OLDMUTUAL

9 Queen Street, Durbanville, 7550
PO Box 863, Durbanville, 7551
omnewbusiness@insuremed.co.za

APPLICATION FORM
OLD MUTUAL GAP COVER

IMPORTANT NOTE

Please note that any non-disclosure or misrepresentation below may result in your claim being rejected or your policy being cancelled or voided from inception.

Please complete the form in writing and print, sign, scan and email the completed form to **omnewbusiness@insuremed.co.za**

1. PRINCIPAL MEMBER DETAILS

Cover Start Date:	0 1 / M M / 2 0 Y Y	Date of Birth:	D D / M M / Y Y Y Y
Title:	Initials:	Surname:	
Full Name:		Gender:	MALE / FEMALE
ID Number:		Fax No:	
Telephone (W):		Cell No:	
Telephone (H):		Email Address:	
Postal Address:	Postal Code:		
Home Address:	Postal Code:		

2. DEPENDANT DETAILS

Spouse/Life Partner:	Name and Surname	Date of Birth:	D D / M M / Y Y Y Y
Child 1:	Name and Surname	Date of Birth:	D D / M M / Y Y Y Y
Child 2:	Name and Surname	Date of Birth:	D D / M M / Y Y Y Y
Child 3:	Name and Surname	Date of Birth:	D D / M M / Y Y Y Y
Child 4:	Name and Surname	Date of Birth:	D D / M M / Y Y Y Y
Child 5:	Name and Surname	Date of Birth:	D D / M M / Y Y Y Y

Eligible Spouse and all children registered as dependants (including full-time students and permanently disabled children) on your medical scheme, will be covered on your Old Mutual Gap Cover policy. Please attach a copy of your medical scheme membership certificate to register dependants on your Old Mutual Gap Cover policy. Limited to 7 (seven) Family members, including the principal member.

IMPORTANT: Any changes must be communicated to Insuremed Administrators within 30 days of the occurence and only dependants that are registered on the policy will be covered.

Please send an updated medical membership certificate via email to **omservice@insuremed.co.za** or fax to **0865 784 920.**

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OLDMUTUAL INSURE

Old Mutual Gap Cover is underwritten by **Old Mutual Insure** Limited. Reg. No. 1970/006619/06. VAT No. 4460101019. Authorised Financial Services Provider (FSP 12).
Old Mutual Gap Cover is administered by Insuremed Administrators (Pty) Limited Reg. No. 2012/019149/07.

3. COVER DETAILS

Medical Scheme: | Scheme No:
Option: | Start Date: D D M M Y Y Y Y
Previous Scheme:
Start Date: D D M M Y Y Y Y | End Date: D D M M Y Y Y Y

4. HEALTH QUESTION

Are you aware of any condition or symptom, for which you or your dependants received medical advice, diagnosis, care or treatment in the past 12 months, which could potentially result in a medical condition, treatment or care within the next 12 months?

(Please select): Yes No If Yes, please complete details of all conditions and symptoms in the table below

Patient First and Last Name	**Condition/Symptom**	**Date of advice, diagnosis, procedure or last treatment**

Please note: The Administrator must be notified if an insured person's state of health changes from the date of signing the application to the date of inception. These conditions will also be excluded as pre-existing conditions.

5. BANKING DETAILS (DEBIT ORDER)

Account Holder:
Name of Bank: | Branch Code:
Account No: | Account type: Cheque Current Savings Transmission
Debit Order Date: 1st 5th 15th 25th

If you are not the account holder, kindly provide the contact details of the account holder in order to obtain their consent to debit their account.

6. ACCOUNT HOLDER DETAILS

Full Name: | Telephone:
Email Address: | Cell No:

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7. DECLARATION BY APPLICANT

7.1 Standard Declaration

I warrant that the information provided to the insurer in connection with the policy, whether in my own handwriting or not, is true and correct. I, the undersigned, hereby declare that:

7.1.1 All the information that I give, whether telephonic, electronic or written, will form part of the policy.

7.1.2 To the best of my knowledge and belief the information provided in connection with this application, whether in my own handwriting or not, is true and I have not withheld any material facts known to me.

