

1. CREATE YOUR PROFILE

Speak with your HR representative or the financial advisor appointed by your employer about the **Corporate Gap Cover** option available to you and the terms and conditions of cover. Based on the discussion, please select the type of application which will form the basis of your contract with us.

New or existing employee who isn't already covered by a **Gap Cover** policy (Complete Sections 3, 4, 6 and 10 - 14. Section 2 is for your HR representative to complete, and Sections 5 and 7 are for your appointed financial advisor to complete.)

Employee switching cover from another **Gap Cover** provider (Complete Sections 3, 4, 6 and 10 - 14, and submit a recent copy of your policy document dated not older than 31 days for underwriting purposes. Section 2 is for your HR representative to complete, and Sections 5, 7 and 9 are for your appointed financial advisor to complete.)

2. EMPLOYER GROUP DETAILS

Employer Group	<input type="text"/>	Employer Group Branch (if applicable)	<input type="text"/>
HR Representative	<input type="text"/>	HR Representative Email Address	<input type="text"/>
Employer Group Stamp / Authorised Signatory	<input type="text"/>		
	Employee Number	<input type="text"/>	
	Employee Appointment Date	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y - <input type="text"/> M <input type="text"/> M - <input type="text"/> D <input type="text"/> D	

(Submit written confirmation from your HR representative that confirms your employment date if you're applying for cover within 90 days of your permanent employment date for underwriting purposes.)

3. MAIN APPLICANT DETAILS

Title	<input type="text"/>	Name	<input type="text"/>	Surname	<input type="text"/>	
ID/Passport No.	<input type="text"/>	Date of Birth	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y - <input type="text"/> M <input type="text"/> M - <input type="text"/> D <input type="text"/> D			
Cellphone No.	<input type="text"/>	Alternative Contact No.	<input type="text"/>			
Physical/Postal Address	<input type="text"/>				Postal Code	<input type="text"/>
Email Address	<input type="text"/>	Medical Aid	<input type="text"/>			
Membership No.	<input type="text"/>	Medical Aid Plan	<input type="text"/>			

4. DEPENDANT DETAILS

Joining as a family? We'll cover you and your spouse on one **Gap Cover** policy, even if you belong to different medical aids or medical aid plans, including the dependants registered on either medical aid plan. Speak with your HR representative or the group's appointed financial advisor about adding your dependants.

If your employer agrees to your dependants joining, add them to your policy whenever you add a dependant to your medical aid plan, as this doesn't happen automatically. When your child dependants move to their own medical aid plans, they must apply for cover on their own **Gap Cover** policies.

Title	<input type="text"/>	Name	<input type="text"/>	Surname	<input type="text"/>
Relationship	<input type="text"/>			ID/Passport No.	<input type="text"/>
Medical Aid	<input type="text"/>			Membership No.	<input type="text"/>
Medical Aid Plan	<input type="text"/>			Date of Birth	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y - <input type="text"/> M <input type="text"/> M - <input type="text"/> D <input type="text"/> D

Title	<input type="text"/>	Name	<input type="text"/>	Surname	<input type="text"/>
Relationship	<input type="text"/>			ID/Passport No.	<input type="text"/>
Medical Aid	<input type="text"/>			Membership No.	<input type="text"/>
Medical Aid Plan	<input type="text"/>			Date of Birth	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y - <input type="text"/> M <input type="text"/> M - <input type="text"/> D <input type="text"/> D

Title	<input type="text"/>	Name	<input type="text"/>	Surname	<input type="text"/>
Relationship	<input type="text"/>			ID/Passport No.	<input type="text"/>
Medical Aid	<input type="text"/>			Membership No.	<input type="text"/>
Medical Aid Plan	<input type="text"/>			Date of Birth	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y - <input type="text"/> M <input type="text"/> M - <input type="text"/> D <input type="text"/> D

Title	<input type="text"/>	Name	<input type="text"/>	Surname	<input type="text"/>
Relationship	<input type="text"/>			ID/Passport No.	<input type="text"/>
Medical Aid	<input type="text"/>			Membership No.	<input type="text"/>
Medical Aid Plan	<input type="text"/>			Date of Birth	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y - <input type="text"/> M <input type="text"/> M - <input type="text"/> D <input type="text"/> D

