



GENESIS-GAP COVER SERIES INDIVIDUAL PAYROLL APPLICATION FORM

Underwritten by Constantia Insurance Company Limited (CICL), Reg. No. 1952/001514/06, FSP No: 31111 (The Insurer)

- THIS IS NOT A MEDICAL SCHEME AND THE COVER IS NOT THE SAME AS THAT OF A MEDICAL SCHEME.
- THIS POLICY IS NOT A SUBSTITUTE FOR MEDICAL SCHEME MEMBERSHIP.
- THE MASTER POLICY ISSUED IS THE SOURCE OF ALL BENEFITS, RIGHTS, AND OBLIGATIONS AND EXCLUSIONS. TO DETERMINE YOUR INDIVIDUAL NEEDS, WE SUGGEST THAT YOU CONTACT YOUR BROKER AND REQUEST ADVICE FROM HIM / HER.

BROKER DETAILS

BROKER / CONSULTANT NAME									
NAME OF BROKERAGE									
FSP NUMBER					BROKER CODE				
BROKER CONTACT NUMBER		AREA CODE						VAT NUMBER	
BROKER E-MAIL ADDRESS					UNIQUE IDENTIFIER (IF NECESSARY)				

PERSONAL PARTICULARS

APPLICANT

TITLE		SURNAME																	
ID OR PASSPORT NUMBER										FIRST NAMES									
DATE OF BIRTH		D	D	M	M	Y	Y	Y	Y										

EMPLOYER

NAME OF EMPLOYER										DATE EMPLOYED		D	D	M	M	Y	Y	Y	Y
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MEDICAL SCHEME

NAME OF MEDICAL SCHEME										PLAN OPTION			
DATE JOINED		D	D	M	M	Y	Y	Y	Y	MEDICAL SCHEME NUMBER			

DEPENDANTS To see who qualifies as a dependant see DECLARATION c)

FIRST NAME (AND SURNAME IF DIFFERENT)	RELATIONSHIP	ID OR PASSPORT NUMBER	DATE OF BIRTH														
			D	D	M	M	Y	Y	Y	Y							

CONTACT DETAILS

POSTAL ADDRESS										PHYSICAL ADDRESS (IF DIFFERENT TO POSTAL)									
POSTAL CODE										POSTAL CODE									
HOME NUMBER	AREA CODE									WORK NUMBER	AREA CODE								
CELL NUMBER	AREA CODE									E-MAIL									

MEDICAL QUESTIONNAIRE

1. DO YOU OR ANY OF YOUR DEPENDANTS SUFFER FROM ANY CHRONIC OR RECURRING ILLNESS OR ANY OTHER SERIOUS AILMENT?	NO	
	YES	
IF "YES" PLEASE SPECIFY		
2. HAVE YOU OR ANY OF YOUR DEPENDANTS RECEIVED TREATMENT OR ADVICE BY A MEDICAL PRACTITIONER IN THE LAST 12 MONTHS?	NO	
	YES	
IF "YES" PLEASE SPECIFY		
NAME OF FAMILY'S GENERAL MEDICAL PRACTITIONER		
CONTACT NUMBER	AREA CODE	
3. HAVE YOU OR ANY OF YOUR DEPENDANTS BEEN HOSPITALISED DURING THE LAST 12 MONTHS?		
		NO
		YES
IF "YES" TO THE ABOVE PLEASE SPECIFY THE CONDITION FOR WHICH HOSPITALISATION WAS NECESSARY		
NAME	DATE HOSPITALISED	REASON FOR HOSPITALISATION
	D D M M Y Y Y Y	
	D D M M Y Y Y Y	
4. DO YOU OR ANY OF YOUR DEPENDANTS EXPECT TO BE HOSPITALISED DURING THE NEXT 12 MONTHS?		
		NO
		YES
IF "YES" TO THE ABOVE PLEASE SPECIFY THE CONDITION FOR WHICH HOSPITALISATION IS NECESSARY		
NAME	EXPECTED DATE OF HOSPITALISATION	REASON FOR HOSPITALISATION
	D D M M Y Y Y Y	
	D D M M Y Y Y Y	

BENEFITS SUMMARY

BENEFIT	DESCRIPTION
GAP COVER	COVERS UP TO 500% OF MEDICAL SCHEME RATE FOR IN-HOSPITAL TREATMENT
TRAVEL-CARE	TRAVEL-CARE OF R5 000 000 PER INSURED
SUB-LIMITATION	R10 000 SUB-LIMITATION COVER BENEFIT PER ADMISSION
CO-PAYMENT	R20 000 CO-PAYMENT BENEFIT PER ADMISSION (INCLUDES MRI, CT & PET SCANS)
CASUALTY BENEFIT	R7 500 CASUALTY BENEFIT PER ADMISSION
CANCER COVER	R200 000 EXCESS. TRADITIONAL CANCER COVER RELATED TO CANCER TREATMENT.
BIOLOGICAL CANCER COVER	R200 000 EXCESS. BIOLOGICAL CANCER DRUG COVER WHEN THE MEDICAL AID IMPOSES A SUB-LIMIT.

