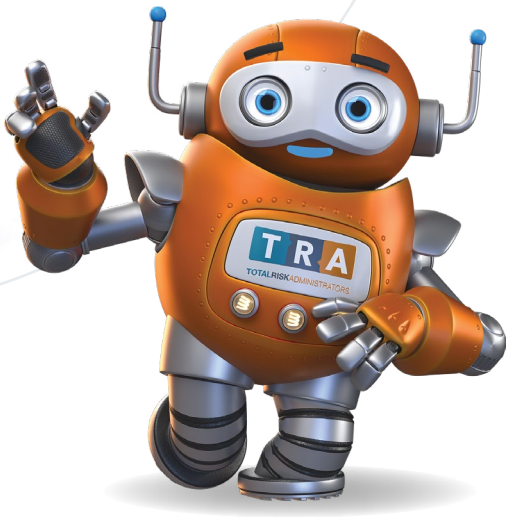
www.totalrisksa.co.za

GAP COVER

In-Hospital Medical Shortfall Cover



2027

PREMIUMS AND BENEFITS

GAP COVER

THE FOLLOWING BENEFITS ARE SUBJECT TO THE APPLICABLE STATUTORY ANNUAL LIMIT PER INSURED PERSON

This amount is calculated annually according to the prescribed table under Regulation 7.2(1) of Regulation 7.2(2) - Policy benefits escalation, in terms of the Short-term Insurance Act, 1998 (Act No. 53 of 1998). This amount is adjusted annually using the official CPI as published by Statistics South Africa (as defined in the Statistics Act, 1999 (Act No. 6 of 1999).

Click HERE to see a table showing the latest limit amount.

