months before the first day of cover will be excluded for 12 months after cover starts;
- Any other physical defect, medical condition, illness or injury that existed within 12 months before the first day of cover will be excluded for 9 months after cover starts.

Details of your general doctor

Name:				Tel No:			
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Please select a "Y" or "N" for each of the below questions. Please answer honestly, accurately and completely.

*** Where you have selected "Y" you must supply us with more information in the space below the questionnaire.**

- | | | |
|--|----------------------------|----------------------------|
| 1. Are you currently pregnant or trying to become pregnant? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 2. Have you recently given birth? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 3. Have you ever been diagnosed with any form of cancer, malignant or pre-malignant tumours? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 4. Have you had any surgical procedure during the past 12 months or are you planning a surgical procedure during the next 12 months? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 5. Do you take chronic or ongoing medication? | <input type="checkbox"/> Y | <input type="checkbox"/> N |

Have you had or do you currently have, any of the medical conditions listed below, for which medical advice, diagnosis, care or treatment was recommended or received within the last 12 months?

- | | | |
|---|----------------------------|----------------------------|
| 6. Any bone or joint condition including ongoing back, shoulder, hip or knee problems, arthritis, rheumatism, fibromyalgia or any other musculoskeletal (back, bone and muscle) condition | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 7. High blood pressure, high cholesterol or lipids, ischaemic / coronary heart disease, chest pains, irregular heartbeat, heart murmur, heart failure, myocardial infarction, angina, peripheral vascular disease, valve lesions or any other heart-related medical condition | <input type="checkbox"/> Y | <input type="checkbox"/> N |

- | | | |
|--|--------------------------|--------------------------|
| 8. Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Stroke, spinal cord injury or any other brain, spinal or nerve condition | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Kidney and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycystic kidney disease or any other renal or urinary condition | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Any condition of the prostate including undescended testes or urinary incontinence | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Any condition of the respiratory system; asthma, tuberculosis, chronic obstructive pulmonary disease (COPD), silicosis, pulmonary or cystic fibrosis or emphysema? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Any other medical condition not listed above that may require treatment or surgery | <input type="checkbox"/> | <input type="checkbox"/> |

*Please provide detail where "Y" has been ticked: _____

TELL US ABOUT YOUR BENEFICIARY

In the event of your death while you are covered on the policy, please tell us who to pay any claim amounts to

Title	Name										Surname									
Identity number												Date of birth	d	d	m	m	y	y	y	y
Mobile number											Physical address:									
Relationship to you																				

YOUR DEPENDENTS' DETAILS

Please complete a separate Dependant Declaration (last page of this form) for each dependant that you wish to add to your policy.

Any dependent for which we don't receive a completed and signed Dependant Declaration will not be covered on the policy and when adding them to cover, they may be subject to waiting periods from the date on which their cover begins.

PROVIDE US WITH YOUR BANKING DETAILS FOR YOUR MONTHLY PREMIUM DEDUCTION

Your premium is payable monthly in advance on the first day of each month. This means that depending on when we receive and process your application form, we may deduct the current and next month's premium at the same time.

Account holder name		Bank name	
Branch name		Branch code	
Account number			

Type of account: Cheque Savings Transmission

Please choose your debit day: 1st 7th 10th 15th 20th 25th

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
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PROVIDE US WITH YOUR BROKER'S DETAILS

INTERMEDIARY DETAILS											
Brokerage name	AON South Africa (Pty) Ltd										
Branch name	Sandton					FSP No.	2	0	5	5	5
Advisor name					Mobile No.						
E-mail address											

By initialling 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.

BROKER DECLARATION AND CONSENT – only applicable when broker is completing application form on behalf of 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.

CLIENT /APPLICANT DECLARATION AND CONSENT

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

1. I hereby apply for the Admed product through my employer 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 my membership of my employer's group scheme with Guardrisk Insurance Company Limited (Guardrisk), 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 and my dependants' cover will and will not pay.

