



Informed Healthcare Solutions (IHS)

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FAX COVER SHEET

To:	Graham Pike of IHS	From:	
Fax:	086 627 7012	Company:	
Tel:	021 712 6686	Tel:	
Pages:		Date:	
Re:	GAP Cover Application		

Comments:

Instructions:

1. Print this document.
2. Fill in the application form and cover letter.
3. Fax the form to us on 086 627 7012 or scan and email it to forms@medicalaidcomparisons.co.za
4. Sit back while we do all the complicated stuff.

Save time and hassle with your medical aid application and make sure it gets the best possible chance of success



ambledown

RISK & UNDERWRITING MANAGERS

For office use only:

POLICY NUMBER:	
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GAP COVER
INDIVIDUAL DEBIT ORDER APPLICATION FORM
 Underwritten by Hollard Group Risk (HGR), a division of The Hollard Insurance Company Limited,
 Reg. No. 1952/003004/06, FSP No: 17698 (The Insurer)

BROKER DETAILS

Broker/ Consultant Name:		Name of Brokerage:	INFORMED HEALTHCARE SOLUTIONS
FSP No.:	12239	Vat No.:	4720160979
Broker Code:	IHS	Unique Identifier (if necessary) :	
Broker e-mail address:		Broker Contact No.:	021 712 6686
Broker Notes in terms of quote provided (if part of an employer group):			

PRODUCT DETAILS

Gap Cover Option Selected:		Monthly Premium Due:		Inception Date:	
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PERSONAL PARTICULARS

Applicant (MUST BE THE PRINCIPAL MEMBER OF THE MEDICAL AID SCHEME)

TITLE:		SURNAME:		FIRST NAMES:	
ID NO:					
NAME OF EMPLOYER:					
DATE EMPLOYED:					
NAME OF MEDICAL AID SCHEME:		PLAN OPTION:			
DATE JOINED:		MEDICAL AID NO.:			

Dependants (IF ADDITIONAL SPACE IS REQUIRED GIVE DETAILS ON SEPARATE SHEET)

FIRST NAME (AND SURNAME IF DIFFERENT)	RELATIONSHIP	I.D. NUMBER
1.		
2.		
3.		

Contact Details

POSTAL ADDRESS					PHYSICAL ADDRESS (IF DIFFERENT TO POSTAL)														
				POSTAL CODE:										POSTAL CODE					

HOME NO.:		WORK NO.:	
AREA CODE		AREA CODE	
CELL NO.:		E-MAIL:	
PREFERRED METHOD OF WRITTEN COMMUNICATION (PLEASE TICK)			E-MAIL
			POST

MEDICAL QUESTIONNAIRE

1. DO YOU OR ANY OF YOUR DEPENDANTS SUFFER FROM ANY CHRONIC OR RECURRING ILLNESS OR ANY OTHER SERIOUS AILMENT?			Y/N
IF "YES" PLEASE SPECIFY:			
2. HAVE YOU OR ANY OF YOUR DEPENDANTS RECEIVED TREATMENT OR ADVICE BY A MEDICAL PRACTITIONER IN THE LAST 12 MONTHS?			Y/N
IF "YES" PLEASE SPECIFY:			
NAME OF FAMILY'S GENERAL MEDICAL PRACTITIONER		CONTACT NO.:	
3. HAVE YOU OR ANY OF YOUR DEPENDANTS BEEN HOSPITALISED DURING THE PRECEDING 5 YEARS?			Y/N
IF "YES" TO THE ABOVE PLEASE SPECIFY THE CONDITION FOR WHICH HOSPITALISATION WAS NECESSARY			
NAME	DATE HOSPITALISED	REASON FOR HOSPITALISATION	
4. DO YOU OR ANY OF YOUR DEPENDANTS EXPECT TO BE HOSPITALISED DURING THE NEXT 12 MONTHS?			Y/N
IF "YES" TO THE ABOVE PLEASE SPECIFY THE CONDITION FOR WHICH HOSPITALISATION IS NECESSARY			
NAME	EXPECTED DATE OF HOSPITALISATION	REASON FOR HOSPITALISATION	
5. ARE YOU OR ANY OF YOUR DEPENDANTS CURRENTLY PREGNANT?			Y/N

PREMIUM PAYMENT

Debit Order Details

ACCOUNT HOLDERS NAME		BANK / BUILDING SOCIETY			
ACCOUNT NUMBER		BRANCH			
BRANCH CODE		ACCOUNT TYPE	CURRENT	TRANSMISSION	SAVINGS

MONTHLY DEBIT ORDER DATE (PLEASE TICK):	1st	15th	20th	25th	28th	LAST DAY OF THE MONTH
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PLEASE NOTE THAT PREMIUMS ARE COLLECTED MONTHLY IN ADVANCE

Having applied for the above mentioned Gap Cover Policy and on acceptance of my application by the insurer, I hereby authorise the insurer or its representative to debit my account, the premiums payable under the above plan on the selected day of each month in accordance with the Debit Order System. Such authorisation shall remain in force and effect until cancelled by myself, in writing with one calendar months notice. I further authorise The Insurer to increase the amount due in terms of the policy from time to time and authorise my bank to effect payment on relevant increases.

Signature of Account Holder

Date

DECLARATION

I declare that I have not withheld any information and I accept that this application and declaration shall be the basis of the contract of insurance between me and the insurer, which will become effective on the first day of the month for which premiums are received. I also acknowledge that I have requested and instructed the broker not to complete a financial needs analysis. Furthermore, I understand and accept that this instruction not to proceed with a full financial needs analysis could have the effect that all my financial needs may not be properly addressed.

Signature of Applicant

Printed Name of Applicant

Date

Please return to:

Ambledown Risk and Underwriting Managers (Pty) Ltd, PO Box 1862, Cramerview, 2060
Tel Number 0861 262533, Fax Number (011) 463 1600
E-mail Address: info@ambledown.co.za