5. BROKERAGE & FINANCIAL ADVISOR DETAILS

Brokerage	<input type="text"/>	Financial Advisor	<input type="text"/>
Brokerage Code	<input type="text"/>	Advisor Code	<input type="text"/>
		Advisor Signature	<input type="text"/>

6. CORPORATE GAP COVER OPTIONS & EXCLUSIONS



Your monthly premium is stated in the quote your employer accepted. Your HR representative or the group's appointed financial advisor can provide premium details. Go to www.stratumbenefits.co.za/corporate-overviews/ or scan the QR code to read more about the benefits our Corporate Gap Cover options provide. Click **View Option** for benefit and general exclusions.



If the Gap Cover option your employer offers isn't shown here, please provide the option name:

Cover Start Date Y Y Y Y - M M - D D

7. RECOMMENDATION

Your financial advisor, as indicated in Section 5 - Brokerage & Financial Advisor Details, will give advice and recommend a Gap Cover option based on the information you provide.

If you don't agree with the advice or recommendation, you should bring this to your financial advisor's attention.

FOR YOUR FINANCIAL ADVISOR TO COMPLETE

This section aims to ensure the applicant's healthcare insurance needs have been reviewed to determine which Gap Cover option best suits their needs. Your recommendation based on these discussions is as follows:

Option	<input type="text"/>
Reasons for your recommendation	<input type="text"/>

FINANCIAL NEEDS ANALYSIS

Please indicate if a needs analysis was done.

A full needs analysis was done. The Insurer may request a copy of the signed document for auditing purposes at any time.

A full needs analysis wasn't done. The applicant understands and agrees with the recommendation.

8. WAITING PERIODS & LIMITED PAYOUT BENEFIT

Waiting periods may apply to you depending on the quote your employer accepted. If you join within **90 days** of your permanent employment date, you'll receive the waiting periods the employer group received when joining. Full waiting periods will apply if you join **after 90 days** of your permanent employment date. The **Cover Letter** you'll receive when your policy is activated will confirm the waiting periods for each insured person.

3 MONTH GENERAL WAITING PERIOD

There's no cover during this period, except for accidents that occur after your and your dependants' cover start dates.

EXCEPTION TO THE RULE

OUT-PATIENT SPECIALIST CONSULTATION BENEFIT offered on our **CORPORATE ELITE PLUS 500** option always receives a **3 Month General Waiting Period**.

12 MONTH PRE-EXISTING MEDICAL CONDITION WAITING PERIOD

There's no cover during this period for investigations, medical procedures, surgeries or treatments related to any illness or medical condition diagnosed or for which advice or treatment was received **12 months** before your or your dependants' cover start dates.

LIMITED PAYOUT BENEFIT

If you or your dependants claim from our **GAP BENEFIT**, **CO-PAYMENT BENEFITS** or **SUB-LIMIT BENEFIT** in the first **10 months** of cover for specific medical events, we'll cover between **20% and 100%** of the **approved claim amount** subject to applicable benefit limits.

The percentage is confirmed in the quote your employer accepted.

If the medical event is related to a medical condition for which you or your dependants received advice or treatment **12 months** before your cover start dates, the claim may be subject to a **Pre-Existing Medical Condition Waiting Period**.

Go to www.stratumbenefits.co.za/limited-payout-benefit/ or scan the QR code to read more about the medical events that form part of the Limited Payout Benefit.

By signing this application form, you acknowledge and accept that your policy may be subject to waiting periods and a limited payout benefit in the first **10 months** of cover for specific medical events.



9. REPLACEMENT POLICY DISCLOSURE FOR TRANSFER APPLICANTS

This section applies to you and your dependants applying to switch cover from another **Gap Cover** provider as indicated in **Section 1 - Create Your Profile**.

REPLACEMENT POLICY DISCLOSURE

- A change in terms and conditions, monthly premiums and benefits will apply as benefits and fee structures between the products offered by **Gap Cover** providers are different.
- If there's a break between the last day of cover with your current provider and the first day of cover with us, full waiting periods may apply.
- The **Cover Letter** you'll receive when your policy is activated will confirm the waiting periods for each insured person.

