ambledown
FINANCIAL SERVICES (PTY) LTD
Ambledown is an Authorised Financial Services Provider, No. 10287

GUARDRISK
TAILORED RISK SOLUTIONS
Guardrisk Insurance Company Limited,
a licensed non-life Insurer and an authorised financial services provider (No.75)

MICROSOFT SA

2026 GAP SUPREME

Individual Debit Order/Payroll Application Form

Broker Details

Broker / consultant name:
Name of brokerage:
FSP number:
Broker code:
Broker contact number:
VAT number:
Broker email address:
Unique identifier *(if necessary)*:

Personal Details

* *FICA Requirements*

Applicant

Title:
Surname:
ID / passport number:
* First names:
Date of birth: D D M M Y Y Y Y
Country of residence:
Country of nationality:
Face to face: Yes: No:
Do you have an existing Gap Cover policy?: Yes: No:

If you have an existing Gap Cover policy - provide a membership certificate including period of cover and insured persons.

Employer

Name of employer:
Date employed: D D M M Y Y Y Y
Occupation:
Industry:

Medical Scheme

Name of medical scheme:
Plan option:
Date joined: D D M M Y Y Y Y
Medical scheme number:

Dependants *(to see who qualifies as a dependant see Declaration c)*

First name *(and surname if different)*	Relationship	ID or passport number	Date of birth
			D D M M Y Y Y Y
			D D M M Y Y Y Y
			D D M M Y Y Y Y
			D D M M Y Y Y Y
			D D M M Y Y Y Y

Contact Details

* *FICA Requirements*

Postal address

Postal code:

Home number:

Work number:

* Physical address *(if different to postal)*

Postal code:

* Cell number:

* Email:

Medical Questionnaire

1. Do you or any of your dependants suffer from any chronic or recurring illness or any other serious ailment?: No / Yes

   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?: No / Yes

   If "yes" please specify:

   Name of family's general medical practitioner:

   Contact number:

3. Have you or any of your dependants been hospitalised during the last 12 months? No / Yes

   If "yes" to the above please specify the condition for which hospitalisation was necessary

Name	Date hospitalised	Reason for hospitalisation
	D D M M Y Y Y Y	
	D D M M Y Y Y Y	
	D D M M Y Y Y Y	
	D D M M Y Y Y Y	

4. Do you or any of your dependants expect to be hospitalised during the next 12 months? No / Yes

   If "yes" to the above please specify the condition for which hospitalisation was necessary

Name	Expected hospitalisation date	Reason for hospitalisation
	D D M M Y Y Y Y	
	D D M M Y Y Y Y	
	D D M M Y Y Y Y	
	D D M M Y Y Y Y	

Failure to provide correct or full relevant information may influence an Insurer on any claims arising from your contract of insurance.

Benefits Summary

Gap Cover

Gap Cover benefit 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. Gap Cover 100 ensures insured persons have up to 600% cover.

Major Medical Co-payment / Deductible Cover

Co-payment benefit covers co-payments or deductibles levied by the medical scheme for in-hospital admissions, listed out-patient procedures, and CT, MRI, and PET scans. Includes a once-off payment per family per year for the penalty imposed by a medical scheme for the use of a non-network hospital. Penalty Co-payment is limited to R15, 000.

Sub-Limitation Cover

Sub-limitation benefit covers charges above the defined in-hospital sub-limits imposed by the medical scheme.

Cancer Cover

The cancer benefit covers the shortfall - either the co-payment after the sub-limitation or the sub-limitation for traditional methods of cancer treatment, or sub-limitation for treatment of cancer with defined biological drugs, immunotherapy, hormone therapy, targeted therapy, photodynamic therapy, and/or stem cell transplants.

Casualty Ward Benefit

Casualty ward benefit covers the cost of a medical or a surgical procedure following an emergency incurred in a hospital casualty unit of a hospital where such costs were not met by the medical scheme.

Premium Waiver Benefit

Provides for a once off payment equal to 6 months of the member's medical scheme contributions and Gap Cover premium. Cover ceases at age 65.

