2020 COVER CONTINUATION FORM

Eligibility for continuation:

In order for cover to continue without waiting periods being applied the following conditions must be met:

1. There must not be a break in cover of more than 90 days between the cover termination date and the cover continuation date. If there is a break in cover of more than 90 days, waiting periods may be applied to you and your dependents' cover;
2. Application for continuation must be received before the cover termination date;
3. If you wish to also change your cover option on your continuation date, please complete and submit an option change form. An option change form is available at www.admedonline.co.za or email us on admed@guardrisk.co.za.
4. To update dependent details, please complete and submit a policy amendment form. A policy amendment form is available at www.admedonline.co.za/details or email us on admed@guardrisk.co.za.

YOUR PERSONAL DETAILS

Title		Surname																	
First name																			
Employer													Policy No.								
Identity no.													Date of birth	d	d	m	m	y	y	y	y
Cover termination date	d	d	m	m	y	y	y	y					Cover continuation date	d	d	m	m	y	y	y	y

YOUR CONTACT DETAILS

Home tel. no.											Mobile number									
Email address																				
Medical aid name													Plan option							
Medical aid No.													Date joined	d	d	m	m	y	y	y	y

YOUR CONTINUATION OPTION

Monthly Admed 2020 non-group rated premiums payable on continuation of cover

	Supreme Gap – R 377	Primary Gap – R 300
I want to continue my cover after I <u>retire</u> from my employer	☐	*(depending on you employer's arrangement your cover will continue as per employer group rates or individual rate)*
I want to continue my cover after I <u>resign</u> or I am <u>retrenched</u> or <u>dismissed</u> from my employer	☐	*(Your premium will change to Admed's non-group rated premium)*
I want to continue cover after my employer terminates its group policy	☐	*(Your premium will change to Admed's non-group rated premium)*
I want to continue cover following <u>death</u> of the principal insured on the policy	☐	*(If the employer allows, your cover will continue at the same premium. If not, your premium will change to the non-group rated premium*

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YOUR BANKING DETAILS

Your premium is payable monthly in advance on the first day of each month. This means that if you are moving from an arrears-paying policy, you may have to pay your last premium with your group policy and your first premium on your new individual policy at the same time

Account holder name		Bank name	
Branch name		Branch code	
Account number			

Type of account: Cheque ☐ Savings ☐ Transmission ☐

Please choose your debit day: 1st ☐ 7th ☐ 15th ☐ 20th ☐ 25th ☐

By initialling this box you: ☐

1. Authorise Guardrisk to debit your account with the monthly premium due in respect of this policy.
2. Acknowledge that this authorisation will remain in force and effect until cancelled by you, in writing with one calendar month's notice.
3. Understand that cancelling the Mandate does not cancel the Agreement. Agreement that the account holder is not entitled to refund for when the Mandate was still active, if such amounts were owed to them.
4. Acknowledge that this Authority may be assigned to a third party if this agreement is also assigned to a third party.
5. Understand and accept that should your premium be adjusted annually on renewal and in the case of benefit restructuring necessitated by changing legislation, with one month's notice and subject to your right of cancellation of cover, the aforementioned authorisation will extend to the adjusted premium.
6. Undertake to inform Guardrisk of any change in your banking details and you authorise Guardrisk to verify such banking details with your bank.
7. Confirm that Guardrisk shall not be held liable for incorrect claim payments made as a result of your failure to inform Guardrisk of your change in banking details
8. Accept that Guardrisk may debit your account on a date other than that specified.
9. Notwithstanding the fact that you grant Guardrisk permission to collect premiums, you acknowledge that it is your responsibility to ensure that premiums are collected for cover to remain in force.
10. Acknowledge that the first payment date will be the first day of the month in which your cover starts.
11. Acknowledge that in the event that the payment day falls on a Sunday, or recognised South African public holiday, the payment day will automatically be the very next ordinary business day.
12. Acknowledge that payment instructions issued from this Mandate will be treated as payment instructions issued personally by the accountholder.
13. Understand that the agreement reference number will be your membership number which will only issued once your application form has been captured.
14. Understand that the debit order transaction on your bank statement will reflect as 'ADMED'.

_____
Signature of bank account holder

Date signed: d d m m y y y y

YOUR DECLARATION AND CONSENT

Please initial each of the following sentences below to confirm that you are in agreement with the statement:

1. I hereby apply for continuation of my Admed cover and I agree to abide by its rules. ☐
2. I declare my understanding that this insurance product is not a substitute for medical scheme cover and that it does not replace my, or my dependents' medical scheme cover. ☐
3. I understand that this product does not insure against every shortfall in medical scheme cover and that I am aware of the circumstances in which my and my dependents' cover will and will not pay. ☐

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4. I further declare my understanding that my and my dependents' eligibility for cover is dependent on my, and my dependents remaining active members of a registered medical scheme and I undertake to advise Guardrisk if I terminate my, or my dependents' medical scheme membership at any time. ☐

5. I authorise the disclosure of relevant medical information by my medical scheme to Guardrisk to assist in the processing of claims under this policy. This information could include my (or one of my dependents') diagnosis, treatment and medical history. I further confirm that my dependents and/or beneficiaries have also provided the necessary authority for their medical scheme to disclose their relevant medical information to Guardrisk to assist in the processing of claims under this policy. ☐

6. I authorise Guardrisk to obtain from any person, medical practitioner or institution, any information that Guardrisk requires for purposes of claims arising from this policy. I authorise such person(s) to give the said information to Guardrisk, and to share with other insurers and medical schemes any information in this application or in any related policy or other document, either directly or through a database operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as Guardrisk or the operators of such database may decide from time to time. I acknowledge that I cannot cancel this authorisation and that it will endure after my death. ☐

7. I authorise Guardrisk to use, review and process any of my or my dependents' personal information provided to Guardrisk in the course of this application and for the purpose of administering cover and processing of future claims under this policy. I further confirm that my dependents and/or beneficiaries have also provided me with the authority to disclose their personal information to Guardrisk. ☐

8. I confirm that I am aware of my right to request a copy of my and my dependents' personal information that Guardrisk holds, that I have the right to request that such personal information is updated, corrected or deleted by Guardrisk and that I have the right to object to the processing of my personal information by lodging a complaint with the Information Regulator. ☐

9. I authorise Guardrisk, or its appointed service provider, to negotiate on my behalf with my medical scheme in respect of shortfall claims that may have arisen from medical events which my medical scheme is legally obliged to cover in full. ☐

10. I authorise Guardrisk to negotiate discounts on my behalf with medical service providers in order to maintain a good risk profile for my cover. If successful, I acknowledge that payment will be made directly to the service provider's bank account and no further payment will be due to me. ☐

11. I undertake to notify Guardrisk of any change in my personal details within a reasonable time period and you indemnify Guardrisk against any liability for any loss that may result from your failure to notify Guardrisk of such change in a timeous manner. ☐

Date signed:

d	d	m	m	y	y	y	y

_____
Signature of Applicant