SANLAM GAP FEDHEALTH NEXGEN POLICY DOCUMENT 2025

FOR THE ELECT & SAVVY MEDICAL AID PLANS

Sanlam

Gap Cover

INSURED BY
CENTRIQ
INSURANCE
A LICENSED NON-LIFE INSURER

Statutory notice:

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 **Medical Scheme** membership.

AfroCentric Health (RF) (Pty) Ltd holds preference shares in Centriq Insurance Company Limited.
Insurance Products are insured by Centriq Insurance Company Limited ("Centriq") a licensed non-life insurer and authorised Financial Services Provider (FSP 3417).

Financial Planning | Retirement | Insurance | Health | Investments | Wealth | Credit

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Disclaimer

This policy is specifically designed for the Fedhealth Elect and Savvy medical aid plans. Should you change medical aid plans with Fedhealth or move to another Medical Scheme provider, you will need to contact your broker to replace this policy with another Gap policy.

Please note that this Policy has certain terms, conditions and exclusions which may differ from Fedhealth medical aid Elect and Savvy plans' terms, conditions, and exclusions. It is therefore important to note that if Fedhealth approves a claim it is not automatic that the Benefits of this Policy will respond, and each claim will be assessed in terms of this Policy's terms, conditions, and exclusions.

This Policy replaces all previous versions of your Sanlam Gap Fedhealth NexGen Policy. All terms and conditions in this Policy are applicable to Insured Parties on the Policy.

All definitions throughout the Policy are indicated with bold font and with the first letter of each word capitalised. Important points are indicated with a bold and blue font type.

Processing of insurance information is done in accordance with the applicable legislation, as well as our Privacy Policies which can be found on our websites:

- www.centriq.co.za

A. Your Insurer

The insurance cover is underwritten by your Insurer: Centriq Insurance Company Limited registration number 1998/007558/06, FSP 3417, a licensed non-life insurer, and is the insurance company providing the Benefits as detailed in this Policy. The cover provided is subject to all the terms and conditions explained throughout your Policy.

B. Definitions

Any words and expressions used in this Policy can refer to either singular or plural and to either gender.

The words and expressions utilised are defined as follows:

B1. **"Accidental Injury"**: Refers to bodily injury caused by violent, unintentional, external and physical means.

B2. **"Benefit or Benefits"**: It is the benefits as listed on the **Benefit Schedule** that are payable to the Insured Party following an Insured Event.

B3. **"Benefit Schedule"**: Refers to Annexure A: Detailed Benefits attached to this policy which sets out the benefits covered and their maximum limits payable.

B4. **"Condition-Specific Waiting Period**": A period during which an **Insured Party** may not claim **Benefits** in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received before the **Insured Party's Effective Date** of cover.

B5. **"Co-payment"**: the fixed, defined Rand amount that the Insured Party is responsible for in terms of Fedhealth's Elect or Savvy medical aid plans for MRI and CT Scans.

B6. **“Eligible Child”**:

- A child born to either the Policyholder or Eligible Spouse of this Policy.
- An Eligible Child includes a legally adopted child or stepchild of a Policyholder. In the event that the Eligible Child reaches the age of 27 years, the child will no longer be an Eligible Child and will therefore no longer be covered under this Policy. On turning 27 and within 30 days of doing so, the Eligible Child may take up a new Policy in their own capacity without any additional waiting periods or exclusions being applied. The age limitation will not be applicable to a Special Needs Child.

B7. **“Eligible Special Dependant”**:

- A dependant who is neither an Eligible Spouse nor a Special Needs Child nor an Eligible Child of the Policyholder but who is a dependant on the Policyholder’s Medical Scheme and has been accepted by the Insurer for such cover under this Policy.
- If no such acceptance is provided by the Insurer, such special dependants are not covered even though they are dependants on the Policyholder’s Medical Scheme.

B8. **“Eligible Spouse”**:

- The partner of the **Policyholder**, whether by means of South African law or religious belief.
- The partner by common law who shares a home with the **Policyholder** and has done so for at least six months.

B9. **“Emergency”**: A serious, unexpected, and dangerous situation requiring immediate action.

B10. **“Family”**: Collectively it refers to the **Policyholder**, Eligible Spouse, Eligible Children, Special Needs Child and/or Eligible Special Dependants as defined in the **Policy**.

