

For Office Use Only	
Broker / Brokerage	R o b M i t c h e l l B r o k e r s - T y r o n e R a m a n
Broker Code	B T R A 0 2 7 4
Leads Company (if applicable)	

Section 1: Personal Details

A copy of the ID of the main insured
 A copy of the medical aid membership certificate
 Proof of address less than three months old (for example utility bill, Telkom account, store account statement, bank statement with address, DSTV account, municipal letter, etc...). Should you not have proof of address in your name, you may provide a declaration by a third party confirming that you share an address with them and provide the third party's proof of ID and proof of address (less than three months old.)

NB: This application will not be processed if any of the items above are not sent through with this form.

Med. Aid Membership Number		Med. Aid Inception Date	Y Y M M D D
Med. Aid Benefit Option		Gap Cover Inception Date	Y Y M M D D
Title	Mr Mrs Ms Prof Dr	Other (please specify)	
First Names (in full)		Initials	
Surname			
Date of Birth	Y Y M M D D	Cell no.	
Gender (main member)	M F O	Alt. Contact no.	
Email Address			
Postal Address			
Employer			

Section 2: Dependant's Details

Name	Contact Number	Email Address	ID Number	Sex (M/F/O)	Relationship to Main Member

Common Law partners need to provide an affidavit proving 12 months of cohabitation for membership to be considered.

Section 3: Product Options (Please tick required products and options)

PROD	BASIC COVER 300	VITAL COVER PLUS	SUPER COVER PLUS	ABSOLUTE COVER PLUS
Under 65's (Age of main insured) premium per policy per month		R220 <input type="checkbox"/>	R250 <input type="checkbox"/>	R450 <input type="checkbox"/>
Premium per Individual per policy per month	R 99 <input type="checkbox"/>			
Premium per Family per policy per month	R165 <input type="checkbox"/>			
Over 65's (Age of main insured) premium per policy per month	R330 <input type="checkbox"/>	R330 <input type="checkbox"/>	R360 <input type="checkbox"/>	R550 <input type="checkbox"/>
Product Choice (please tick)				

None R10 pm R20 pm R30 pm R40 pm R50 pm

Section 4: Debit Order Details (person responsible for payment to complete)

Bank	<input type="text"/>	Debit order date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Branch	<input type="text"/>	Account Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Branch Code	<input type="text"/>	Account Holder	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Type of Account	<input type="checkbox"/> Cheque	<input type="checkbox"/> Savings	<input type="checkbox"/> Transmission	<input type="checkbox"/> Other	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

The abbreviated short name TOTALRISK GAPCOVERTRA is the reference that should appear on your bank statement. Any queries relating to your debit order can be made by calling 011 372 1540.

Section 5: Gap Cover Waiting Periods

General waiting period: There is no general 3 month waiting period.
 10 Month condition specific waiting period: No claims may be submitted within the first 10 months of membership for any Gap Cover policy if they relate to any of the following conditions:

- Head, neck and spinal procedures (including stimulators) e.g. Laminectomy
- All types of hernia procedures
- Endoscopic procedures e.g. Colonoscopy, Gastroscopy
- Pregnancy and childbirth (including caesarean delivery)
- Gynaecological conditions e.g. Hysterectomy
- Joint replacement (including Arthroplasty, Arthroscopy, Metatarsal Osteotomy) but excluding treatment due to accidental trauma
- Inability to walk / move without pain
- Any renal, kidney and bladder conditions
- Cardiac (relating to the heart)
- Dentistry (unless due to accidental trauma or oncology)
- Cataracts and / or eye laser surgery (including all eye and lens procedures)
- Neurological conditions and procedures (including stimulators)
- Organ transplants (including cochlear implants)
- Reconstructive surgery as a result of an incident or condition that occurred prior to membership (including skin grafts)
- Mental health or psychiatric conditions (including depression)
- Varicose veins
- Oesophagitis, Gastroenteritis and Gastro-Intestinal Disorders
- Male genital system (including prostatectomy)
- Carpal Tunnel Syndrome
- Any Ear, Nose and Throat procedures (including nasal, sinus, tonsil and adenoid procedures)

All claims for these conditions received within the waiting period will be reviewed by medical management to identify pre-existing conditions.
 Cancer diagnosis waiting period: If a policyholder is diagnosed with any form of cancer prior to membership, all related claims will be subject to a 9 month waiting period. If a policyholder has previously been diagnosed with cancer and is currently in remission, the policyholder needs to advise the insurer by way of medical evidence that the remission period has been for two or more consecutive years.
 Pre-existing medical condition/s waiting period: NO claims relating to any pre-existing condition/s that may lead to hospitalisation (excluding cancer: see above) will be covered within the first six (6) months of membership. The Insurer reserves the right to request any clinical information from a Policyholder's doctor should a claim in this period indicate, and/or relate to, a pre-existing condition.
All claims for these conditions received within the waiting period will be reviewed by medical management to identify pre-existing conditions.