8. I further declare my understanding that my and my dependents' eligibility for cover is dependent on my, and my dependents remaining active members of a registered medical scheme and I undertake to advise Guardrisk if I terminate my, or my dependents' medical scheme membership at any time.
9. I provide authority for my employer to make a cover nomination on my behalf and furthermore indemnify Guardrisk against liability for any loss that may result from an incorrect nomination of such cover by the employer.
10. I accept that any notice given to my employer is deemed to have been given to me.
11. I declare my understanding that my employer has appointed an intermediary to the group policy and has authorised Guardrisk to make payment of monthly commission, calculated as 20% of the first R299 of monthly premium and 15% of the remaining monthly premium, to such appointed intermediary.
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 dependents') diagnosis, treatment and medical history. I further confirm that my dependents and/or beneficiaries have also provided the necessary authority for their medical scheme to disclose their relevant medical information to Guardrisk to assist in the 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 I cannot cancel this authorisation and that it will endure after my death.
14. I authorise Guardrisk to use, review and process any of my or my dependents' 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 dependents and/or beneficiaries have also provided me with the authority to disclose their personal information to Guardrisk.
15. I confirm that I am aware of my right to request a copy of my and my dependents' 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.
16. I authorise Guardrisk, or its appointed service provider, to negotiate on my or my dependents' 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 (prescribed minimum benefits).
17. I authorise Guardrisk to negotiate discounts on my or my dependents' 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.
18. 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.
19. I authorise Guardrisk to disclose all relevant information to the appointed broker 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 dependents') medical diagnosis, treatment and history as well as personal information. I further confirm that my dependents and/or beneficiaries have also provided the necessary authority to disclose their relevant information to the appointed broker to assist in the processing of this application form, administrating of this policy and any claims processed by Guardrisk on this policy.
20. I declare my understanding that only if a binder holder has been appointed to the group policy, will a payment of a monthly binder fee be made by Guardrisk to the binder holder. This binder fee is calculated as a percentage of the monthly gross premium. The binder fee is paid to the binder holder for the performance of this function, however it is important to note that this does not affect the premium charged to you, as the cost of the fee is carried from our expense reserving.

Date signed:

d	d	m	m	y	y	y	y
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Signature of Applicant

DEPENDENT DECLARATION

Please complete the below for each dependent named on your policy

Dependant declaration no 1 of _____

Title		First name		Surname	
Identity number				Date of birth	d d m m y y y y
Relationship				Gender	Male Female

THEIR PREVIOUS GAP COVER (if not covered on a previous gap policy of yours)					
Previous Insurer					
Previous cover option		Previous Policy Number			
Start date	d	d	m	m	y y y y
		End date	d	d	m m y y y y

Please attach proof of this previous gap cover.

PROVIDE US WITH MORE INFORMATION ABOUT THIS DEPENDENT'S HEALTH

Failure to disclose pre-existing medical conditions may result in limited or excluded benefits.

Important to note:

- Any cancer, birth or pregnancy-related medical condition that existed within 12 months before the first day of cover will be excluded for 12 months after cover starts;
- Any other physical defect, medical condition, illness or injury that existed within 12 months before the first day of cover will be excluded for 9 months after cover starts.

Details of your general doctor

Name:		Tel No:	
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Please select a "Y" or "N" for each of the below questions. Please answer honestly, accurately and completely.

* Where you have selected "Y" you must supply us with more information in the space below the questionnaire.

- | | | |
|--|----------------------------|----------------------------|
| 1. Is this dependent currently pregnant or trying to become pregnant? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 2. Has this dependent recently given birth? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 3. Has this dependent ever been diagnosed with any form of cancer, malignant or pre-malignant tumours? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 4. Has this dependent had any surgical procedure during the past 12 months or planning a surgical procedure during the next 12 months? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 5. Does this dependent take chronic or ongoing medication? | <input type="checkbox"/> Y | <input type="checkbox"/> N |

Have you had or do you currently have, any of the medical conditions listed below, for which medical advice, diagnosis, care or treatment was recommended or received within the last 12 months?

- | | | |
|---|----------------------------|----------------------------|
| 6. Any bone or joint condition including ongoing back, shoulder, hip or knee problems, arthritis, rheumatism, fibromyalgia or any other musculoskeletal (back, bone and muscle) condition | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 7. High blood pressure, high cholesterol or lipids, ischaemic / coronary heart disease, chest pains, irregular heartbeat, heart murmur, heart failure, myocardial infarction, angina, peripheral vascular disease, valve lesions or any other heart-related medical condition | <input type="checkbox"/> Y | <input type="checkbox"/> N |