B11. **“General Waiting Period”**: The period in which an **Insured Party** may not claim any **Benefits**, except for **Benefits** directly arising from **Accidental Harm**.

B12. **“Hazardous Sport”**: It includes, but is not limited to, participation in or use of any of the following:

- All forms of motorised racing, speed tests or aerobatics, whether by land, sea or air;
- Mountaineering, trekking or hiking above an altitude of 4 000 metres;
- Hunting, shooting or deploying firearms in any manner other than for self-defence purposes.

B13. **“Hospital”**: Any institution in South Africa which meets all of the following criteria:

- Provides surgical and medical diagnostic and therapeutic facilities for **Treatment** and care of sick or injured persons under the supervision of **Medical Practitioners**. This includes mental health institutions.
- Provides 24 hour nursing services to sick or injured persons within the aforementioned facilities.

B14. **“Hospital Episode”**: The period of time between admission to **Hospital** of an **Insured Party** until the time of discharge from the **Hospital** of the same **Insured Party** for the same **Insured Event**.

B15. **“Illness”**: Any physical disease or sickness which manifests in an **Insured Party** but is not a disease or sickness which is of such a nature as to be incapable of diagnosis by objective evidence or which, even though capable of diagnosis by such evidence, has not been diagnosed as such.

In other words it must be capable of diagnosis and have been diagnosed.

B16. **“Inception Date”**: the first day of the month on which cover commences for the **Insured Party** as noted in the **Policy Schedule**.

B17. **“Insurer”**: Centriq Insurance Company Limited, (reg 1998/007558/06), a licensed non-life insurer an authorised Financial Services Provider (FSP 3417).

B18. **“Insured”** or **“Insured Party”**: Refers to the **Policyholder**, **Eligible Spouse, Eligible Child** or **Eligible Special Dependant**, as defined in this **Policy**.

B19. **“Insured Event”**: Any one or more of the following:

- **Accidental Injury, Illness** or other health incidents that cause an **Insured Party** to be admitted to a **Hospital** and to undergo **Treatment** or **Medical Procedures**.
- **Accidental Injury** that directly causes an **Insured Party** to receive **Emergency** medical treatment at the casualty ward of a **Hospital**.
- MRI or CT scan whether as an out-patient or in-patient.

B20. **"Medical Expense Shortfall Policy"**: An Accident and Health policy, as defined in Category 1 of section 7.2(1) of regulations to the Short-term Insurance Act, No 53 of 1998.

B21. **"Medical Practitioner"**: A person who is suitably qualified and registered with the Health Professions Council of South Africa to practice medicine.

B22. **"Medical Procedure"**: A medical procedure is a course of action intended to achieve a result in the delivery of healthcare. A medical procedure with the intention of determining, measuring, or diagnosing a patient's condition.

B23. **"Medical Scheme"**: A Medical Scheme as registered under the Medical Schemes Act.

B24. **"Medical Schemes Act"**: to the **Medical Schemes** Act No. 131 of 1998.

B25. **"Network Hospital"**: A list of **Hospitals** specified by Fedhealth's Elect or Savvy medical aid plans, as their network hospital.

B26. **"Per Annum"**: The period from 1 January to 31 December of any year.

B27. **"Penalty Co-payment"**: a Penalty **Co-payment** applied by Fedhealth's Elect or Savvy medical scheme plans, that would otherwise not have been applied had the Insured Party made use of a **Network Hospital**.

B28. **"Policy"**: Consists of this policy document as well as the Policy Schedule **Policy Schedule**.

B29. **"Policy Exclusions"**: The list of services, conditions or events detailed in the **"Policy Exclusion"** section of this **Policy** which are excluded from cover at all times.

B30. **"Policy Schedule"**: the schedule attaching to and forming part of this **Policy** that defines the Fedhealth medical aid plan, Policyholder, Inception Date, monthly Premium and Waiting Periods and other information that pertains to the cover provided under this Policy.

B31. **"Policyholder"**: The Insured Party who applied for cover under this Policy for himself/herself and his designated Family (if you have selected to pay the Family Policy Premium) on inception of this Policy, who has been accepted by the Insurer to be eligible for the insurance cover provided by this Policy.

B32. **"Premium or Premiums"**: The monthly amount due to the **Insurer** payable by, or on behalf of the **Policyholder**.

