TD Administrative Services (Pty) Ltd
Reg No 2014/090534/07
An authorised financial service provider
FSP7379
Tel: 086 111 2348
E-mail: enquiries@tdas.co.za
Unit 1, Coram Park
86 Ferero Avenue
Randpark Ridge, 2169
www.tdas.co.za

GAP COVER: APPLICATION FOR MEMBERSHIP

THIS IS NOT A MEDICAL SCHEME AND THE COVER IS NOT THE SAME AS THAT OF A MEDICAL SCHEME
THIS POLICY IS NOT A SUBSITUTE FOR MEDICAL SCHEME MEMBERSHIP

PERSONAL PARTICULARS OF APPLICANT

SURNAME				
FIRST NAMES				
TITLE	MR	MRS	MS	OTHER:
ID NUMBER				
POSTAL ADDRESS				
CELLPHONE NUMBER				
HOME TELEPHONE NUMBER				
WORK TELEPHONE NUMBER				
EMAIL ADDRESS				

Note – we will communicate via email unless specifically requested otherwise

Date cover to commence	
Note – cover may not be backdated. Unless advised otherwise cover will commence on the 1st day of the month following receipt of the application form	
Cover:	Gap **and** Gap Plus (including co-payment cover)
Medical Aid Company	
Medical Aid Option	
Medical Aid Number	

Please indicate spouse and children that are covered under your medical aid

First Name	Surname	ID Number	Relationship
			Spouse
			Child 1
			Child 2
			Child 3
			Child 4
			Child 5

COVER IS RESTRICTED TO THE MAIN MEMBER OF THE MEDICAL AID, THEIR SPOUSE, WHO IS LISTED AS A DEPENDENT ON THE MAIN MEMBER'S MEDICAL AID, ANY UNMARRIED CHILDREN WHO HAVE NOT YET TURNED 21 YEARS OF AGE OF THE MAIN MEMBER OR SPOUSE LISTED ON THE MAIN MEMBERS MEDICAL AID.

PARENTS, EVEN IF ON THE MAIN MEMBERS MEDICAL AID, ARE NOT COVERED UNDER THIS POLICY.

MEDICAL QUESTIONNAIRE – PLEASE CIRCLE EITHER THE Y OR N ALL QUESTIONS MUST BE ANSWERED		
1	DO YOU OR ANY OF YOUR DEPENDANTS SUFFER FROM ANY CHRONIC OR RECURRING ILLNESS OR ANY OTHER SERIOUS AILMENT?	Y / N
2	HAVE YOU OR ANY OF YOUR DEPENDANTS BEEN HOSPITALISED DURING THE PRECEDING 5 YEARS? IF '"YES" PLEASE SPECIFY THE CONDITION / DATE AND DEPENDANT FOR WHICH HOSPITALISATION WAS NECESSARY	Y / N
3	DO YOU OR ANY OF YOUR DEPENDANTS EXPECT TO BE HOSPITALISED DURING THE NEXT 12 MONTHS? IF '"YES" PLEASE SPECIFY THE CONDITION / DEPENDANT FOR WHICH HOSPITALISATION MAY BE NECESSARY	Y / N
4	ARE YOU OR ANY OF YOUR DEPENDANTS CURRENTLY PREGNANT	Y / N

ALL CLAIMS ARE EXCLUDED FOR THE FIRST THREE MONTHS OF COVER AND PRE-EXISTING CONDITIONS AND PREGNANCY ARE NOT COVERED DURING THE FIRST 12 MONTHS OF COVER

DEBIT ORDER DETAILS

ACCOUNTHOLDER NAME		BANK			
ACCOUNT NUMBER		BRANCH			
BRANCH CODE		TYPE	CURRENT	SAVING	TRANSMISSION

Having applied for the policy detailed above, and on acceptance of my application by the insurer, I hereby authorise the insurer or its representative to debit my account with 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.

DECLARATION BY INSURED MEMBER

I declare that, to the best of my knowledge, all the information disclosed on this questionnaire is true and correct. I understand that if I withhold information or submit false information, the policy will be invalid, and I will forfeit any premiums that I have paid. I am applying for membership of the indicated policy. I confirm that I understand the full details of the policy, and that it is my responsibility to advise the administrator should my personal particulars change.

Replacement: It is usually not in your best interest to replace an existing insurance policy

POPIA

I hereby consent to TD Administrative Services 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 TD Administrative Services 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 TD Administrative Services details of any of my personal information TD Administrative Services holds on my behalf and details of how my personal information has been processed.

TD Administrative Services will use its best endeavors to ensure your personal information is reliable, however it remains your responsibility to advise TD Administrative Services (Pty) Ltd of any changes to your personal information in a timely manner. The information supplied to TD Administrative Services 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 TD Administrative Services consent to process my personal information as provided above.

Applicant Signature		Date	

VERY IMPORTANT

Cover has not been granted, implied or otherwise, under this application until you have received written confirmation from the administrator

TD Administrative Services (Pty) Ltd (Reg. No 2014/090534/07) is an authorised Financial Services Provider and is acting as a non-mandated intermediary on behalf of Guardrisk Insurance Company Limited (Reg. No 1992/0016939/06), the Insurer of this policy, in terms of an agreement between the parties entered into as required in terms of section 48 A of the Short-Term Insurance Act No 53 of 1998. TD Administrative Services performs binder and administrative functions.