Admed
The heartbeat of Gap

# Admed Gap Cover Voluntary Group Application Form – Debit Order Investec Bank Ltd

**2026**

Thank you for deciding to apply for gap insurance cover with Admed, a division of Guardrisk Insurance Company Limited (Reg. 1992/001639/06, FSP No. 75). This document is an application form for cover. Please complete the form accurately and completely in order that we may process your application.

**Contact us**

Tel: 0860 102 936, Email: admed@guardrisk.co.za

**Who we are**

Admed, a division of Guardrisk Insurance Company Limited – Registration number 1992/001639/06, Financial Service Provider No. 75

**What you must do**

1. Fill in the form.
2. Submit the necessary supporting documents with your completed claim form.
3. Submit your application by emailing the form to us, with your medical aid membership certificate.

**Once you have submitted your application form:**

- If any details are missing or we need more information, we will contact you.
- We will activate your membership and we will email you a confirmation of cover, along with your policy wording.
- If you do not hear from us 2 weeks after sending us your application, please contact us on **0860 102 936** or email **admed@guardrisk.co.za**.

**When you sign this application, you confirm that you have read and understood the terms and conditions of cover and agree to them.**

| | | | | |
|---|---|---|---|---|
| Tell us who is completing this form | Client/applicant | Yes ☐ | No ☐ | Please read and initial each declaration under client/applicant declaration and consent. |
| | Appointed financial adviser | Yes ☐ | No ☐ | Please read and initial each declaration under financial adviser declaration and consent. |

## 1: Employer details

| | | | |
|---|---|---|---|
| Name of employer | INVESTEC BANK LTD | | |
| Branch name (if applicable) | | Employee number | |
| Date of employment | D D M M Y Y Y Y | | |

## 2: Personal details

### Policy holder details

| | | | | | |
|---|---|---|---|---|---|
| Title | | Initials | | First name | |
| Surname | | | | | |
| ID/Passport number | | | | Date of birth | D D M M Y Y Y Y |
| Medical aid name | | | | Plan option | |
| Medical aid number | | | | Date joined | D D M M Y Y Y Y |

Please attach medical aid membership certificate (not older than 1 month) or medical aid application form if you are taking medical aid at the same time as your gap cover. Please note that it is your responsibility to inform us if you are not on a medical aid when your gap cover is incepted. All dependants must reflect on your medical aid certificate, be named on your cover with us and must be covered on your medical aid at the time of a claimable event.

### Contact details

| | | | |
|---|---|---|---|
| Physical address | | | |
| | | Postal code | |
| Postal address (if different) | | | |
| | | Postal code | |
| Telephone - work | | Cellphone number | |
| Email address | | | |

## 3: Dependants

Dependants, including your spouse, children and adult dependants.

You do not need to list your dependents on this application form, as we cover all your dependents, that includes your spouse, your adult dependants, and your children, as long as they're registered on your medical scheme option.

## 4: Contract start date

You confirm that you have read and understand the benefits that are covered on the selected cover option.

If we receive your application after the 15th day of the month, we may make a double deduction from your bank account.

Please select your cover and monthly premium option: ☐ **Supreme Gap** **R 4 2 6** ☐ **Primary Gap** **R 2 9 2**

*The monthly premium is inclusive of commission and where applicable a binder fee and VAT.*

When do you want your cover to start? **0 1** M M Y Y Y Y

Cover can only start on the first day of the calendar month following application. No requests for backdating of cover will be considered.

## 5: Previous gap cover details

Have you or any of your dependants previously belonged to any other gap cover? If yes, please give us the details. Yes ☐ No ☐

Previous insurer

Previous cover option | Previous policy number

Start date D D M M Y Y Y Y | End date D D M M Y Y Y Y

**Please attach proof of your previous gap cover if applicable.**

**All dependants must reflect on this certificate in order to benefit from reduced or no waiting periods being applied to their cover. If your dependants are moving cover from a different insurer, please also attach their proof of cover with your application.**

## 6: Underwriting

We will apply underwriting to you and your dependants covered on your medical scheme as follows:

**Pre-existing conditions exclusions**

1. **General rule**

   You and your dependants covered on your medical scheme will not be entitled to claim for a period of **12 months** from the start date of your policy for **any** medical condition where, in the 12 months before your policy start date, you:

   - received medical advice, diagnosis, care, or treatment, or
   - could reasonably have been expected to receive such advice, diagnosis, care, or treatment.

2. **Pregnancy**

   If you or your dependants covered on your medical scheme fall pregnant **before the start date of your policy**, this will be regarded as a pre-existing condition. All pregnancy and birth-related claims will therefore be excluded for **12 months** from the start date of your policy.

3. **Continuation of cover**

   If, immediately before the start date of this policy, you were insured under another gap cover policy with similar benefits:

   - the pre-existing condition waiting period will only apply to the **unexpired portion** of the waiting period from your previous policy, and
   - the full 12-month waiting period will still apply to any benefit not covered under your previous policy.