- | | | |
|--|--------------------------|--------------------------|
| 8. Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Stroke, spinal cord injury or any other brain, spinal or nerve condition | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Kidney and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycystic kidney disease or any other renal or urinary condition | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Any condition of the prostate including undescended testes or urinary incontinence | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Any condition of the respiratory system; asthma, tuberculosis, chronic obstructive pulmonary disease (COPD), silicosis, pulmonary or cystic fibrosis or emphysema? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Any other medical condition not listed above that may require treatment or surgery | <input type="checkbox"/> | <input type="checkbox"/> |

Please provide detail where "Y" has been ticked: _____

DEPENDENT DECLARATION

Please complete the below for each dependent named on your policy

Dependant declaration no 2 of _____

Title		First name		Surname	
Identity number				Date of birth	d d m m y y y y
Relationship				Gender	Male Female

THEIR PREVIOUS GAP COVER (if not covered on a previous gap policy of yours)																	
Previous Insurer																	
Previous cover option				Previous Policy Number													
Start date	d	d	m	m	y	y	y	y	End date	d	d	m	m	y	y	y	y

Please attach proof of this previous gap cover.

PROVIDE US WITH MORE INFORMATION ABOUT THIS DEPENDENT'S HEALTH

Failure to disclose pre-existing medical conditions may result in limited or excluded benefits.

Important to note:

- Any cancer, birth or pregnancy-related medical condition that existed within 12 months before the first day of cover will be excluded for 12 months after cover starts;
- Any other physical defect, medical condition, illness or injury that existed within 12 months before the first day of cover will be excluded for 9 months after cover starts.

Details of your general doctor

Name:		Tel No:	
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Please select a "Y" or "N" for each of the below questions. Please answer honestly, accurately and completely.

* Where you have selected "Y" you must supply us with more information in the space below the questionnaire.

- | | | |
|--|----------------------------|----------------------------|
| 1. Is this dependent currently pregnant or trying to become pregnant? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 2. Has this dependent recently given birth? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 3. Has this dependent ever been diagnosed with any form of cancer, malignant or pre-malignant tumours? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 4. Has this dependent had any surgical procedure during the past 12 months or planning a surgical procedure during the next 12 months? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 5. Does this dependent take chronic or ongoing medication? | <input type="checkbox"/> Y | <input type="checkbox"/> N |

Have you had or do you currently have, any of the medical conditions listed below, for which medical advice, diagnosis, care or treatment was recommended or received within the last 12 months?

- | | | |
|---|----------------------------|----------------------------|
| 6. Any bone or joint condition including ongoing back, shoulder, hip or knee problems, arthritis, rheumatism, fibromyalgia or any other musculoskeletal (back, bone and muscle) condition | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 7. High blood pressure, high cholesterol or lipids, ischaemic / coronary heart disease, chest pains, irregular heartbeat, heart murmur, heart failure, myocardial infarction, angina, peripheral vascular disease, valve lesions or any other heart-related medical condition | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 8. Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 9. Stroke, spinal cord injury or any other brain, spinal or nerve condition | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 10. Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition | <input type="checkbox"/> Y | <input type="checkbox"/> N |

11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	<input type="checkbox"/>	<input type="checkbox"/>
12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	<input type="checkbox"/>	<input type="checkbox"/>
13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	<input type="checkbox"/>	<input type="checkbox"/>
14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	<input type="checkbox"/>	<input type="checkbox"/>
15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	<input type="checkbox"/>	<input type="checkbox"/>
16. Kidney and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycystic kidney disease or any other renal or urinary condition	<input type="checkbox"/>	<input type="checkbox"/>
17. Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>
18. Any condition of the prostate including undescended testes or urinary incontinence	<input type="checkbox"/>	<input type="checkbox"/>
19. Any condition of the respiratory system; asthma, tuberculosis, chronic obstructive pulmonary disease (COPD), silicosis, pulmonary or cystic fibrosis or emphysema?	<input type="checkbox"/>	<input type="checkbox"/>
20. Any other medical condition not listed above that may require treatment or surgery	<input type="checkbox"/>	<input type="checkbox"/>

*Please provide detail where "Y" has been ticked: _____

DEPENDENT DECLARATION

Please complete the below for each dependent named on your policy

Dependant declaration no 3 of _____

Title		First name		Surname	
Identity number				Date of birth	d d m m y y y y
Relationship				Gender	Male Female

THEIR PREVIOUS GAP COVER (if not covered on a previous gap policy of yours)																	
Previous Insurer																	
Previous cover option				Previous Policy Number													
Start date	d	d	m	m	y	y	y	y	End date	d	d	m	m	y	y	y	y

Please attach proof of this previous gap cover.