Dread Disease (Severe Illness) Benefit

Provides a once off dread disease benefit, limited to the first diagnosis of cancer. ** See dread disease exclusions. Cover ceases at age 65.

All Gap Cover Benefits highlighted in green are limited to **R219,845** per insured person per year or any higher amount which may be published by the Regulator during the year.

Product Summary & Selection

Product	Listed benefits	Specific limitation per insured person per year	Overall limitation per insured person per year	Premium per family per month (incl. VAT) 18-65 years old
Gap Supreme	Gap Cover 100 Co-payment Cover		**R219,845** or any higher amount published by the Regulator	◯ **R262.00**
	Penalty co-payment	R15,000		
	Sub-limit Cover Cancer Cover			
	Casualty benefit	R11,000		
	Premium Waiver benefit	Limited to 6 months medical aid contributions and Gap Cover premium	** See Premium Waiver exclusion	
	Dread Disease benefit	Once off **R50,000** on diagnosis	** See Dread Disease exclusions	

Inception date *(date cover is to commence)* D D M M Y Y Y Y

Premiums are reviewed annually, effective from 1 January. The Insurer reserves the right to alter the premium at any time by providing the Insured with 31 days' written notice, subject to the change being based on sound actuarial reasons.

* *Dread Disease Exclusions*

- All tumours, which are histologically described as pre-malignant, as non-invasive or as Cancer in situ.
- All forms of lymphoma in the presence of any Human Immunodeficiency Virus.
- Kaposi's sarcoma in the presence of any Human Immunodeficiency Virus.
- Any skin Cancer other than malignant melanoma.
- Cancerous cells that have not invaded the surrounding or underlying tissue.
- Early Cancer of the prostate gland or breast. (Stage1 described as T1a, N0, M0, G1)
- Seniors (65 years & older) excluded.

Specific condition

- The Dread Disease benefit terminates at the member reaching the benefit expiry age, or age 65.

** *Premium Waiver Exclusion*

- Seniors (65 years & older) excluded.

Specific condition

- The Premium Waiver benefit terminates at the member reaching the benefit expiry age, or age 65.

Premium Payment

Debit Order Details

Account holder's name:		Bank / Building Society:	
Account number:		Branch:	
Branch code:		Account type:	☐ Current
Source of funds:			☐ Transmission
			☐ Savings

Please select preferred debit order collection date

1st ☐ 7th ☐ 15th ☐ 20th ☐ 25th ☐ 28th ☐ Last day of the month ☐

I, the undersigned, hereby request and authorise the Insurer or its representative to deduct the premium payable under the above plan against my bank account or institution (or any other bank or institution or branch where my account is kept or transferred to) on the preferred debit order collection date.

Should the collection date selected fall on a weekend or public holiday, I understand that a debit will be processed against my account on the first working day following the weekend or public holiday. I further declare that:

- I authorise my bank or institution (as stated) to debit my account with all debits which may be presented by the company as if I personally signed for each one.
- I also understand that the details of each debit order will be printed on my bank statement as a separate line as proof thereof.
- I declare that all bank costs related to this debit order system and approval, will be for my own account.
- I understand and accept that I or the company can change this arrangement at any time in writing (by giving the other party 31 days' notice) or cancel this arrangement, given that it won't have any effect on the deductions of the company which was already agreed and authorised herein.
- I understand and accept that all payments in terms of this agreement will be made without any prejudice.
- I understand and accept that if any payment in terms of this agreement is not received, the relevant policy/ies will be cancelled effective from the last day of the uninterrupted period for which payment(s) were received.
- I accept that this request and authorisation will be applicable for all amounts payable from inception and monthly thereafter.
- I acknowledge that I need to ensure that premiums are collected for cover to remain in force.
- I understand and accept that the company reserves the right to adjust the premiums by giving thirty one (31) days written notice prior to the effective date of the change.

SIGNATURE OF ACCOUNT HOLDER DATE D D M M Y Y Y Y

Premium Payment

Payroll Details

Employer name:		Employee name:	
Employee cost centre:		Employee surname:	
Date employed:	D D	Employee number:	
Source of funds:			

Please note that if premiums are paid via payroll they will be collected monthly in arrears (unless otherwise specified) for the current month of cover.