## 7: Your beneficiary details

Your Admed Gap Cover policy has two benefits that will pay your nominated beneficiary an amount of money should you die as a result of a violent crime or an accident. The beneficiary nomination is important as, should one not be nominated, the funds will be paid into your estate.

Title | Initials | First name

Surname

ID/Passport number | Cellphone number

Physical address

Postal code

Date of birth D D M M Y Y Y Y | Relationship to you

## 8: Banking details for monthly premium deduction

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Name of account holder | | | | | | | | | | | |
| Account holder ID/passport number | | | | | | | | | | | |
| Name of bank | | | | | | | | | | | |
| Account number | | | | | | | | | | | |
| Account type | Current/Cheque | | Savings | | Transmission | | | | | | |
| Branch code | | | | | | | | Branch name | | | |
| Please choose your debit order date | 1st | | 7th | | 10th | | 15th | | 20th | | 25th |

## 9: Debit order mandate

**By initialling this box you:**

1. Authorise Guardrisk to debit your account with the monthly premium due in respect of this policy.
2. Acknowledge that this authorisation will remain in force and effect until cancelled by you, in writing with one calendar month's notice.
3. Understand that cancelling the Mandate does not cancel the Agreement. Agreement that the account holder is not entitled to refund for when the Mandate was still active, if such amounts were owed to them.
4. Acknowledge that this Authority may be assigned to a third party if this agreement is also assigned to a third party.
5. Understand and accept that should your premium be adjusted annually on renewal and in the case of benefit restructuring necessitated by changing legislation, with one month's notice and subject to your right of cancellation of cover, the aforementioned authorisation will extend to the adjusted premium.
6. Undertake to inform Guardrisk of any change in your banking details and you authorise Guardrisk to verify such banking details with your bank.
7. Confirm that Guardrisk shall not be held liable for incorrect claim payments made as a result of your failure to inform Guardrisk of your change in banking details.
8. Accept that Guardrisk may debit your account on a date other than that specified.
9. Notwithstanding the fact that you grant Guardrisk permission to collect premiums, you acknowledge that it is your responsibility to ensure that premiums are collected for cover to remain in force.
10. Acknowledge that the first payment date will be the first day of the month in which your cover starts.
11. Acknowledge that in the event that the payment day falls on a Sunday, or recognised South African public holiday, the payment day will automatically be the very next ordinary business day.
12. Acknowledge that payment instructions issued from this Mandate will be treated as payment instructions issued personally by the accountholder.
13. Understand that the agreement reference number will be your membership number which will only be issued once your application form has been captured.
14. Understand that the debit order transaction on your bank statement will reflect as 'ADMED'.

| **Signature of bank account holder** | | **Date signed** | D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|---|---|---|

## 10: Broker details

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Brokerage name | **Alexander Forbes Financial Services** | | | | | | | | | | | | | | | | | | | |
| Branch name | **JHB** | | | | | | | | | | FSP No. | **1** | **1** | **7** | **7** | | | | | |
| Advisor name | **Marco Panicco** | | | | | | | | | | | | | | | | | | | |
| Telephone - work | | | | | | | | | | | Cellphone number | | | | | | | | | |
| Email address | **admedapplications@alexforbes.com** | | | | | | | | | | | | | | | | | | | |

**By initialling this box you confirm that your financial adviser has communicated the below to you:**

1. That he/she is mandated by an authorised Financial Services Provider (FSP), as set out above, to act on behalf of that FSP as a representative.
2. That he/she is an accredited financial adviser in terms of the FAIS Act at the date of signing this application form.
3. That he/she accepts their appointment by you to provide advice and ongoing intermediary services in respect of this policy.
4. That he/she has made you aware of the commission payable by Guardrisk to him/her in respect of this policy.
5. That he/she has conducted a financial needs analysis and this insurance product is suitable to meet your insurance needs.
6. That he/she has explained the insurance product to you and you understand how the product works, what is covered and what is not covered, as well as how to claim from the policy.
7. That he/she is responsible for providing you with his/her contact details and he/she is accountable for any advice given to you about completion of this application form.

Underwritten by Guardrisk Insurance Company Limited. Guardrisk is a part of the Momentum Group
An Authorised Financial Services Provider and Licensed non-life Insurer (FSP No 75)
The Marc, Tower 2, 129 Rivonia Road, Sandton, 2146
Tel: 0860 102 936 I Email admedapplications@guardrisk.co.za

GUARDRISK
TAILORED RISK SOLUTIONS
Part of the Momentum Group

## 11: Broker declaration and consent – only applicable when a broker is completing the application form on behalf of the client

**Please initial each of the following sentences below to confirm that you are in agreement with the statement:**

1. The applicant has authorised you to complete this application form on their behalf and you confirm that the information provided is true and accurate as advised by your client.
2. You can provide proof of your client's above mentioned authorisation timeously on request by Guardrisk.
3. You declare that your client has read the below client/applicant declaration and that your client accepts each declaration that you are signing on their behalf.

