2020 MEDGAP OPTION CHANGE FORM

You can **downgrade** from Supreme Gap to Primary Gap at any time of the year by completing and submitting this form to us at least one calendar month before the date of change.

When you do this, we will change your cover option with us at the end of the month in which you let us know.

Your new premium will be applicable from the date on which your new benefits begin.

You may only **upgrade** from Primary Gap to Supreme Gap once per year, on your renewal date.

TELL US ABOUT YOU

Title				Surname																			
First Names																							
Employer													Member no										
Identity number													Date of birth	d	d	m	m	y	y	y	y		

YOUR CONTACT DETAILS

Office / home number											Mobile number												
Email address																							

YOUR OPTION CHANGE

I want to <u>UPGRADE</u> from Primary Gap to Supreme Gap ☐ Please complete section "A" below
(you may only upgrade on your policy renewal date)

I want to <u>DOWNGRADE</u> from Supreme Gap to Primary Gap ☐ Please complete section "B" below
(you may downgrade at any time, subject to a calendar month's written notice)

SECTION A – PRODUCT OPTION UPGRADE

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.

Please select a "Y" or "N" for each of the below questions. Please answer honestly, accurately and completely.

1.	Are you currently pregnant or trying to become pregnant?	Y	N
2.	Have you recently given birth?	Y	N
3.	Have you ever been diagnosed with any form of cancer, malignant or pre-malignant tumours?	Y	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?	Y	N
5.	Do you take chronic or ongoing medication?	Y	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	Y	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	Y	N
8. Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse	Y	N
9. Stroke, spinal cord injury or any other brain, spinal or nerve condition	Y	N
10. Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition	Y	N
11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Y	N
12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	Y	N
13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	Y	N
14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	Y	N
15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	Y	N
16. Kidney and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycystic kidney disease or any other renal or urinary condition	Y	N
17. Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders	Y	N
18. Any condition of the prostate including undescended testes or urinary incontinence	Y	N
19. Any other medical condition not listed above that may require treatment or surgery	Y	N

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

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_____

PROVIDE US WITH MORE INFORMATION ABOUT YOUR DEPENDENT'S HEALTH

Please complete the below for each dependent named on your policy. Failure to disclose pre-existing medical conditions may result in limited or excluded benefits.

Dependent 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*

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.

Please select a "Y" or "N" for each of the below questions. Please answer honestly, accurately and completely.

1. Is this dependent currently pregnant or trying to become pregnant?	Y	N
2. Has this dependent recently given birth?	Y	N
3. Has this dependent ever been diagnosed with any form of cancer, malignant or pre-malignant tumours?	Y	N
4. Has this dependent had any surgical procedure during the past 12 months or planning a surgical procedure during the next 12 months?	Y	N
5. Does this dependent take chronic or ongoing medication?	Y	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	Y	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	Y	N
8. Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse	Y	N
9. Stroke, spinal cord injury or any other brain, spinal or nerve condition	Y	N
10. Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition	Y	N
11. Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Y	N
12. Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	Y	N
13. Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	Y	N

14. Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	Y	N
15. Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	Y	N
16. Kidney and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycystic kidney disease or any other renal or urinary condition	Y	N
17. Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders	Y	N
18. Any condition of the prostate including undescended testes or urinary incontinence	Y	N
19. Any other medical condition not listed above that may require treatment or surgery	Y	N

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

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SECTION B – PRODUCT OPTION DOWNGRADE

By submitting this product option downgrade application from Supreme Gap to Primary Gap you confirm your understanding that the following benefits will no longer be available to you from the date of downgrade:

	Initial here
1. Benefit for co-payments on oncology Treatment programmes	
2. Oncology extender benefit	
3. Benefit for shortfalls in internal prosthesis costs	
4. Accidental and Emergency casualty benefit	
5. Lump sum benefit for first time, minimum-severity cancer diagnosis	
5. Lump sum benefit for first time, minimum-severity cancer diagnosis	
6. Lump sum benefit for personal Accidental Death and Permanent and Total Disability	
7. Violent Crime benefit	
8. Premium waiver benefit	
9. Trauma counselling benefit	
10. Baby bump benefit	

- **Your cover option will change on the first day of the month following the receipt of your completed and signed option change form.**
- **The new premium will be applicable from the date on which your new benefits begin.**

SECTION C - MEMBER DECLARATION

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

1. I declare that the information that I have supplied is true and correct and that I have not withheld anything which may be material to or likely to affect the assessment of my risk. I understand that in the event of any material non-disclosure or misrepresentation my policy may be rendered null and void, that I will forfeit any and all contributions and that Guardrisk may decline to indemnify or compensate me for any claims under any section of cover. ☐

2. I understand that any new dependent added may be subject to waiting periods and that these waiting periods have been communicated to me. ☐

3. 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. ☐

4. 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. ☐

5. 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. ☐

6. 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. ☐

7. 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. ☐

8. I undertake to notify Guardrisk of any change in my personal details within a reasonable time period and you indemnify Guardrisk against any liability for any loss that may result from your failure to notify Guardrisk of such change in a timeous manner. ☐

9. 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. ☐

Signature of Member _____ Date signed | d | d | m | m | y | y | y | y |