Sanlam

INSURED BY CENTRIQ INSURANCE
A LICENSED NON-LIFE INSURER

Retail Application Form

Important note

Please complete and sign this form and return to your Broker who will submit on your behalf. Only applications received by your Broker will be accepted. Applications received after the 15th of the current month will only be activated on the 1st of the following month. Dedicated Sanlam Gap email address: **Gapinfo@centriq.co.za**

A. Policyholder Details

☐ I do not currently have Gap Cover

☐ I currently have Gap Cover with another provider but I wish to transfer my cover to Sanlam Gap

Title: Name: Surname:

ID No. (compulsory field): Date of Birth: Y Y Y Y M M D D

Cellphone No.: Alternative Contact No:

Physical/Postal Address:

Postal Code:

Email Address:

Please note *that cover can only be granted if you are a member of a medical aid scheme and not health insurance.*

Health insurance policies are not medical aid schemes which are governed by the Medical Schemes Act (No. 131 of 1998)

B. Medical Scheme Cover Detail

Medical Scheme: Option:

Start date of medical scheme membership: Y Y Y Y M M D D

Membership number:

Please note *that cover can only be granted if you are a member of a medical aid scheme and not health insurance.*
Health insurance policies are not medical aid schemes which are goverened by the Medical Schemes Act (No. 131 of 1998)

C. Dependant Details

We will cover you, your spouse / partner and child dependant (up until the age of 27 years) on one Gap cover policy, even if you belong to different medical scheme or medical scheme plans.

Title: ______ Name: ______ Surname: ______

Relationship: ______ ID No. (compulsory field): ______

Medical Scheme: ______ Membership No.: ______

Medical Scheme Plan: ______ Date of Birth: Y Y Y Y M M D D

Title: ______ Name: ______ Surname: ______

Relationship: ______ ID No. (compulsory field): ______

Medical Scheme: ______ Membership No.: ______

Medical Scheme Plan: ______ Date of Birth: Y Y Y Y M M D D

Title: ______ Name: ______ Surname: ______

Relationship: ______ ID No. (compulsory field): ______

Medical Scheme: ______ Membership No.: ______

Medical Scheme Plan: ______ Date of Birth: Y Y Y Y M M D D

Title: ______ Name: ______ Surname: ______

Relationship: ______ ID No. (compulsory field): ______

Medical Scheme: ______ Membership No.: ______

Medical Scheme Plan: ______ Date of Birth: Y Y Y Y M M D D

Title: ______ Name: ______ Surname: ______

Relationship: ______ ID No. (compulsory field): ______

Medical Scheme: ______ Membership No.: ______

Medical Scheme Plan: ______ Date of Birth: Y Y Y Y M M D D

D. Pre-Existing Medical Condition Disclosure

As the main applicant, you're responsible for answering this section for yourself and your dependants because you have the necessary knowledge and consent.

12 Month Pre-Existing Medical Condition Waiting Period
There's no cover during this period for investigations, medical procedures, surgeries or treatments related to any illness or medical condition diagnosed or for which advice or treatment was received 12 months before your or your dependants' cover start dates.

Claims received in the first 12 months of your or your dependants' cover start dates for planned medical events that weren't disclosed to us may be rejected based on non-disclosure.

Please let us know of any change in your or your dependants' health statuses between signing and submitting the application form and your policy's start date.

Provide details of any illness or medical condition relevant to you and your dependants.

Name	Pre-existing Medical Condition	Last Treatment Date
		Y Y Y Y M M D D
		Y Y Y Y M M D D
		Y Y Y Y M M D D
		Y Y Y Y M M D D
		Y Y Y Y M M D D
		Y Y Y Y M M D D

E. Planned Medical Events

Please indicate if any pre-existing medical condition stated in Section C – Pre-Existing Medical Condition Disclosure necessitates an investigation, medical procedure, surgery or treatment within the first 12 months of your policy's start date.

Name	Planned Medical Event	Medical Event Date
		Y Y Y Y M M D D
		Y Y Y Y M M D D
		Y Y Y Y M M D D
		Y Y Y Y M M D D
		Y Y Y Y M M D D
		Y Y Y Y M M D D

F. Waiting Periods

Waiting periods may apply from your and your dependants' cover join date, however not to accidents which occur subsequent to your join date. Your Policy schedule you receive upon activation will outline the waiting periods for each insured on your policy.

3 month general waiting period - there is no cover during this period, except for accidents that occur subsequent to your and your dependants' cover join dates.

12 month pre-existing medical condition waiting period - there is no cover during this period for investigations, medical procedures, surgeries or treatments related to any illness or medical condition diagnosed, or for which advice of treatment was received 12 month prior to your or your dependants join dates.

G. Debit Order Details

By signing this section and upon acceptance of your application, you:

1. authorise Centriq Insurance to accept this debit order authority as confirmed payment instruction issued by the account holder.
2. authorise Centriq Insurance to debit your account for monthly policy premiums payable in advance or arrears on the selected debit order date.
3. understand that the debit order deductions will be processed through a computerised system provided by the South African Banks. Details of each deduction will be referenced on your bank statement with the prefix "Sanlam Gap Cover" and an 8-digit number.
4. accept that depending on the selected debit order date, a double or triple debit order may be incurred.
5. agree that this debit order authority will remain in force until cancelled in writing by the principal insured person.
6. accept that Centriq the insurer may cancel your policy if:
   6.1 premiums aren't received for three consecutive months;
   6.2 the bank account being debited is closed;
   6.3 the account holder is deceased; or if
   6.4 authority to debit is no longer granted.
7. understand that policy premiums include VAT but aren't tax deductible, as medical scheme contributions. An IT3 tax certificate can't be issued for this purpose.
8. accept that the policy premium may be adjusted during an annual renewal or due to benefit restructuring necessitated by legislation with 31 days written notice. Subject to your right of cancellation of cover, the debit order authority will extend to the adjusted premium.
9. I acknowledge that I need to ensure that premiums are collected for cover to remain in force.