B33. **"Prescribed Minimum Benefits (PMBs)"** Are a set of defined benefits provided to beneficiaries of **Medical Schemes** to ensure that all **Medical Scheme** members have access to certain minimum health services.

B34. **"Special Needs Child":** Any child, including a legally adopted child or stepchild of the **Policyholder**, who on account of either a physical or mental disability, is unable to financially support him/herself and remains reliant on the **Policyholder** for support and care.

B35. **"Treatment":** Any form of medical advice, diagnosis, care or treatment provided by a **Medical Practitioner** for the purpose of treating or monitoring the medical condition of an Insured Party.

C. Claims

Following an **Insured Event**, the **Insured Party,** will at their own expense:

- Notify **Centriq** of any claim in writing as soon as possible but not later than **six months** after the end of the **Insured Event**. Claims submitted more than **six months** after the end of the Insured Event may not be covered.
- Supply written proof, copies of medical accounts or other information as may reasonably be required for **Centriq** to process the claim or to ensure the validity of the claim. These documents include: a completed **Claims Form, Doctor's Accounts, Hospital Account; Claims Transaction History Report**. There may be additional information requested, such as medical reports as required and determined on a case-by-case basis.
- Provide authority for **Centriq** to inspect as often as is necessary all current or past medical information or clinical records including the results of any diagnostic tests and submit to medical examination on behalf of and at the expense of **Centriq**.
- Where the **Insured Party** is not the **Policyholder**, the **Policyholder** will provide or obtain permission or consent from the Insured Party to comply with the above condition, failing which the processing of the relevant claims will be suspended until the required permissions or consent are obtained.

- **Assessing claims**. Claims are assessed on a line-by-line basis. Each line has a code on your healthcare or service provider's account, and this accounts for the total amount charged. These codes describe the Medical Procedure/s or Treament/s that was performed or the service that was provided. Your **Medical Scheme** must pay a portion of the cost of a coded line from your hospital or risk benefit in order for that claim line shortfall to be covered by your **Gap Cover** unless you are claiming for a **Benefit** with different qualifying criteria such as a Family Protector or a defined **Co-payment**.
- **Claims** flagged as **Prescribed Minimum Benefit** (PMB) **Medical Procedures** or claims with a high values may be investigated with your **Medical Scheme** or discussed with your service provider for possible discount negotiation. PMB's are a set of defined benefits that **Medical Schemes** are required to cover by law. This means that as a **Medical Schemes** member, you shouldn't incur any out-of-pocket medical expenses related to a PMB.

Any **Benefit** payable in respect of an **Insured Event** shall only become payable after the end of the **Treatment** relating to the **Insured Event** but at the sole discretion of the Insurer. Interim **Benefit** payments can be made to you after a 31-day period during an **Insured Event**.

All **Benefits** payable will be paid to you or your legal representative whose receipt of the **Benefits** will be a full discharge of liability.

No **Benefit** payable shall carry interest.

Any discount accrued by an **Insured Party** against the amount owing to any healthcare provider will be included in the calculation of the **Benefits** of this **Policy**.

If the Insurer rejects any claim, or disputes the quantum of a claim, the **Insured Party** has **90 days** to send a written statement to the Insurer, challenging this decision. If the Insurer persists in rejecting the claim or disputing the quantum, the Insured Party can take legal action and have a summons issued and served on the Insurer, within **six months (180 days)** after the expiry of the **90 days** period; failing which, the **Insured Party** will forfeit his claim and will have no further claim in terms of this **Policy**.

Payment of any **Benefit** depends on the **Insured Party** supplying such medical evidence as is required by the Insurer to assess the validity of the claims or for an **Insured Party** to undergo any medical examination if requested and paid for by the Insurer.

D. Premiums

- All **Premiums** are **payable monthly in advance or arrears by the last working day of the month**. Non-payment of **Premiums** may lead to the rejection of a claim or cover being suspended and any **Benefit** payable will be suspended until all **Premiums** have been received by the Insurer.
- If the **Premium** is not paid on the payment date, you have a **30 day grace period** after which we will automatically deduct the outstanding **Premiums** from the same account to ensure continuous cover. If this **Premium** is also not paid you **will have no cover for the period for which you did not pay**.
- Should your **Premium** remain **outstanding after the third month** your cover will be **cancelled as of the last day of the month** in which you made your last successful payment.
- Should you cancel or stop your debit order, it will be deemed that you have cancelled your cover and you will not enjoy the **30 day grace period**. In the event that you reinstate your **Policy** thereafter, your **Policy** will be treated as a new **Policy** and the grace period will only apply from the second month of cover thereafter.
- Your **cover starts on the first calendar day of a particular month** and cannot be backdated.
- Your **Premium** will be **reviewed annually**.
- The **Insurer may adjust the Premiums by giving at least 31 days written notice**.