7.1.3 I understand that this is an accident and health policy with stated benefits in terms of the Short-term Insurance Act 53 of 1998. 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 a medical scheme.

7.1.4 I acknowledge that the sharing of claims information and underwriting (including credit information) by insurers is essential to enable the insurance industry to underwrite policies and assess risk fairly and reduce the incidence of fraudulent claims, in the public interest and with a view to limiting premiums. I hereby waive any rights to privacy in any claim information supplied by me or on my behalf in respect of any insurance claim made or lodged by me and I consent to such information being disclosed to any other insurance company or its agent. I also waive any rights to privacy and consent to the disclosure of any information relevant to claims concerning me or any person I represent. I also acknowledge that information provided by me may be verified against other legitimate sources or databases.

7.1.5 That I specifically give consent to Insuremed Administrators to contact my current medical scheme and healthcare providers, as well as the current medical scheme and healthcare providers of my dependants on this policy, to confirm any health information relating to underwriting and claims to Insuremed Administrators upon request. I understand that Insuremed Administrators will regard any health information supplied by my, or my dependants' medical scheme or healthcare providers as confidential and will only disclose it to another party upon my express consent.

7.1.6 Where applicable, I hereby authorise Old Mutual Gap Cover to draw against the above bank account all amounts due to Old Mutual Gap Cover in terms of this insurance cover. Should the relevant premiums be adjusted by the Insurer, I hereby confirm that the adjusted amount may be drawn from the above account subject to the notice period outlined in the policy document. This request is to remain in force unless cancelled within 30 days' written notice.

7.1.7 This consent is to remain in force after my death.

8. FEES AND COMMISSION

8.1 I acknowledge and appoint Optivest Health Services (FSP no. 13475) as intermediary to provide ongoing intermediary services to me regarding this policy. I agree that the insurer may pay commission to the intermediary in terms of the Short-term Insurance Act 53 of 1998.

9. IMPORTANT TERMS AND CONDITIONS OF THIS POLICY

9.1 I understand and agree that:

9.1.1 To qualify for benefits under this policy, I must be a member, and my insured family must be dependants of a medical scheme approved in terms of the Medical Schemes Act and my dependants must be registered as dependants on the policy.

9.1.2 Cover will commence on the 1st day of the calendar month for which the insurer accepts my application for insurance and receives my first premium.

9.1.3 The Policy Premium may be changed annually, after the insurer has given me 30 days' notice. If I do not pay my premiums in full, I will not be covered.

9.1.4 In terms of the policy, the insurer will pay the difference between the surgical and consultation fees charged by health professionals for insured events and the benefits payable by my medical scheme. Terms and conditions will apply as stipulated in the policy contract.

9.1.5 Termination of cover will take place if I have given a calendar month's written notice of cancellation, if 2 consecutive premiums are unpaid, or if a dependant does not qualify for cover on my policy.

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9.1.6 Benefits will not be paid:

9.1.6.1 If the medical scheme pays the entire claim or pays short due to scheme limits or exclusions.

9.1.6.2 If I do not submit my claim within 4 months after end of the Covered Event, as defined in the Terms & Conditions.

9.1.6.3 For the first 12 months of cover in respect of any pre-existing condition. (Please refer to full definition and details supplied on the Policy Contract).

9.1.7 This policy does not cover Prescribed Minimum Benefits (PMB) as defined in the Medical Schemes Act 131 of 1998 with Regulations, which are payable by my medical scheme.

9.1.8 The full terms and conditions are provided in the Policy Contract and Terms & Conditions.

Full Name: ______________________ Signature: ______________________

Date: D D M M 2 0 Y Y

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