Account Type: ☐ Cheque ☐ Savings

Bank: _____ Account No.: _____

Account Holder: _____

Debit Order Date: ☐ 1st ☐ 7th ☐ 15th ☐ 25th ☐ Last Day

Debit order deductions or Payment Terms are in Arrears or Advance
(This is dependent on the strike date chosen. 1st, 7th, 15th is collected in advance and 25th and Last Day is collected in arrears).

Sanlam Gap Comprehensive	Individual	Add Mediclinic Extender
Individuals younger than 30 years	☐ R320 per month	☐ R51 per month
Individuals 30 - 45 years	☐ R444 per month	☐ R51 per month
Individuals 45 - 60 years	☐ R495 per month	☐ R51 per month
Individuals 60 years and older	☐ R832 per month	☐ R93 per month

Sanlam Gap Comprehensive	Family	Add Mediclinic Extender
Families younger than 30 years	☐ R485 per month	☐ R114 per month
Families 30 - 45 years	☐ R540 per month	☐ R114 per month
Families 45 - 60 years	☐ R582 per month	☐ R114 per month
Families 60 years and older	☐ R999 per month	☐ R193 per month

Cover Start Date: Y Y Y Y M M 0 1

Policy Type:

☐ **Single Policy** - If you are joining as a single Policyholder, you accept that cover will only apply to yourself and that should any changes be required, you must notify Centriq, within 90 days. This includes the addition of dependants. Premiums are payable monthly.

☐ **Family Policy** - If you are joining as a family, you accept that Cover will apply to you, your spouse and your children. Cover for children only applies until they reach the age of 27 years. Should any changes be required, you must notify Centriq, within 90 days. This includes the addition of dependants. Premiums are payable monthly.

I, the Premium payer, hereby authorise Centriq to draw against the above bank account all amounts due to Centriq in terms of this insurance cover. Should the relevant Premiums be adjusted, I hereby confirm that the adjusted amount may be drawn from the above account subject to the notice period outlined in the Policy. This request is to remain in force unless cancelled by one month's written notice.

Please submit a copy of your bank statement or a bank detail confirmation letter not older than 3 months with this form.

Premium Payer Signature: _____

I. Broker Details

Brokerage: Broker Name:

Brokerage House Code: Broker Code: Signature:

H. Declaration

I, (full name) with ID number hereby declare that this application form, whether in my handwriting or not, is accurate and complete and forms the basis of the contract of insurance between the Insurer and myself. I hereby apply for the insurance product/s (underwritten by Centriq) and agree to abide by its Policy rules and conditions and any amendments thereto which may be made from time to time.

Accurate information
I confirm that all the information provided herein is complete and true and that I have not concealed any relevant or pertinent information that may affect the evaluation of risk considered under this policy for cover.

I understand that the provision of any false, misleading or missing information could result in my application being rejected or my policy being cancelled or claims being rejected. Should this occur, I agree to refund all benefit payments that I have received in relation to this policy of insurance.

Premium payments
Premiums for the selected insurance product/s are payable monthly and deducted by Centriq. The payment reference will reflect as: Sanlam Gap. Premiums that are in arrears will result in my policy being suspended or possibly terminated.

Benefit payments
In the event that any policy benefit becomes payable subsequent to my death, I hereby provide an irrevocable authority for such benefits to be paid directly to my surviving spouse or failing such circumstance to the nominated guardians or trustees responsible for the future care of my minor children or failing either of the preceding events to my estate.

Medical history
I hereby provide irrevocable authority for Centriq, the Insurer, to obtain any of my or my dependant's medical history from any Medical Service Provider, Medical Scheme, insurance company or healthcare broker for the purposes of assessing this application for insurance as well as the underwriting of any future risk or the assessment of any claim that relates to this insurance cover.

Disclosure documents
I have read and understood the Sanlam Gap Cover Disclosure Notice which I received together with this Application Form.

Policy exclusions and terms and conditions
Please refer to your policy document for the full list of exclusions and terms and conditions.

Full Name: Signature:

Date: Y Y Y Y M M D D

POPIA Consent

Use of Personal Information Declaration

I consent to Centriq Insurance, and its operators, processing, and further processing, my personal information in accordance with the Protection of Personal Information Act, for the purposes of concluding, and performing in terms of, this insurance contract.

For further information please read our Privacy Notice, which can be found on **www.centriq.co.za**

In the event that you qualify for the automated claims submission process, do you consent that we process your claim?

☐ Yes ☐ No

May we contact you for marketing purposes, for example, when we run competitions or launch new products?

☐ Yes ☐ No

How may we contact you?

☐ Email ☐ SMS/WhatsApp ☐ Telephone only ☐ All methods

Once signed, this application form should be returned to your servicing Broker.

T 0861 111 167
E **Gapinfo@centriq.co.za**