GUARDRISK
TAILORED RISK SOLUTIONS
A subsidiary of MMI Holdings

PROVIDENCE GAP 2017 APPLICATION - PAYROLL DEDUCTION

This document is an application form for cover. Please complete the form accurately and completely in order that we may process your application.

DETAILS OF YOUR EMPLOYER (If applicable)

Name of employer	Providence Gap 2017 - Rumed
Contract name	Payroll: Providence Gap 2017 Voluntary Group
Branch (if applicable)	
Employee no.	Date employed: d d m m y y y y

TELL US ABOUT YOU

YOUR DETAILS

Title	--Sele	Surname	
First names			
Identity no.		Date of birth	d d m m y y y y
Name of medical aid	--Select--	Plan option	
Medical aid no.		Date joined	d d m m y y y y

YOUR DEPENDENTS (If additional space is required give details on separate sheet)

First name	Surname	Relationship	ID Number
1		--Select--	
2		--Select--	
3		--Select--	
4		--Select--	
5		--Select--	

NB: *If your child does not yet have an identity number, please insert their date of birth in the following format: ddmmyyyy00000*

All dependents must reflect on your Providence Gap Certificate of Cover and must be covered on your medical aid at the time of a claimable event.

YOUR CONTACT DETAILS

Postal address	Postal code	Physical address	Postal code
Home		Mobile	
E-mail address:			

YOUR ANNUAL HOUSEHOLD INCOME *(This is for legislative reporting purposes only)*

< R1 646 pm ○	R1 647 – R2 094 pm ○	R2 095 – R2 698 pm ○	R2 699 – R3 652 pm ○	R3 653 – R5 244 pm ○
R5 245 – R8 307 pm ○	R8 308 – R12 169 pm ○	R12 170 – R16 852 pm ○	R16 853 – R24 636 ○	> R24 636 ○

TELL US WHICH COVER OPTION YOU WOULD LIKE

By submitting this application for cover on Providence Gap you confirm your acceptance of the monthly premium of R90 per month.

Please indicate your desired month of commencement of cover: | m | m | y | y | y | y |

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

PROVIDE US WITH MORE INFORMATION ABOUT YOUR AND YOUR DEPENDANTS' HEALTH

	Yes	No
Do you or any of your dependants have any existing medical condition that may result in a claim with us?	◯	◯
Are you or any of your dependants currently undergoing any medical treatment?	◯	◯
Are you or any of your dependants currently pregnant or trying to become pregnant?	◯	◯
Have you or any of your dependants ever been diagnosed with any form of cancer?	◯	◯
Do you or any of your dependants expect to be hospitalised during the next 12 months?	◯	◯

If your answer to any of the above questions is "yes" please provide details below:

Name	Details

Non-disclosure or misrepresentation of the above will result in your policy being cancelled or voided from inception. Guardrisk Insurance Company Limited reserves the right to decline your application for cover on the basis of your answers to the above questions.

PROVIDE US WITH YOUR BANKING DETAILS

Name of account holder		Name of bank	--Select--		
Name of branch		Branch code			
Account no.		Savings ◯	Cheque ◯	Transmission ◯	
This bank account will be used for:				Claim Payments	✔

By submitting this application you:

1. Authorise Guardrisk to debit your account with the monthly premium due in respect of this policy as well as to make claim payments to this account.
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 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.
4. Undertake to inform Guardrisk of any change in your banking details and you authorise Guardrisk to verify such banking details with your bank.
5. 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
6. You accept that Guardrisk may debit your account on a date other than that specified.
7. 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.

PROVIDE US WITH YOUR BROKER'S DETAILS

INTERMEDIARY DETAILS

Brokerage name			
Branch name		FSP no.	
Advisor name		Mobile	
E-mail address			

By submitting this application 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.

YOUR DECLARATION

By submitting this declaration you confirm that you:

1. Hereby apply for the Providence Gap product and you agree to abide by its policy rules.
2. Declare that the information that you have supplied is correct and complete and that this declaration shall be the basis of the contract of insurance between Guardrisk and you, which will become effective on the first day of the month for which premiums are paid.
3. Confirm your understanding that should this application be incomplete, your application may not be processed by Guardrisk.
4. Confirm your understanding that should any material information be withheld or incorrectly furnished during the application process, Guardrisk may cancel the insurance contract and premiums paid may be used to offset expenses incurred by Guardrisk.
5. Declare your understanding that this insurance product is not a substitute for medical scheme cover and that it does not replace your medical scheme.
6. Understand that this product does not insure against every shortfall in medical scheme cover and that you are aware of the circumstances in which your policy will and will not pay.
7. Further declare your understanding that your eligibility for cover is dependent on your remaining an active member of a registered medical scheme and you undertake to advise Guardrisk if you terminate your medical scheme membership at any time.
8. Provide authority for your employer to make a cover nomination on your behalf and furthermore indemnify Guardrisk against liability for any loss that may result from an incorrect nomination of such cover by the employer.
9. Accept that any notice given to your employer is deemed to have been given to you.
10. Provide authority for your employer to appoint an intermediary to this policy on your behalf and you authorise to make payment of monthly commission, calculated as 20% (excl. VAT) of your gross monthly premium, to such appointed intermediary.
11. Accept and understand that are limiting your right to privacy. You authorise Guardrisk to obtain from any person, other insurer, medical aid, medical practitioner/institution, any information that Guardrisk requires for purposes of claims arising from this policy. You 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 your death) and in such detailed, abbreviated or coded form as Guardrisk or the operators of such database may decide from time to time. You acknowledge that you cannot cancel this authorisation and that it will endure after your death.
12. Authorise Guardrisk to negotiate on your behalf with your medical aid in respect of claim shortfalls that may have arisen from medical events which your medical aid is legally obliged to cover in full.
13. Undertake to notify Guardrisk of any change in your 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.

SUBMIT