UCT STAFF GAP COVER SERIES
CHANGE OF OPTION APPLICATION FORM

Underwritten by Constantia Insurance Company Limited (CICL), Reg. No. 1952/001514/06, FSP No: 31111 (The Insurer)

- **THIS IS NOT A MEDICAL SCHEME AND THE COVER IS NOT THE SAME AS THAT OF A MEDICAL SCHEME.**
- **THIS POLICY IS NOT A SUBSTITUTE FOR MEDICAL SCHEME MEMBERSHIP.**
- **THE MASTER POLICY ISSUED IS THE SOURCE OF ALL BENEFITS, RIGHTS, AND OBLIGATIONS AND EXCLUSIONS. TO DETERMINE YOUR INDIVIDUAL NEEDS, WE SUGGEST THAT YOU CONTACT YOUR BROKER AND REQUEST ADVICE FROM HIM / HER.**

BROKER DETAILS

BROKER / CONSULTANT NAME			
NAME OF BROKERAGE			
FSP NUMBER		BROKER CODE	
BROKER CONTACT NUMBER	AREA CODE	VAT NUMBER	
BROKER E-MAIL ADDRESS		UNIQUE IDENTIFIER (IF NECESSARY)	

PERSONAL PARTICULARS

APPLICANT

TITLE		SURNAME	
ID OR PASSPORT NUMBER		FIRST NAMES	
DATE OF BIRTH	D D M M Y Y Y Y		

EMPLOYER

NAME OF EMPLOYER		DATE EMPLOYED	D D M M Y Y Y Y

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
			D D M M Y Y Y Y

CONTACT DETAILS

POSTAL ADDRESS		PHYSICAL ADDRESS (IF DIFFERENT TO POSTAL)	
POSTAL CODE		POSTAL CODE	
HOME NUMBER	AREA CODE	WORK NUMBER	AREA CODE
CELL NUMBER	AREA CODE	E-MAIL	

BENEFITS SUMMARY

BENEFIT	DESCRIPTION
GAP SERIES	• GAP COVER 100 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. LIMITED TO 5 TIMES THE SCHEME TARIFF. • CO-PAYMENT BENEFIT COVERS CO-PAYMENTS OR DEDUCTIBLES LEVIED BY THE MEDICAL SCHEME FOR IN-HOSPITAL ADMISSIONS, LISTED OUTPATIENT PROCEDURES AND MRI AND CT SCANS. • SUBLIMITATION BENEFIT COVERS CHARGES ABOVE THE DEFINED IN-HOSPITAL SUB-LIMITS IMPOSED BY THE MEDICAL SCHEME. • CANCER BENEFIT COVERS THE SHORTFALL, EITHER THE CO-PAYMENT AFTER THE SUB-LIMITATION OR THE SUB-LIMITATION FOR CANCER TREATMENT FOR TRADITIONAL METHODS OR FOR EITHER THE CO-PAYMENT OR SUB-LIMITATION FOR TREATMENT OF CANCER WITH BIOLOGICAL DRUGS. • 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.
DREAD DISEASE (SEVERE ILLNESS) BENEFIT	• PROVIDES A ONCE OFF DREAD DISEASE BENEFIT, LIMITED TO DIAGNOSIS OF CANCER. * SEE DREAD DISEASE EXCLUSIONS - SENIORS (66 YEARS & OLDER) EXCLUDED.
PREMIUM WAIVER BENEFIT	• PROVIDES A LUMP SUM PAYMENT EQUAL TO **6 MONTHS** OF THE MEMBER'S MEDICAL SCHEME CONTRIBUTION. - SENIORS (66 YEARS & OLDER) EXCLUDED.
LPE PRIMARY	• GAP COVER 100 BENEFIT; PLUS • PROVIDES 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. • 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.

PRODUCT SUMMARY & SELECTION

PRODUCT	LISTED BENEFITS	SPECIFIC LIMITATION PER INSURED PERSON PER ANNUM	OVERALL LIMITATION PER INSURED PERSON PER ANNUM	PREMIUM PER FAMILY PER MONTH (incl. VAT) **18-65 YEARS OLD**	PREMIUM PER FAMILY PER MONTH (incl. VAT) **66 YEARS & OLDER**
UCT KEY GAP	- GAP COVER 100		**R157,000**	☐ **R160.00**	
	- CASUALTY BENEFIT	**R10,000**			
	- MEDICAL EXPENSES RELATED TO 3 DEFINED PROCEDURES	**A R50,000 LIMITATION APPLIES TO ANY ONE OF THE 3 DEFINED PROCEDURES**			
UCT GAP PLUS SENIOR	- GAP COVER 100 - CO-PAYMENT COVER		**R157,000**		☐ **R370.00**
	- CASUALTY BENEFIT	**R10,000**			
UCT GAP CANCER	- GAP COVER 100 - CO-PAYMENT COVER - CANCER COVER		**R157,000**	☐ **R220.00**	
	- CASUALTY BENEFIT	**R10,000**			
	- DREAD DISEASE BENEFIT	**ONCE OFF R50,000 ON DIAGNOSIS**	*** See dread disease exclusions**		
UCT GAP IN-HOSPITAL	- GAP COVER 100 - CO-PAYMENT COVER - SUB-LIMIT COVER		**R157,000**	☐ **R300.00**	
	- CASUALTY BENEFIT	**R10,000**			
UCT GAP COMPREHENSIVE	- GAP COVER 100 - CO-PAYMENT COVER - SUB-LIMIT COVER - CANCER COVER		**R157,000**	☐ **R320.00**	
	- CASUALTY BENEFIT	**R10,000**			
	- DREAD DISEASE BENEFIT	**ONCE OFF R50,000 ON DIAGNOSIS**	*** See dread disease exclusions**		
UCT GAP EXECUTIVE	- GAP COVER 100 - CO-PAYMENT COVER - SUB-LIMIT COVER - CANCER COVER		**R157,000**	☐ **R335.00**	
	- CASUALTY BENEFIT	**R10,000**			
	- DREAD DISEASE BENEFIT	**ONCE OFF R50,000 ON DIAGNOSIS**	*** See dread disease exclusions**		
	- PREMIUM WAIVER BENEFIT	**LIMITED TO 6 MONTHS MEDICAL AID CONTRIBUTIONS**	**** See premium waiver exclusion**		

INCEPTION DATE (DATE COVER IS TO COMMENCE) D D M M Y Y Y Y

*** 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 (66 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 (66 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 HOLDERS NAME		BANK / BUILDING SOCIETY	
ACCOUNT NUMBER		BRANCH	
BRANCH CODE		ACCOUNT TYPE	☐ CURRENT
			☐ 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 it's 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 30 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.

AGREEMENT OF APPLICANT DATE D D M M Y Y Y Y

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 and is financially dependent on the Principal Insured Person.
   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.

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

Broker Details: NMG Consultants And Actuaries (Proprietary) Limited, FSP No: 12968, Tel: 031 566 2133, Fax: 031 566 2181