TRANSFER PROCESS & UNDERWRITING

If you switch cover when your existing policy is still within a **General Waiting Period**, the remainder of this waiting period may be carried over to your new policy.

PRE-EXISTING MEDICAL CONDITION WAITING PERIOD APPLICABLE TO **LIKE-FOR-LIKE BENEFITS** AND/OR **ENHANCED BENEFITS**

If you switch cover when your existing policy has been active for **less than 12 months**:

- the remainder of any **Pre-Existing Medical Condition Waiting Period** may be carried over to your new policy; and
- if our policy offers benefits that your existing policy doesn't offer, a **6 Month Pre-Existing Medical Condition Waiting Period** may apply to the enhanced benefits.

If you switch cover when your existing policy has been active for **12 months or longer**, a **6 Month Pre-Existing Medical Condition Waiting Period** may apply to the enhanced benefits.

Waiting periods that apply won't exceed the waiting periods confirmed in the quote the employer group accepted.

Please disclose any medical event planned in the first **10 months** of your policy's start date in **Section 11 - Planned Medical Events**.

By signing this application form, you acknowledge and accept that your policy may be subject to waiting periods.

FOR YOUR FINANCIAL ADVISOR TO COMPLETE

Please provide details of the policy replacement in the table below:

POLICY REPLACEMENT RECORD	CURRENT PRODUCT	REPLACEMENT PRODUCT
Name of Insurer		Guardrisk Insurance Company Limited
Product Name		
Cancellation and Cover Start Dates		
Premium		
Differences in Products		
Reasons for Transferring Cover		

10. PRE-EXISTING MEDICAL CONDITION DISCLOSURE

The question below must be answered regardless of whether a Pre-Existing Medical Condition Waiting Period will apply to you and your dependants.

Please let us know of any change in your or your dependants' health statuses between signing and submitting the application form and your policy's start date.

Have you or any of your dependants been diagnosed with any illness, seen by or been advised to see a healthcare provider, or visit a medical facility for an investigation, medical procedure, surgery, or test in the past 12 months, except for the common cold, routine dental work and routine check-up?

Yes No If "Yes", please provide more details about the last treatment date.

NAME	PRE-EXISTING MEDICAL CONDITION	LAST TREATMENT DATE
		Y Y Y Y - M M - D D
		Y Y Y Y - M M - D D
		Y Y Y Y - M M - D D
		Y Y Y Y - M M - D D
		Y Y Y Y - M M - D D

11. PLANNED MEDICAL EVENTS

Please indicate if any pre-existing medical condition stated in **Section 10 - Pre-Existing Medical Condition Disclosure** necessitates an investigation, medical procedure, surgery or treatment within the first **10 months** of your policy's start date.

NAME	PLANNED MEDICAL EVENT	MEDICAL EVENT DATE
		Y Y Y Y - M M - D D
		Y Y Y Y - M M - D D
		Y Y Y Y - M M - D D
		Y Y Y Y - M M - D D
		Y Y Y Y - M M - D D

12. YOUR PAYMENT PROFILE

Please complete this section if you're the policy premium payer.

By signing this section and upon acceptance of your application, you:

1. authorise **Stratum Benefits** to accept this debit order authority as confirmed payment instruction issued by the account holder.
2. authorise **Stratum Benefits** to debit your account for monthly policy premiums payable in advance on the selected debit order date.
3. understand that the debit order deductions will be processed through a computerised system provided by the South African Banks. Details of each deduction will be referenced on your bank statement with the prefix "**Stratum**" and an **8-digit number** ending with "**Netcash**".
4. understand that selecting an annual premium won't result in a premium discount.
5. accept that depending on the selected debit order date, a double or triple debit may be incurred.
6. understand that cover will commence after the first premium is received.
7. agree that this debit order authority will remain in force until cancelled in writing by the principal insured person.
8. accept that **Stratum Benefits** may cancel your policy if:
 - 8.1 premiums aren't received for two consecutive months;
 - 8.2 the bank account being debited is closed;
 - 8.3 the account holder is deceased; or if
 - 8.4 authority to debit is no longer granted.
9. understand that this debit order authority may only be assigned to a third party if this contract is assigned accordingly.
10. understand that the debit order date will default to the following working day if the payment date falls on a Sunday or recognised South African public holiday.
11. accept that if a debit order deduction is returned, an administration fee of **R 25.00** will be added to the following premium deduction.
12. accept that you're not entitled to any refund of amounts deducted while this debit order authority is in force if such payments are legally due.
13. understand that policy premiums include VAT but aren't tax deductible, as medical aid contributions. An IT3 tax certificate can't be issued for this purpose.
14. accept that the policy premium may be adjusted during an annual renewal or due to benefit restructuring necessitated by legislation with **31 days** written notice. Subject to your right of cancellation of cover, the debit order authority will extend to the adjusted premium.
15. accept that your responsibility is to ensure premiums are collected and paid to remain covered.