Having applied for the policy detailed above, and on acceptance of my application by the Insurer, I hereby authorise my salaries/payroll division to deduct the above premium from my salary and remit to the Insurer on a monthly basis. Such authorisation shall remain in force and effect until cancelled by myself, in writing with thirty one (31) days notice or I leave the employ of my current employer. I further authorise the Insurer to increase the amount as per amendments of the policy and authorise my salaries/payroll division to effect payment on relevant increases. I understand and accept that the company reserves the right to adjust the premiums by giving thirty one (31) days written notice prior to the effective date of the change.

SIGNATURE OF ACCOUNT HOLDER DATE D D

Use of Personal Information Declaration

I hereby consent to Ambledown processing my personal information, including but not limited to, the administrative functions listed below.

- Processing this application;
- Processing of future instructions submitted;
- Communications with me in relation to any matters in relation to my policy.

I consent to Ambledown disclosing and transferring my personal information to any contracted 3rd party for the purposes of collecting premiums, claim assessments and statutory reporting in connection with this contract.

I acknowledge I have the right to –

- object to the processing of my personal information on reasonable grounds unless legislation allows for such processing, in the manner prescribed by the POPI Act;
- lodge a complaint with the Information Regulator;
- request from Ambledown details of any of my personal information Ambledown holds on my behalf and details of how my personal information has been processed.

Ambledown will use its best endeavors to ensure your personal information is reliable, however it remains your responsibility to advise Ambledown of any changes to your personal information in a timely manner. The information supplied to Ambledown must be complete, correct and up to date.

I understand why my personal information is required and the purpose it will be used and I, hereby, give Ambledown consent to process my personal information as provided above.

SIGNATURE OF APPLICANT PRINTED NAME OF APPLICANT DATE D D M M Y Y Y Y

Participating Entities

- Insurer/underwriter - Guardrisk Insurance Company Limited (GICL), a licensed non-life Insurer, a Cell Captive Insurer and an authorised financial services provider, Reg. No. 1992/001639/06, FSP No. 75. Tel: 011 669 1000 / www.guardrisk.co.za.
- Vida Product Services (Pty) Ltd (Vida), a Cell Captive Owner and an authorised financial services provider, Reg. No. 2021/447551/07, FSP No. 52285.
- Ambledown Financial Services (Pty) Ltd (Ambledown), an Underwriting Manager Agency (UMA) and an authorised financial services provider, Reg. No. 2004/006271/07, FSP No. 110287.
- Your broker – Please refer to section labeled "Broker Details".

Relationship between Vida and GICL

This Policy is subject to a cell captive relationship between GICL and Vida, as a result of a shareholder and subscription agreement concluded between GICL and Vida, whereby Vida is entitled to share in the profits and losses generated by the insurance business.

Therefore, this is an arrangement whereby GICL shares equity with Vida through a shareholding arrangement and provides Vida a vehicle through which to write insurance risks.

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 should this application not be considered as part of a full financial needs analysis and I have instructed the broker not to proceed with a full financial needs analysis, this 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 during a general 3 month waiting period for all treatment received unless the treatment was required as a result of an accident (external violent physical means).
b. No benefits will be payable for treatment during the first 12 months of the policy if treatment or advice was received 12 months prior to inception of the policy that related to the subsequent treatment.
c. 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.
    i. Only one spouse is allowed.
    ii. The maximum age for a child dependant is under 21. This age may be extended to 25 (under 26) in respect of an unmarried child who is a dependant on the Principal Insured Person's Medical Scheme.
    iii. No cover is provided for extended family members.

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.

I confirm that a key information disclosure document has been provided to me by my intermediary / broker that sets out key information. The key information document can also be viewed on: www.ambledown.co.za/compliance

SIGNATURE OF APPLICANT PRINTED NAME OF APPLICANT DATE D D M M Y Y Y Y

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

Brokerage: FSP number:
Tel number: Email address:

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