PROVIDE US WITH MORE INFORMATION ABOUT THIS DEPENDENT'S HEALTH

Failure to disclose pre-existing medical conditions may result in limited or excluded benefits.

Important to note:

- Any cancer, birth or pregnancy-related medical condition that existed within 12 months before the first day of cover will be excluded for 12 months after cover starts;
- Any other physical defect, medical condition, illness or injury that existed within 12 months before the first day of cover will be excluded for 9 months after cover starts.

Details of your general doctor

Name:		Tel No:	
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Please select a "Y" or "N" for each of the below questions. Please answer honestly, accurately and completely.

* Where you have selected "Y" you must supply us with more information in the space below the questionnaire.

- | | | |
|--|----------------------------|----------------------------|
| 1. Is this dependent currently pregnant or trying to become pregnant? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 2. Has this dependent recently given birth? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 3. Has this dependent ever been diagnosed with any form of cancer, malignant or pre-malignant tumours? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 4. Has this dependent had any surgical procedure during the past 12 months or planning a surgical procedure during the next 12 months? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 5. Does this dependent take chronic or ongoing medication? | <input type="checkbox"/> Y | <input type="checkbox"/> N |

Have you had or do you currently have, any of the medical conditions listed below, for which medical advice, diagnosis, care or treatment was recommended or received within the last 12 months?

- | | | |
|---|----------------------------|----------------------------|
| 6. Any bone or joint condition including ongoing back, shoulder, hip or knee problems, arthritis, rheumatism, fibromyalgia or any other musculoskeletal (back, bone and muscle) condition | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 7. High blood pressure, high cholesterol or lipids, ischaemic / coronary heart disease, chest pains, irregular heartbeat, heart murmur, heart failure, myocardial infarction, angina, peripheral vascular disease, valve lesions or any other heart-related medical condition | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 8. Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 9. Stroke, spinal cord injury or any other brain, spinal or nerve condition | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 10. Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition | <input type="checkbox"/> Y | <input type="checkbox"/> N |

11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	<input type="checkbox"/>	<input type="checkbox"/>
12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	<input type="checkbox"/>	<input type="checkbox"/>
13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	<input type="checkbox"/>	<input type="checkbox"/>
14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	<input type="checkbox"/>	<input type="checkbox"/>
15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	<input type="checkbox"/>	<input type="checkbox"/>
16. Kidney and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycystic kidney disease or any other renal or urinary condition	<input type="checkbox"/>	<input type="checkbox"/>
17. Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>
18. Any condition of the prostate including undescended testes or urinary incontinence	<input type="checkbox"/>	<input type="checkbox"/>
19. Any condition of the respiratory system; asthma, tuberculosis, chronic obstructive pulmonary disease (COPD), silicosis, pulmonary or cystic fibrosis or emphysema?	<input type="checkbox"/>	<input type="checkbox"/>
20. Any other medical condition not listed above that may require treatment or surgery	<input type="checkbox"/>	<input type="checkbox"/>

*Please provide detail where "Y" has been ticked: _____

DEPENDENT DECLARATION

Please complete the below for each dependent named on your policy

Dependant declaration no 4 of _____

Title		First name		Surname	
Identity number				Date of birth	d d m m y y y y
Relationship				Gender	Male Female

THEIR PREVIOUS GAP COVER (if not covered on a previous gap policy of yours)																	
Previous Insurer																	
Previous cover option				Previous Policy Number													
Start date	d	d	m	m	y	y	y	y	End date	d	d	m	m	y	y	y	y

Please attach proof of this previous gap cover.

PROVIDE US WITH MORE INFORMATION ABOUT THIS DEPENDENT'S HEALTH

Failure to disclose pre-existing medical conditions may result in limited or excluded benefits.

Important to note:

- Any cancer, birth or pregnancy-related medical condition that existed within 12 months before the first day of cover will be excluded for 12 months after cover starts;
- Any other physical defect, medical condition, illness or injury that existed within 12 months before the first day of cover will be excluded for 9 months after cover starts.

Details of your general doctor

Name:		Tel No:	
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Please select a "Y" or "N" for each of the below questions. Please answer honestly, accurately and completely.

* Where you have selected "Y" you must supply us with more information in the space below the questionnaire.

