

Underwritten by Guardrisk Insurance Company Limited (GICL), a licensed non-life Insurer, Reg. No. 1992/001639/06, FSP No. 75.

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 email address:

Unique identifier (if necessary):



Personal details

Applicant *FICA requirements

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:

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

Do you have an existing Gap Cover policy?:

Yes:

No:

Employer

Name of employer:

Date employed: D D M M Y Y Y Y

Occupation:

Industry:

Medical scheme

Pick n Pay medical scheme:

Other medical scheme:

Date joined: D D M M Y Y Y Y

Other medical scheme number:

Dependants (to see who qualifies as a dependant see declaration a)

First name (and surname if different)

Relationship

ID or passport number

Date of birth

| | | | | | | | | | | | | | | | | | |
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Contact details *FICA requirements

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:

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 |
|----------------|---|--|---|--|
| Gap Supreme | - Gap Cover 100 - Co-payment Cover | | R198,660 or any higher amount published by the Regulator | ○ |
| | - 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 | |
| | - ER24 Virtual Support & Boston Online Home Education | | | |

*** Dread Disease exclusions:**

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

- 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

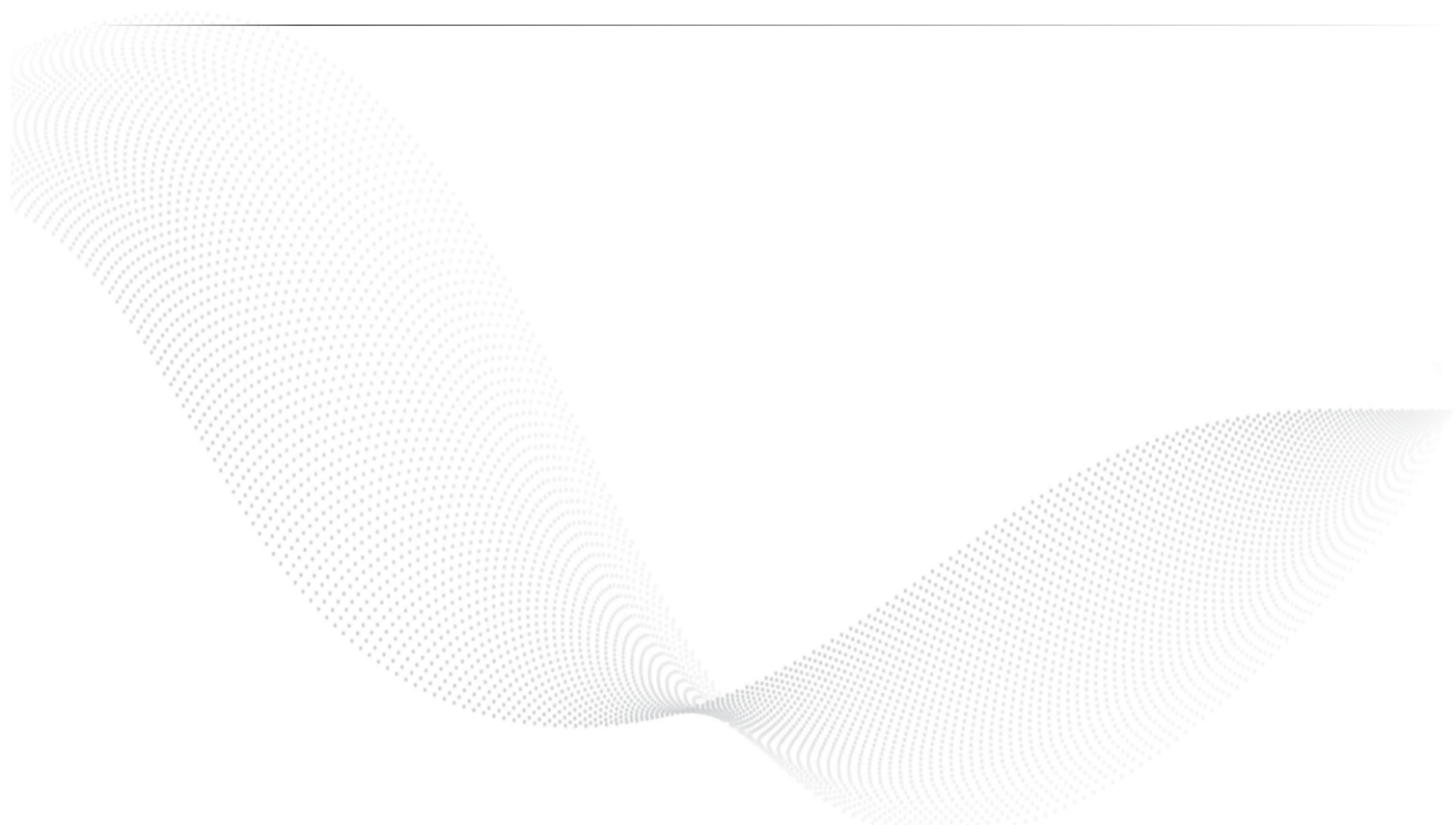
- The Dread Disease benefit terminates at the member reaching the benefit expiry age, or age 65.