E. General Terms and Conditions

Jurisdiction and Currency

This **Policy** shall be subject to the jurisdiction of the courts of the **Republic of South Africa and South African law will apply**. The payment of all **Premiums** and **Benefits** shall be made in the currency of the **Republic of South Africa**.

Commencement of Cover

Cover will begin on the first day of the calendar month for which the **Premium** has been paid, subject to all the terms and conditions of this **Policy**.

Cover and Benefits

- Cover shall only be in force or effective if the **Insured Parties** are also current and paid up beneficiaries of a Fedhealth Elect or Savvy medical aid plan.
- This **Policy, Benefit Schedule, Policy Schedule** and correspondence sent to the Policyholder, the **Policyholder's** application for insurance, and any written or spoken statement made by the **Policyholder** or on his/her behalf, forms the contract between the **Policyholder** and the **Insurer**.
- The Insurer **may change** the **Policy Exclusions**, **Benefits** or how the **Benefits** are calculated by giving **31 days written notice**.

Eligible Spouse

Should you have more than one spouse who could qualify as an **Eligible Spouse** then you must make an unreversible nomination of one spouse as the **Eligible Spouse**. **Benefits** will only be paid to the nominated **Eligible Spouse** or the **Eligible Special Dependant**.

Should you die, the nominated **Eligible Spouse** may transfer the **Policy** of cover into their own name within 30 days without any additional waiting periods or exclusions being applied.

F. Termination of Cover

You may cancel this cover at any time, by giving a calendar months, prior written notice. A calender months notice will be considered from the 1st of the month to the 31st of the same month.

Should your Medical Scheme plan have ended before the date of cancellation of your Gap cover **Policy**, your cancellation will be backdated to the Medical Scheme cancellation date and a full refund of premium for this period will be processed.

In the event that any fraudulent act is committed by any **Insured Party** or any **Service Provider**, the Insurer reserves the right to immediately cancel this cover and/or to institute legal proceedings against the relevant party to recover any losses.

In the event that the **Insured Party**, or any person acting on behalf of the **Insured Party**, has misrepresented, inaccurately described or not provided all the details that affect the risk insured under this **Policy**, the Insurer may declare that the whole of this **Policy** or any part thereof is invalid. In such an event, the **Insurer** shall be entitled to reject any claim under this **Policy** and/or to void this **Policy** from the **Policy Start Date**.

G. Waiting Periods

The **Insurer** shall apply waiting periods to the cover of an **Insured Party** as outlined below:

During the first 3 months of being an Insured Party, a General Waiting Period shall apply except for Benefits directly arising from Accidental Injury.

During the first 12 months of being an Insured Party, a Condition-Specific Waiting Period shall apply. Where this is applied, a pre-existing questionnaire will be requested at claim stage, within the first 12 months. The requirement is that this questionnaire is completed by the diagnosing Medical Practitioner.

Waiting Periods shall be applied to the cover of the relevant **Insured Party**, from the time that such **Insured Party's** cover commences under this **Policy.**

In the event that an **Insured Party** previously had a **Medical Expense Shortfall Policy**, not longer than **90 Days** before the **Inception Date**, the period of the **General Waiting Period** and **Condition-Specific Waiting Period** shall be reduced by the expired portion of the **General Waiting Period** and **Condition-Specific Waiting Period** served under such previous policy.

Waiting periods will not be applied to a newborn, **Eligible Child, Special Needs Child or Eligible Spouse** if they are registered with **Centriq** within **90 Days** and added to the **Policy**, as a dependant, from the birth or marriage date.

Premiums will be payable from the birth or marriage date.

Should the **Eligible Child** or **Eligible Spouse** not be registered with **Centriq** within **90 Days**, full waiting periods will be applied to the **Insured Party**.