- | | | |
|--|----------------------------|----------------------------|
| 1. Is this dependent currently pregnant or trying to become pregnant? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 2. Has this dependent recently given birth? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 3. Has this dependent ever been diagnosed with any form of cancer, malignant or pre-malignant tumours? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 4. Has this dependent had any surgical procedure during the past 12 months or planning a surgical procedure during the next 12 months? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 5. Does this dependent take chronic or ongoing medication? | <input type="checkbox"/> Y | <input type="checkbox"/> N |

Have you had or do you currently have, any of the medical conditions listed below, for which medical advice, diagnosis, care or treatment was recommended or received within the last 12 months?

- | | | |
|---|----------------------------|----------------------------|
| 6. Any bone or joint condition including ongoing back, shoulder, hip or knee problems, arthritis, rheumatism, fibromyalgia or any other musculoskeletal (back, bone and muscle) condition | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 7. High blood pressure, high cholesterol or lipids, ischaemic / coronary heart disease, chest pains, irregular heartbeat, heart murmur, heart failure, myocardial infarction, angina, peripheral vascular disease, valve lesions or any other heart-related medical condition | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 8. Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 9. Stroke, spinal cord injury or any other brain, spinal or nerve condition | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 10. Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition | <input type="checkbox"/> Y | <input type="checkbox"/> N |

11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	<input type="checkbox"/>	<input type="checkbox"/>
12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	<input type="checkbox"/>	<input type="checkbox"/>
13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	<input type="checkbox"/>	<input type="checkbox"/>
14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	<input type="checkbox"/>	<input type="checkbox"/>
15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	<input type="checkbox"/>	<input type="checkbox"/>
16. Kidney and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycystic kidney disease or any other renal or urinary condition	<input type="checkbox"/>	<input type="checkbox"/>
17. Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>
18. Any condition of the prostate including undescended testes or urinary incontinence	<input type="checkbox"/>	<input type="checkbox"/>
19. Any condition of the respiratory system; asthma, tuberculosis, chronic obstructive pulmonary disease (COPD), silicosis, pulmonary or cystic fibrosis or emphysema?	<input type="checkbox"/>	<input type="checkbox"/>
20. Any other medical condition not listed above that may require treatment or surgery	<input type="checkbox"/>	<input type="checkbox"/>

*Please provide detail where "Y" has been ticked: _____



Benefits of appointing Aon South Africa Healthcare as your intermediary

Aon Healthcare is committed to providing you with exceptional service at every interaction. We have a team of professional, fully accredited advisors to assist you with all your medical schemes, Gap cover and Primary care enquiries.

Our philosophy is to:



Guide:

our members in selecting the medical scheme, Gap cover insurance or Primary care options aligned to their needs.



Educate:

our members with ongoing training throughout the year, end of year medical schemes and Gap cover benefits and rate changes.



Protect:

the rights of members by applying the Medical Scheme Act and scheme rules when resolving disputes with the medical schemes on behalf of the members.

Catalogue of services and technological platform accessible to our members

- **Microsites:** Provides you with access to voice recorded Induction, Year-end renewal, Year-end launch highlight presentations, brochures, COVID-19 updates, various application forms.
- **Aon Resolution Centre:** Professional assistance with your Medical scheme, Gap cover or Primary care claim resolution, comparison or benefit explanation.
- **Year-end renewal communications:** Access to member letters providing updates on the following:
 - **Alert** - Provides high level summary of benefits and rates changes launched by medical scheme, Gap cover insurance as well as Primary care providers.
 - **Member letter** - Provides comprehensive information in relation to the benefits and rates changes implemented by Medical scheme, Gap cover or Primary care provider.
 - **Guidance letter** - Aon generates guidance letters for members that are under or over insured. The purpose of the guidance letter is to guide a member on selecting an appropriate option aligned to his/her needs.
- **Ad-Hoc Alerts:**
 - Ad-hoc updates pertaining to Medical schemes industry or providers specific updates.

Cost of appointing Aon

We are pleased to inform you that there is **no additional fee** charged by Aon when you appoint Aon Healthcare as your Healthcare intermediary. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme whether you have appointed Aon as broker or not. This monthly commission is 3% of the contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Section 65 of the Medical Schemes Act, 131 of 1998, plus value added tax (VAT). In terms of Primary Care Insurance products we earn maximum 3%. Gap Cover Insurance products, we earn commission on a sliding scale from 5% up to 20% depending on policy holder's monthly contributions.

Connect with us

We focus on communication and engagement, across insurance retirement and health, to advise and deliver solutions that create great client impact. We partner with our client and seek solutions for their most important people and HR challenges. We have an established presence on social media to engage with our audiences on all matters related to risk and people.