**** Premium Waiver exclusion:**

- Seniors, over the age of 65 excluded.

Specific condition

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





Premium payment

Payroll details (for active employees)

| | |
|--------------------------------|-------------------|
| Employer name: | Employee name: |
| Employee cost centre: | Employee surname: |
| Date employed: D D M M Y Y Y Y | 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 M M Y Y Y Y

Debit order details (for retirees/continuation members)

If you do not receive a salary from Pick n Pay payroll, you need to complete this section

| | | |
|------------------------|--------------------------|--------------|
| Account holder's name: | Bank / building society: | |
| Account number: | Branch: | |
| Branch code: | Account type: | |
| Source of funds: | | Current |
| | | Transmission |
| | Savings | |

Please select preferred debit order collection date

1st

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 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



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

| | | | | | | | |
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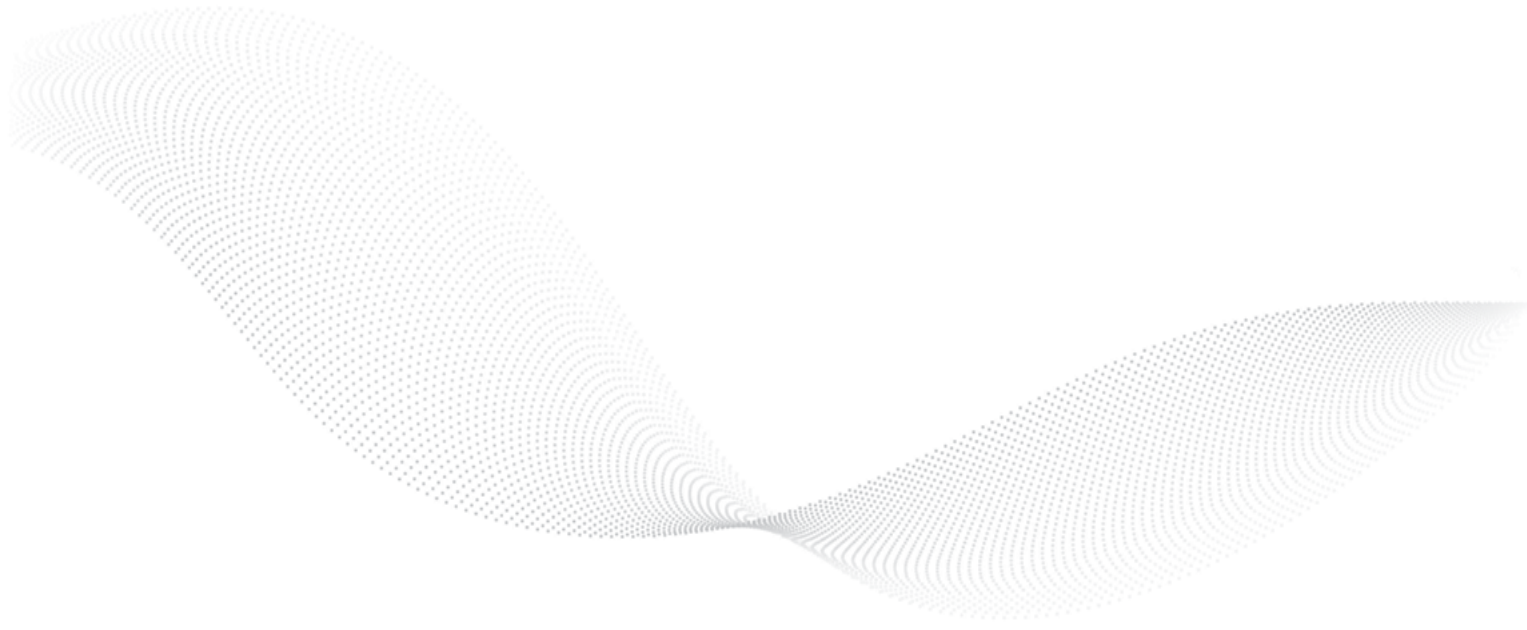
Participating Entities

- 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.
- 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.

SIGNATURE OF APPLICANT

PRINTED NAME OF APPLICANT

DATE

| | | | | | | | |
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| 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: premium@ambledown.co.za

NMG healthcare consultant: Le-Anne Mongie, Email: picknpaygap@nmg.co.za, Tel Office: 021 943 1800, Tel Direct: 021 943 1884,
7th floor, 78 On Edward, Edward Street, Bellville, South Africa
NMG Consultants and Actuaries (Pty) Ltd – FSP1296