PRODUCT SUMMARY & SELECTION

PRODUCT	LISTED BENEFITS	SPECIFIC LIMITATION PER INSURED / PER ADMISSION / EXCESS	OVERALL LIMITATION PER INSURED PERSON PER ANNUM	PREMIUM PER FAMILY PER MONTH (incl. VAT) 18-65 YEARS OLD
PRIMARY PLAN	- GAP COVER		R157,000	<input type="checkbox"/>
	- TRAVEL-CARE	R5,000,000 PER INSURED		
VITAL PLAN	- GAP COVER		R157,000	<input type="checkbox"/>
	- SUB-LIMIT COVER	R10,000 PER ADMISSION		
	- CO-PAYMENT COVER	R20,000 PER ADMISSION		
ULTIMATE PLAN	- TRAVEL-CARE	R5,000,000 PER INSURED	R157,000	<input type="checkbox"/>
	- GAP COVER			
	- SUB-LIMIT COVER	R10,000 PER ADMISSION		
	- CO-PAYMENT COVER	R20,000 PER ADMISSION		
	- CASUALTY BENEFIT	R7,500 PER ADMISSION		
- TRADITIONAL CANCER COVER	R200,000 EXCESS			
- BIOLOGICAL CANCER COVER	R200,000 EXCESS			
- TRAVEL-CARE	R5,000,000 PER INSURED			

 INCEPTION DATE (DATE COVER IS TO COMMENCE)

D	D	M	M	Y	Y	Y	Y
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PREMIUM PAYMENT

PAYROLL DETAILS

EMPLOYER NAME		EMPLOYEE NAME	
EMPLOYEE COST CENTRE		EMPLOYEE SURNAME	
DATE EMPLOYED	D D M M Y Y Y Y	EMPLOYEE NUMBER	

PLEASE NOTE THAT IF PREMIUMS ARE PAID VIA PAYROLL THEY WILL BE COLLECTED MONTHLY IN ARREARS (UNLESS OTHERWISE SPECIFIED) FOR THE CURRENT MONTH OF COVER.

Having applied for the policy detailed above, and on acceptance of my application by the Insurer, I hereby authorise my salaries/ payroll division to deduct the above premium from my salary and remit to the Insurer on a monthly basis. Such authorisation shall remain in force and effect until cancelled by myself, in writing with 30 days notice or I leave the employ of my current employer. I further authorise the Insurer to increase the amount due in terms of the policy from time to time and authorise my salaries/ payroll division to effect payment on relevant increases.

AGREEMENT OF APPLICANT

DATE

D	D	M	M	Y	Y	Y	Y
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DECLARATION

I declare that I have not withheld any information and I accept that this application and declaration shall be the basis of the contract of insurance between me and the Insurer, which will become effective on the first day of the month for which premiums are received. I also acknowledge that should this application not be considered as part of a full financial needs analysis and I have instructed the broker not to proceed with a full financial needs analysis, this could have the effect that all my financial needs may not be properly addressed.

I further confirm that the following notable conditions have been explained to me:

- a) No benefits will be payable during a general 3 month waiting period for all treatment received unless the treatment was required as a result of an accident (external violent physical means).
- b) No benefits will be payable for treatment during the first 12 months of the policy if treatment or advice was received 12 months prior to inception of the policy that related to the subsequent treatment.
- c) Not all your dependants on your medical scheme are automatically covered under this policy, only your eligible spouse and your eligible children are covered as per the policy definitions.
 - i. Only one spouse is allowed.
 - ii. The maximum age for a child dependant is under 21. This age may be extended to 25 (under 26) in respect of an unmarried child who is a dependant on the Principal Insured Person's Medical Scheme.
 - iii. No cover is provided for extended family members.

I confirm that although I have completed this application form, it does not constitute an insurance contract until a membership number is assigned, policy issued and premium is successfully paid.

SIGNATURE OF APPLICANT

PRINTED NAME OF APPLICANT

DATE

D	D	M	M	Y	Y	Y	Y
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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