The Insurer reserves the right to waive the **Waiting Periods** for the **Insured Parties**. Any such waiver applied will be indicated on the **Policy Schedule**.

H. Policy Exclusions

The **Insurer** shall not be liable for any claim caused by or related to, whether such cause or related cause is as a direct or indirect consequence of any of the following:

- Any **Treatment** or **Medical Procedure** related to obesity.
- Cosmetic surgery except in the case where reconstructive cosmetic surgery is necessitated, in the sole opinion of the Insurer, as a direct result of **Accidental Injury** or other essential non-elective **Treatment** or **Medical Procedure**.
- Suicide, attempted suicide or wilful injury to oneself.
- Abortion, attempted abortion or any complications related thereto unless **Treatment** is, in the sole opinion of the **Insurer**, of a non-elective nature.
- Any procedure or examination where there is no factual indication of impairment in normal health.
- The consumption of any drug or narcotic, whether legal or illegal, unless legally prescribed by and taken following the instructions of a **Medical Practitioner**.
- The failure of an **Insured Party** to follow any medical advice given by a Medical Practitioner.
- Any incident, **Illness, Accidental Injury**, or event directly or indirectly caused by the continuous and excessive consumption of alcohol or where the **Insured Party** suffers from alcoholism.
- Any incident, **Illness, Accidental Injury** or event directly or indirectly attributable to the **Insured Party** having a blood alcohol content of more than thirty milligrams per one hundred millilitres of blood.
- Nuclear weapons, nuclear material, ionising radiations or contamination by radioactivity from any nuclear fuel, or any nuclear waste, or from the combustion of nuclear fuel which includes any self-sustaining process of nuclear fission.
- Participation or attempted participation by any **Insured Party** in any of the following:
  - Defence force, police force, medical rescue service, firefighting service, correctional services facility or the disarming of explosives;
  - Aviation activities where any medical expense incurred in relation to such activities are insured by any other party (excludes fare-paying passengers in a licensed passenger carrying aircraft);
  - **Hazardous Sport**, regardless of whether activities are performed privately, socially, during practice sessions, while participating in organised events, as an amateur or a professional.
- Any acts or attempted acts, including participation or attempted participation by any **Insured Party**, of any of the following:
  - Civil commotion, labour disturbances, riot, strike, lock-out or public disorder or any activity which is calculated or directed to bring about any of the following:
  - War, invasion, act of a foreign enemy, hostilities, civil war or warlike operations (regardless of whether war is declared or not);
  - Mutiny, military rising or usurped power, martial law or state of siege, or any other event or cause which determines the proclamation or maintenance of martial law or state of siege, insurrection, rebellion or revolution;
  - Any act (whether on behalf of an organisation, body, person or group of persons) calculated or directed to overthrow or influence any state or government or any provincial, local or tribal authority with force or using fear, terrorism or violence;
  - Any act calculated or directed to bring about loss or damage to further any political aim, objective or cause, or to bring about any social or economic change, or in protest against any state or government, or any provincial, local or tribal authority, or for inspiring fear in the public, or any section thereof;

- Terrorism. An act of terrorism means the use or threat of violence for political, religious, personal or ideological reasons. This may or may not include an act that is harmful to human life. It could be committed by any person or group of persons, acting alone, on behalf of or with any organisation or government. It includes any act committed to influence any government or inspire fear in the public;
- The act of any lawfully established authority in controlling, preventing, suppressing or in any other way dealing with any event referred to above.

- Any claim that does not form part of the registered benefits of the **Insured Party's** Fedhealth Elect or Savvy medical aid plan but has been paid on an ex gratia basis by Fedhealth.
- The following procedures, items, services, **Service Providers** or events:
  - Breast augmentation;
  - Gastroplasty, lipectomy or otoplasty;
  - Gender reversal procedures;
  - Therapeutic massage therapists;
  - TTO (To-Take-Out) medicines.
- Any expenses incurred as a result of an injury in a motor vehicle accident that are subsequently recoverable by the relevant **Insured Party** from the Road Accident Fund.
- Any expenses incurred as a result of an injury on duty that are subsequently recoverable by the relevant **Insured Party** from Workman's Compensation Fund.
- Any criminal act or attempted criminal act by an **Insured Party** which includes the submission of any fraudulent information or the use of any fraudulent means to obtain any **Benefit** under this **Policy**.
- Expenses incurred for transport charges or for services rendered whilst being transported in any vehicle, vessel or craft whether or not such vehicle, vessel or craft is specifically designed for medical emergency transport.
- Any act by an **Insured Party** that wilfully exposed the **Insured Party** to danger (except where such an act is to save human life).
- Any **Treatment** or **Medical Procedure** that, in the sole opinion of the Insurer is of such a nature that it is not considered to be medically necessary, or where alternative conservative **Treatment** would provide a similar outcome or is of such a nature that there is no likely improvement in the medical condition of the **Insured Party**.
- Any **Hospital Episode, Treatment** or **Medical Procedure** relating to the **Insured Event** which begins after the cancellation of this **Policy**.
- Any **Treatment** or **Medical Procedure** where such treatment occurred outside of the period of cover.