## 12: Client/applicant declaration and consent

**Please initial each of the following sentences below to confirm that you agree with the statement:**

1. I hereby apply for the Admed product through my employer and I agree to abide by its rules.
2. I declare that the information that I have supplied is correct and complete and that this declaration shall be the basis of my membership of my employer's group scheme with Guardrisk Insurance Company Limited (Guardrisk), which will become effective on the first day of the month for which premiums are paid.
3. I confirm my understanding that should this application be incomplete, my application may not be processed by Guardrisk.
4. I confirm my understanding that should any material information be withheld or incorrectly furnished during the application process, Guardrisk may cancel my cover and premiums paid may be used to offset expenses incurred by Guardrisk.
5. I understand that my and my dependants' cover may be subject to waiting periods and that these waiting periods have been communicated to me prior to my application for cover.
6. I declare my understanding that this insurance product is not a substitute for medical scheme cover and that it does not replace my, or my dependants' medical scheme cover.
7. MEMBER + DEPENDANTS: I acknowledge that, although Admed has not required the submission of any medical information from myself or my dependants, no cover shall be provided for a period of 12 months in respect of any medical condition from which I or any of my dependants were suffering at the time of joining the policy.
8. I understand that this product does not insure against every shortfall in medical scheme cover and that I am aware of the circumstances in which my and my dependents' cover will and will not pay.
9. I further declare my understanding that my and my dependents' eligibility for cover is dependent on my, and my dependents remaining active members of a registered medical scheme and I undertake to advise Guardrisk if I terminate my, or my dependents' medical scheme membership at any time.
10. I provide authority for my employer to make a cover nomination on my behalf and furthermore indemnify Guardrisk against liability for any loss that may result from an incorrect nomination of such cover by the employer.
11. I accept that any notice given to my employer is deemed to have been given to me.
12. I declare my understanding that my employer has appointed an intermediary to the group policy and has authorised Guardrisk to make payment of monthly commission, calculated as 20% of the first R299 of monthly premium and 15% of the remaining monthly premium, to such appointed intermediary.
13. I authorise the disclosure of relevant medical information by my medical scheme to Guardrisk to assist in the processing of claims under this policy. This information could include my (or one of my dependents') diagnosis, treatment and medical history. I further confirm that my dependents and/or beneficiaries have also provided the necessary authority for their medical scheme to disclose their relevant medical information to Guardrisk to assist in the processing of claims under this policy.
14. I authorise Guardrisk to obtain from any person, medical practitioner or institution, any information that Guardrisk requires for purposes of claims arising from this policy. I authorise such person(s) to give the said information to Guardrisk, and to share with other insurers and medical schemes any information in this application or in any related policy or other document, either directly or through a database operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as Guardrisk or the operators of such database may decide from time to time. I acknowledge that I cannot cancel this authorisation and that it will endure after my death.
15. I authorise Guardrisk to use, review and process any of my or my dependents' personal information provided to Guardrisk in the course of this application and for the purpose of administering cover and processing of future claims under this policy. I further confirm that my dependents and/or beneficiaries have also provided me with the authority to disclose their personal information to Guardrisk.
16. I confirm that I am aware of my right to request a copy of my and my dependents' personal information that Guardrisk holds, that I have the right to request that such personal information is updated, corrected or deleted by Guardrisk and that I have the right to object to the processing of my personal information by lodging a complaint with the Information Regulator.
17. I authorise Guardrisk, or its appointed service provider, to negotiate on my or my dependents' behalf with my medical scheme in respect of shortfall claims that may have arisen from medical events which my medical scheme is legally obliged to cover in full (prescribed minimum benefits).
18. I authorise Guardrisk to negotiate discounts on my or my dependents' behalf with medical service providers in order to maintain a good risk profile for my cover. If successful, I acknowledge that payment will be made directly to the service provider's bank account and no further payment will be due to me.

## 12: Client/applicant declaration and consent (continued)

19. I undertake to notify Guardrisk of any change in my personal details within a reasonable time period and I indemnify Guardrisk against any liability for any loss that may result from my failure to notify Guardrisk of such change in a timeous manner.

20. I authorise Guardrisk to disclose all relevant information to the appointed broker on my policy to assist in the processing of this application form, for the purpose of administering cover and processing of all future claims under this policy. This information could include my (or one of my dependents') medical diagnosis, treatment and history as well as personal information. I further confirm that my dependents and/or beneficiaries have also provided the necessary authority to disclose their relevant information to the appointed broker to assist in the processing of this application form, administrating of this policy and any claims processed by Guardrisk on this policy.

21. I declare my understanding that only if a binder holder has been appointed to the group policy, will a payment of a monthly binder fee be made by Guardrisk to the binder holder. This binder fee is calculated as a percentage of the monthly gross premium. The binder fee is paid to the binder holder for the performance of this function, however it is important to note that this does not affect the premium charged to you, as the cost of the fee is carried from our expense reserving.

Signed at

**Signature of applicant**

**Date** D D M M Y Y Y Y

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