Account Type	<input type="checkbox"/> Cheque	<input type="checkbox"/> Savings	<input type="checkbox"/> Bank	<input type="text"/>	Account Number	<input type="text"/>					
Account Holder	<input type="text"/>										
Debit Order Date	<input type="checkbox"/> 1st	<input type="checkbox"/> 4th	<input type="checkbox"/> 7th	<input type="checkbox"/> 15th	<input type="checkbox"/> 20th	<input type="checkbox"/> 25th	<input type="checkbox"/> 28th	<input type="checkbox"/> Last Day	<input type="checkbox"/> Term	<input type="checkbox"/> Monthly	<input type="checkbox"/> Annual

FINANCIAL ADVISOR PROFESSIONAL FEE

You may pay your appointed financial advisor a professional fee over and above the monthly commission payable. If you agree to pay a fee, your advisor must explain the additional services you can expect for the fee.

The professional fee will be added to your policy premium and paid to your advisor monthly. You may cancel, reduce, or increase the professional fee anytime.

Professional Fee (Increments of R 10.00)	R <input type="text"/>	Product Premium	R <input type="text"/>	Total Monthly Premium	R <input type="text"/>	Account Holder Signature	<input type="text"/>
---	------------------------	-----------------	------------------------	-----------------------	------------------------	--------------------------	----------------------

13. PROSPECTIVE POLICYHOLDER CONSENT

As the main applicant applying for insurance cover, you understand and acknowledge that the **Gap Cover** policy you're applying for isn't a medical aid, doesn't provide similar cover as medical aid and can't be substituted for a medical aid membership.

As a prospective policyholder, you have the right to information about the insurer, underwriting manager, and other matters of importance about the insurance product you're purchasing.

Go to www.stratumbenefits.co.za/2024-stratum-benefits-pre-inception-disclosures/ or scan the QR code to view or download our **Pre-Inception Disclosure Notice**.

By signing this application form, you acknowledge that you've read the **Pre-Inception Disclosure Notice** and understand the terms and conditions.



Main Applicant Signature	<input type="text"/>	Date	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y	-	<input type="text"/> M <input type="text"/> M	-	<input type="text"/> D <input type="text"/> D
--------------------------	----------------------	------	---	---	---	---	---

14. PROTECTION OF PERSONAL INFORMATION

USE OF PERSONAL INFORMATION DECLARATION

Information is processed as set out in our **Privacy Policy**. By accepting these terms and conditions and providing personal information, you agree and permit us to use your data accordingly.

Go to www.stratumbenefits.co.za/popi-privacy-policy/ or scan the QR code to view or download our **POPI Privacy Policy**.

May we contact you for marketing purposes, for example, when we run competitions or launch new products? Yes No

How may we contact you? Email, SMS and Telephone Email only SMS only Telephone only



Send the completed application form to your financial advisor or email us at yourapplication@stratumbenefits.co.za.

Please contact us if you haven't received confirmation of cover or your policy documents within **7 working days** from submitting your application form.



Stratum Benefits (Pty) Ltd, an authorised FSP 2111, is underwritten by Guardrisk Insurance Company Limited, a licensed non-life insurer and authorised FSP 75.



010 593 0981 086 633 3761 yourapplication@stratumbenefits.co.za +27 10 448 0861

www.stratumbenefits.co.za