For more information from Aon Employee Benefits on healthcare, retirement benefits and a wide range of topics feel free to go to www.aon.co.za

<http://www.facebook.com/Aonhealthcare>
Click "Like" on our page (Aon healthcare)

http://twitter.com/Aon_SouthAfrica
Click "follow" on our profile

Aon Employee Benefits – Healthcare

Aon South Africa Pty Ltd, an Authorised Financial Service Provider, FSP # 20555.

<http://www.aon.co.za/disclaimer>

On all services provided, Aon's Terms & Conditions of Business, as amended from time to time, are applicable and can be found at

<http://www.aon.co.za/terms-of-trade> or will be sent to you upon request.

[Privacy Notice](#)

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Disclaimer:

Although care is taken to represent the rates and benefits correctly, errors and omissions could occur. In case of any conflict, the rules of the affected medical scheme prevail. Any decisions regarding your medical scheme portfolio should be made in conjunction with your Aon Employee Benefits consultant or manager. While Aon has taken reasonable steps to ensure that the information contained in this report is relevant, accurate and current, no warranties of any kind, whether express or implied, including but not limited to the accuracy, completeness, relevance or fitness for a particular purpose are given and Aon expressly disclaims any liability for any loss or damage that may arise from the use of this report. This report is confidential and intended solely for the use of the individual or entity to whom it is addressed. If you received this report in error, you should not disseminate, distribute or copy this report and you should notify Aon if you are not the intended recipient and destroy the report. The report is copyright of Aon SA (Pty) Ltd. You may not, except with our express written permission, distribute or commercially exploit the report. Aon hereby authorizes you to copy the report for non-commercial use within your organization only.

POPIA

Protection of Personal Information Act 4 of 2013 (POPIA), Medical Schemes are requesting a signed Broker Appointment letter to make certain information available to Aon South Africa (Pty) Ltd.



Contact us on: **0860 100 404**, P.O.Box 78367, Sandton, 2146, www.aon.co.za

FSP number: 20555; CMS number: ORG895

Follow our [website link](#) for further information on Aon's processing of your personal information

Acknowledgement of appointment

I acknowledge and appoint Aon South Africa (Pty) Ltd as my financial advisor for all matters related to my Gap Cover Provider.

My ID: _____ and policy number: _____

Signed at (Town or City): _____ on yy/mm/dd: _____

I have been informed that there is no additional fee charged by Aon for providing you with healthcare intermediary services. Aon earns monthly commission which is already included in the monthly contribution you pay over to the Gap Cover Provider. Monthly commission is part of your total monthly contributions paid to the Gap Cover Provider. This monthly commission is limited to 20% of the monthly contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Short-term Insurance Act 53 of 1998, plus Value Added Tax (VAT).

Monthly premium band	Maximum Commission Level
Above R1 200	5 %
R601 to R1 200	10 %
R300 to R600	15 %
Less than R300	20 %

Permission to process my personal information as well as personal information of all dependents included on my membership application form and I consent to Aon South Africa (Pty) Ltd accessing information listed on the table below.

I give consent for the disclosure of information about me.

Policy no: _____ ID or passport no: _____

Gap Provider: _____ Aon Broker Code: _____

Title: _____ Initials: _____ Surname: _____

First name(s) (as per identity document): _____

The following information should be made available to my appointed Broker as is necessary:

Personal examples	Benefit examples	Financial examples	Medical examples
Policy number Date of birth ID number Postal and e-mail Address Physical address Contact details	Type of cover Waiting period details	Total monthly premiums	Claims statement from Medical Scheme and / or Gap Cover Insurance Claims statement from provider



By signing this letter of appointment , I confirm that I have fully read and understood the contents of this document and provide my express consent for Aon South Africa (Pty) Ltd (“Aon”) to process my Personal Information including but not limited to special personal information, as well as that of my beneficiaries and where necessary including my minor children (as defined in the Protection of Personal Information Act no 4 of 2013) for the purposes set out herein and which Personal Information may be shared and or disclosed with any party including but not limited to service providers who Aon (in it’s reasonable discretion) has an obligation or requirement to share or disclose my Personal Information and that of my beneficiaries and where necessary my minor children in compliance with its obligations in law or contract.

Signed at (Town or City): _____ on yy/mm/dd: _____

Signature: _____