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Benefits on offer

Sanlam Gap Fedhealth NexGen Cover.

- The **Benefits** listed below apply to Fedhealth's Elect & Savvy medical scheme plan options.
- The **Benefits** listed below apply only for services rendered within the territory of the Republic of South Africa. Any services provided outside of the borders of South Africa are excluded from cover.
- The **Benefits** listed below are deemed as separate benefits and may qualify for coinciding yet distinct benefits, as the case may be.

Benefit	Benefit Description
Penalty Co-payment Benefit	The **Benefit** payable is equal to the **Penalty Co-payment** amount, as defined in Fedhealth's Elect or Savvy medical aid plans for the voluntary use by an **Insured Party** of a **Hospital** that is not a **Network Hospital**. A maximum of one such event is covered **Per Annum** and up to a maximum amount of **R9 050** for an **Insured Party** on the Fedhealth Savvy medical aid plan or **R15 460** for an **Insured Party** on the Fedhealth Elect medical aid plan.
MRI and CT Scan Co-payment	The **Benefit** amount payable is equal to the Co-payment amount, as defined in the rules of Fedhealth's Elect or Savvy medical aid plans in respect of MRI and CT scans. A maximum of one such event is covered **Per Annum** and up to a maximum amount of **R4 900**.
Casualty Ward Co-payment Contribution	The **Benefit** payable is equal to the **Co-payment** amount, as defined in the rules of Fedhealth's Elect or Savvy medical scheme plans in respect of **Emergency Treatment** in a casualty ward. The **Benefit** will only apply in the event of **Emergency Treatment** required as a result of **Accidental Injury**. A maximum of one such event is covered **Per Annum** and up to a maximum amount of **R840**.
Sports Injury Accidental Casualty for Appliances, External Accessories and Orthotics	The **Benefit** payable is for Appliances, external accessories and orthotics which are provided within a casualty ward of a **Hospital** as a result of a sports related **Accidental Injury**. Examples of Appliances, external accessories and orthotics include but are not limited to: • Crutches • Wheelchairs • Neck Braces • Moon Boots • Support braces Limited to a maximum amount of **R1 680** per option **Per Annum**.

Premium	Single	Family
Under 35 years	R70	R118
Older than 35 years	R87	R173

Sanlam Gap Automated Claims Process

SIMPLIFIED

PREVIOUS PROCESS		AUTOMATED PROCESS
Medical event occurs	1	Medical event occurs
Medical provider submits claims to medical scheme for payment	2	Medical provider submits claims to medical scheme for payment
Medical Scheme assesses claims and identifies shortfalls	3	Medical Scheme assesses claims and identifies shortfalls
Member receives statement noting payment shortfalls, requiring payment	4	Member receives statement noting payment shortfalls, requiring payment
Member completes paperwork and submits to Sanlam Gap (Gapinfo@centriq.co.za)	5	Member does not complete ANY PAPERWORK as all information is automatically sent by the medical scheme directly to Sanlam Gap for assessment, according to the policy benefits
Paperwork is received by Sanlam GAP and assessed, according to the policy benefits	6	
Once all documentation is received, claims shortfalls are paid within 7 to 14 working days	7	Claims shortfalls are paid within 7 to 14 working days
Member is paid and send a statement as confirmation	8	Member is paid and send a statement as confirmation

Please direct all queries to our **Customer Care Centre** on **0861 111 167**.

Contact Information

Sanlam Gap Cover
T: 0861 111 167
E: Gapinfo@centriq.co.za
www.sanlam.co.za

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