ambledown
FINANCIAL SERVICES (PTY) LTD

nmg BENEFITS

UCT : WINDOW PERIOD 2016

For office use only:

POLICY NUMBER:	

GAP COVER SERIES
UCT STAFF DEBIT ORDER APPLICATION FORM
Underwritten by Constantia Insurance Company Limited (CICL), Reg. No. 1952/001514/06, FSP No: 31111 (The Insurer)

BROKER DETAILS

Broker/ Consultant Name:	DOM CORTONE	Name of Brokerage:	NMG
FSP No.:		Vat No.:	
Broker Code:	NC494	Unique Identifier (if necessary) :	
Broker e-mail address:	dcortone@nmg.co.za	Broker Contact No.:	021 943-1800

PRODUCT SUMMARY

UCT GAP & IN-HOSPITAL	GAP COVER: COVERS CHARGES ABOVE THE MEDICAL SCHEME TARIFF FOR ASSOCIATED SERVICES IN-HOSPITAL, LISTED OUT-PATIENT PROCEDURES, CHEMOTHERAPY OR RADIOTHERAPY FOR THE TREATMENT OF CANCER AND KIDNEY DIALYSIS; PLUS CO-PAYMENT COVER: COVERS CO-PAYMENTS OR DEDUCTIBLES LEVIED BY THE MEDICAL SCHEME FOR IN-HOSPITAL ADMISSIONS, LISTED OUTPATIENT PROCEDURES AND MRI AND CT SCANS; PLUS SUB-LIMIT COVER: COVERS CHARGES ABOVE DEFINED IN-HOSPITAL SUB-LIMITS IMPOSED BY THE MEDICAL SCHEME
UCT GAP & CANCER	GAP COVER; PLUS CO-PAYMENT COVER; PLUS CANCER COVER: COVERS THE SHORTFALL, EITHER OF THE CO-PAYMENT AFTER THE SUB-LIMITATION OR THE AMOUNT ABOVE THE SUB-LIMITATION FOR CANCER TREATMENT USING TRADITIONAL METHODS OR USING BIOLOGICAL CANCER DRUGS
UCT GAP COMPREHENSIVE	GAP COVER; PLUS CO-PAYMENT COVER; PLUS CANCER COVER; PLUS SUB-LIMIT COVER
UCT KEY GAP	GAP COVER; PLUS A BENEFIT EQUAL TO THE COST OF IN-HOSPITALISATION AND ASSOCIATED MEDICAL EXPENSES (AS DEFINED) RELATING TO ONE OF THE LISTED PROCEDURES LESS THE COVER PROVIDED BY THE MEDICAL SCHEME OPTION: **THREE** DEFINED PROCEDURES
UCT GAP EXECUTIVE	GAP COVER; PLUS CO-PAYMENT COVER; PLUS CANCER COVER; PLUS SUB-LIMIT COVER; PLUS THE COST OF A MEDICAL OR SURGICAL PROCEDURE FOLLOWING AN EMERGENCY INCURRED IN A HOSPITAL CASUALTY UNIT OF A HOSPITAL WHERE SUCH COST WERE NOT MET BY THE MEDICAL SCHEME AND LIMITED TO R7,500 IN AGGREGATE PER FAMILY PER ANNUM

PRODUCT SELECTION

PRODUCTS AVAILABLE	√	PLEASE SELECT MONTHLY PREMIUM
UCT GAP IN-HOSPITAL		R160.00 PER FAMILY PER MONTH
UCT GAP CANCER		R140.00 PER FAMILY PER MONTH
UCT KEY GAP		R110.00 PER FAMILY PER MONTH
UCT GAP COMPREHENSIVE		R180.00 PER FAMILY PER MONTH
UCT GAP EXECUTIVE		R185.00 PER FAMILY PER MONTH

INCEPTION DATE (DATE COVER IS TO COMMENCE)

D	D	M	M	Y	Y	Y	Y

PERSONAL PARTICULARS

Applicant

TITLE:		SURNAME:					FIRST NAMES:						
ID NO:													
NAME OF EMPLOYER:	University of Cape Town												
DATE EMPLOYED:													
NAME OF MEDICAL AID SCHEME:							PLAN OPTION:						
DATE JOINED:							MEDICAL AID NUMBER;						

Dependants (One spouse allowed. Maximum child dependant age limit is 25yrs old. No cover is provided for extended family members.)

FIRST NAME (AND SURNAME IF DIFFERENT)	RELATIONSHIP	I.D. NUMBER
1.		
2.		
3.		
4.		
5.		
6.		
7.		

CONTACT DETAILS

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

HOME NO.:	AREA CODE		WORK NO.:	AREA CODE	
CELL NO.:			E-MAIL:		

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 12 MONTHS?	Y/N	
IF "YES" TO THE ABOVE PLEASE SPECIFY THE CONDITION FOR WHICH HOSPITALISATION WAS NECESSARY		

NAME	DATE HOSPITALISED	REASON FOR HOSPITALISATION

4. HAVE YOU OR ANY OF YOUR DEPENDANTS BEEN DIAGNOSED WITH CANCER?	Y/N	
IF "YES" TO THE ABOVE PLEASE SPECIFY THE NAMES OF DEPENDANTS DIAGNOSED WITH CANCER		
5. 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 HOSPITILISATION	REASON FOR HOSPITALISATION

6. 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

PLEASE NOTE THAT PREMIUMS ARE COLLECTED IN ADVANCE ON THE 1ST OF EACH MONTH

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 first 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. Notwithstanding the fact that I grant the Insurer permission to collect premiums, I acknowledge that I need to ensure that premiums are collected for cover to remain in force.

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.

I further confirm that the following notable conditions have been explained to me:

a) No benefits will be payable for biological cancer drugs under the Gap Cover cancer benefits for a member already diagnosed with cancer at inception of this policy.
b) Not all your dependants on your medical scheme are automatically covered under this policy, only your eligible spouse and your eligible children are covered as per the policy definitions.
c) Full underwriting conditions will apply to members joining cover from 1 May 2016 onwards.

I confirm that although I have completed this application form, it does not constitute an insurance contract until a membership number is assigned, policy issued and premium is successfully paid.

Signature of Applicant **Printed Name of Applicant** **Date**

Please return to your broker or alternatively:

Ambledown Financial Services (Pty) Ltd,
PO Box 1862, Cramerview, 2060
Tel Number 0861 262533, Fax Number (011) 463 1600
E-mail Address: admin@ambledown.co.za