Section 6: Terms and Conditions

- All Gap Cover policies are subject to an aggregate gap cover annual limit of R
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- No in-hospital dentistry claims unless authorised by the Scheme or related to dependants under the age of 18 years. No osseointegrated dental implants will be covered.
- No co-payment or sub-limit amounts will be covered under the Basic Cover 300 product.
- This Gap Cover application, which may result in a policy being taken out, will not provide cover if the policyholder and dependants do not belong to a medical aid scheme registered with the Council for Medical Schemes.
- Claims to the value of R100 or less will be subject to an excess of the same amount.
- **Gap Cover is not a medical aid scheme. The cover is not the same as that of a medical scheme. The cover is not a substitute for a medical scheme membership.**
- Gap Cover is distinct from, but supplementary to medical aid cover. Should you change your medical aid scheme please advise TRA for record purposes.
- TRA requires 30 days notice of resignation from any product. Failure to advise TRA of resignation from a medical aid does not constitute a valid claim for a refund of premiums collected.
- If new and eligible Dependants are to be added to the Policy, TRA must be informed within 30 days and provided with written notice of such an addition to the Policy. Thereafter, this claim will **under no circumstances** be valid and will not be paid. If the dependant/s are registered after the 30-day period mentioned above, waiting periods and exclusions will apply.
- **Please refer to the policy document for a full list of terms and conditions.**
- **Consent for Communication:** TRA has a duty to keep policyholders updated about any offers and new products that are made available from time to time. TRA might communicate about these. As a policyholder who has accepted this policy, you accept this possible communication channel.

Section 7: Member Declaration and Consent

	FULL SIGNATURES REQUIRED	
MEMBER HEALTH	SIGN	Are you or any of your dependant/s expecting surgery or planning hospitalisation or treatment in the next 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide brief details of your planned treatment or hospitalisation: _____ Please note that certain medical conditions and related procedures may be subject to various limitations and waiting periods (see section 5 above).
MEMBER	SIGN	I have read the terms and conditions above and I am fully aware of the contents thereof.
MEMBER	SIGN	I hereby authorise the disclosure of relevant medical information by my medical aid to Total Risk Administrators (Pty) Ltd ("TRA"). This type of information will typically include my diagnosis and ICD-10 diagnostic code. I understand and acknowledge that my medical information will not be disclosed to any unauthorised persons.
PREMIUM	SIGN	SHORT TERM (ST): Gap Cover R Broker Fee (if applicable) R Total R
MEMBER	SIGN	I hereby authorise TRA to deduct an amount of R..... from my bank account, monthly in advance, for my premiums to the insurance products chosen by me on this application form. Premiums are subject to an annual review. The Insured needs to submit notice of resignation to the Insurer 30 days prior to resignation date and must be received in writing. Details of each withdrawal will be printed on my bank statement, with the reference TOTALRISK GAPCOVERTRA, which will enable me to identify the deduction. Mandate: I/We acknowledge that all payment instructions issued by you shall be treated by my/our above-mentioned Bank as if the instructions have been issued by me/us personally. Cancellation: I/We agree that although this Authority and Mandate may be cancelled by me/us, such cancellation will not cancel the Agreement. I/We shall not be entitled to any refund of amounts which you have withdrawn while this Authority was in force, if such amounts were legally owing to TRA. Assignment: I/We acknowledge that this Authority may be ceded or assigned to a third party if the Agreement is also ceded or assigned to that third party, but in the absence of such assignment of the Agreement, this Authority and Mandate cannot be assigned to any third party.
BROKER AUTHORIZATION:	SIGN	I hereby appoint _____ as my healthcare consultant with immediate effect and understand that _____ will supply me with ongoing advisory services with regard to my healthcare solutions and has access to my personal documentation.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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NAME AND SURNAME _____ PRINCIPAL POLICYHOLDER SIGNATURE _____ PREMIUM PAYER SIGNATURE (if different to Principal Policyholder) _____ DATE _____

IMPORTANT INFORMATION

Total Risk Administrators (Pty) Ltd (TRA) is an authorised financial services provider. FSP No 40815.
 Please send this completed form to your intermediary for submission to TRA.



TOTALRISKADMINISTRATORS

Administered by:

Total Risk Administrators (Pty) Ltd (TRA), an authorised financial services provider
 FSP No 40815



Underwritten by:

Auto & General Insurance Company Limited,
 an Authorised Insurer & Financial Services Provider - Reg No 1973/016880/06