2022 MEDGAP COVER AMENDMENT FORM

Please complete section A, B and the relevant section in order for your amendment form to be processed.

SECTION A Type of amendment *(mandatory)*

☐	**Update details**	Complete Section B, C and I
☐	**Change banking details**	Complete Section B, C, D and I
☐	**Change medical aid details**	Complete Section B, C, E and I
☐	**Change main member**	Complete Section B, C, F and I
☐	**Cancel cover**	Complete Section B, G and I
☐	**Remove dependents**	Complete Section B, C, H and I
☐	**Add dependents**	Complete Section B, C, I and J *(please complete a separate section J for each dependent being added)*

SECTION B Personal information *(mandatory)*

Title		Surname																	
First names																			
Employer group														Member No.					
Identity/Passport No.														Date of birth	d	d	m	m	y	y	y	y
Mobile No.											Email								

SECTION C Update details

New surname	(Attach marriage certificate / divorce decree)																		
Physical address																			
														Postal code					
Postal address																			
														Postal code					
Office tel. no.											Mobile no.								
Email address																			

SECTION D Change banking details

This bank account is to be used to: Collect premiums ☐ Pay claims ☐

Account holder name															Bank name				
Branch name															Branch No.				
Account No.													Cheque		Savings		Transmission		
Please choose your debit day:	1st ☐	7th ☐	10th ☐	15th ☐	20th ☐	25th ☐													

If the accountholder and main member / policyholder is not the same person, please provide us with a written and signed letter from the account holder to authorise Guardrisk Insurance Company Limited to deduct premiums from the nominated bank account.

By submitting this amendment form 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 issued once your application form has been captured.
14. Understand that the debit order transaction on your bank statement will reflect as 'MEDGAP'.

SECTION E Change medical aid details

Medical aid name		Plan option	
Medical aid no.		Date joined	d d m m y y y y

Please attach an up-to-date medical aid membership certificate.
All dependants 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.

SECTION F Change main member

Who is to become the main member?					
Title		Surname			
First name					
Identity No.			Date of birth	d d m m y y y y	
On what date must this change be effective?				d d m m y y y y	
What is the reason for this change?					
What will happen to the existing main member?	Move them to a dependent status ☐		Remove them from cover ☐		

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SECTION G Cancel cover

You may cancel your cover by giving 30 calendar days' written notice. There is no cash value to this cover if it is cancelled. If after cancelling your cover, you decide to continue with this cover, waiting periods may apply from the date on which your new cover starts.

At the end of which month must this cancellation be effective?	d	d	m	m	y	y	y	y

Please tell us why you are cancelling your cover with us	

SECTION H Remove dependents

Please tell us which dependents you would like to remove from your cover.

Dependent 1

Title		Surname			
First names				Relationship	
Identity No.				Date of birth	d d m m y y y y
Why is this dependent being removed?					

Dependent 2

Title		Surname			
First names				Relationship	
Identity No.				Date of birth	d d m m y y y y
Why is this dependent being removed?					

Dependent 3

Title		Surname			
First names				Relationship	
Identity No.				Date of birth	d d m m y y y y
Why is this dependent being removed?					

SECTION I 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 |

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SECTION J Add dependents - please complete the below for each dependent named on your policy

Dependent no 1 of _____

Title		Surname											Start date	d	d	m	m	y	y	y	y
First names													Relationship								
Identity No.													Date of birth	d	d	m	m	y	y	y	y

Their previous gap cover (if applicable):

Previous insurer																			
Previous cover option													Previous policy no.							
Start date	d	d	m	m	y	y	y	y					End date	d	d	m	m	y	y	y	y

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

Please attach an up-to-date medical aid membership certificate.
All dependants 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.

PROVIDE US WITH MORE INFORMATION ABOUT YOUR 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.

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

Is the dependent currently pregnant or trying to become pregnant?	Y	N
Has the dependent recently given birth?	Y	N
Has the dependent ever been diagnosed with any form of cancer, malignant or pre-malignant tumours?	Y	N
Has the dependent had any surgical procedure during the past 12 months or are you planning a surgical procedure during the next 12 months?	Y	N
Does the dependent take chronic or ongoing medication?	Y	N

Has the dependent had or do they 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?

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
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
Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse	Y	N
Stroke, spinal cord injury or any other brain, spinal or nerve condition	Y	N
Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition	Y	N

Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Y	N
Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	Y	N
Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	Y	N
Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	Y	N
Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	Y	N
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
Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders	Y	N
Any condition of the prostate including undescended testes or urinary incontinence	Y	N
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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