PRODUCT	BASIC COVER 300	VITAL COVER PLUS	SUPER COVER PLUS	ABSOLUTE COVER PLUS
Gap Cover In and out-of-hospital tariff shortfalls The **shortfall** that arises after your medical aid has processed your account and is due to service providers charging above scheme tariff for authorised procedures e.g. childbirth. The cover is limited to a percentage of the original scheme tariff. (Subject to the shortfall being paid from the In-Hospital or Major Medical Benefit). Out-of hospital shortfalls are subject to a defined list of procedures. Click HERE to view.	300%	700%	700%	700%
Prescribed Minimum Benefits A set of defined benefits, as per the Medical Schemes Act, in terms of which all medical schemes have to cover the costs related to the diagnosis, treatment and care of: any emergency medical condition; a limited set of 270 medical conditions; and 27 chronic conditions.	Covered, subject to medical aid review	Covered, subject to medical aid review	Covered, subject to medical aid review	Covered, subject to medical aid review
Tariff Shortfalls for Theatre and Ward Fees, Consumables, Laparoscopic/Endoscopic Equipment Applies to authorised in-hospital and in-lieu of hospital procedures, where the medical aid pays a portion of the fees from its in-hospital or major medical benefit. (Includes MRI/CT/PET scans consumables.)	R550 per policy per annum	R1 100 per policy per annum	R3 310 per policy per annum	R5 510 per policy per annum
Tariff Shortfall for Targeted Pain Relief Pain Relief Benefit - Provides cover for targeted pain relief treatment during surgery or following a severe trauma. This is covered even if the medical aid pays from day-to-day benefits or savings, provided the treatment forms part of an authorised in-hospital procedure, funded from the medical aid's Risk or Major Medical Benefit.	Unlimited but subject to the aggregate annual limit per insured person per annum	Unlimited but subject to the aggregate annual limit per insured person per annum	Unlimited but subject to the aggregate annual limit per insured person per annum	Unlimited but subject to the aggregate annual limit per insured person per annum
Tariff Shortfall Benefit for Hospitalised Psychiatric Care Tariff Shortfall cover for service provider costs related to in-hospital mental health admissions requiring psychiatric care.	21 days	21 days	21 days	21 days
Step-Down facility Benefit A once-off lump sum **from day 11** onwards for extended stays in a registered step-down or sub-acute care facility following hospitalisation.	No Benefit	No Benefit	R8 400 per insured person per annum	R12 600 per insured person per annum
Shortfalls on Specialist Consultations Cover for specialist consultations before a related in-hospital procedure. Claims must be submitted after discharge from hospital. **Limited to the following number of consults p.p.p.a (up to a max of R530 per consult)**	1 consult per policy per annum	2 consults per policy per annum	3 consults per policy per annum	4 consults per policy per annum
Casualty Unit Benefit (Casualty/ER Unit linked to a hospital) • Accidents only, including sports related injuries. • Children under the age of 8 ONLY - May be admitted for any treatment between the hours of 7pm to 7am from Monday to Friday, from 7pm on a Friday until 7am on a Monday, and all day on a public holiday.	Up to R3 820 per policy per annum	Up to R10 190 per policy per annum	Up to R15 050 per policy per annum	Up to R25 470 per policy per annum
Casualty follow-up consultations (The initial treatment must have taken place in a casualty/ER unit linked to a hospital following an accident.)	1 follow-up consultation per policy per annum at an ER unit *(accident-related only)*	1 follow-up consultation per policy per annum at an ER unit *(accident-related only)*	1 follow-up consultation per policy per annum at an ER unit *(accident-related only)*	1 follow-up consultation per policy per annum at an ER unit *(accident-related only)*
Emergency Medical Services (ambulance) The **shortfall** related to the use of Out-of-Network (Non-DSP) emergency medical services.	No Benefit	No Benefit	No Benefit	Unlimited but subject to the aggregate annual limit per insured person per annum
Co-Payment Benefit In Network • The co-payment or deductible that your medical aid charges you for certain in-hospital procedures, **e.g. a gastroscopy, colonoscopy, sigmoidoscopy or proctoscopy**. • The co-payment or deductible that your medical aid charges you for certain procedures performed in the doctor's rooms **e.g. a gastroscopy, colonoscopy, sigmoidoscopy or proctoscopy** BUT which have been authorised and paid from the In-Hospital or Major Medical benefit. • This co-payment or deductible is NOT related to the scheme tariff and service provider charge **shortfall** or designated service provider arrangements.	No Benefit	Up to R15 050 per policy per annum	Up to R69 460 per policy per annum	Unlimited but subject to the aggregate annual limit per insured person per annum
Co-Payment Benefit Out of Network i.e. Voluntary use of a non-designated service provider • The co-payment or deductible that your medical aid charges you for certain in-hospital procedures. • This co-payment or deductible is NOT related to the scheme tariff and service provider charge **shortfall** or designated service provider arrangements.	No Benefit	No Benefit	1 co-payment per policy per annum Up to R5 790	2 co-payments per policy per annum up to a combined limit of R18 520
Co-Payment Benefit Out Of Hospital MRI / CT / PET Scans The co-payment or deductible that your medical aid charges you for MRI / CT / PET scans BUT which have been authorised and paid from the In-Hospital or Major Medical benefit.	No Benefit	No Benefit	1 MRI / CT / PET scan per policy per annum up to R13 890	2 scans per policy per annum. Unlimited but subject to the aggregate annual limit per insured person per annum
Sub-Limit Benefit Internal Prostheses Covers the shortfall after your medical aid sub-limit for internal prostheses is reached, where authorised and paid from In-Hospital or Major Medical benefits. Subject to policy exclusions; stimulators and electrodes are excluded.	No Benefit	Up to R6 060 per policy per annum	Up to R12 730 per policy per annum	Unlimited but subject to the aggregate annual limit per insured person per annum. Up to R75 250 per event
Sub-Limit Benefit MRI / CT / PET Scans The **shortfall** on a service provider account that is not covered because you have reached the sub-limit for MRI / CT / PET scans imposed by your medical aid AND which has been authorised and paid from the In-Hospital or Major Medical benefit.	No Benefit	No Benefit	1 MRI / CT / PET scan per policy per annum up to R4 170	2 MRI / CT / PET scans per policy per annum up to R6 950 per scan
Sub-Limit Colonoscopies and Gastroscopies The **shortfall** on a service provider account that is not covered because you have reached the sub-limit for Colonoscopies and Gastroscopies imposed by your medical aid AND which has been authorised and paid from the In-Hospital or Major Medical benefit.	No Benefit	No Benefit	Up to R15 050 per policy per annum. Up to R3 970 per event	Up to R25 440 per insured person per annum. Up to R6 620 per event
Dental Benefit The **shortfall** that arises after your medical aid has processed your account and is due to service providers charging above scheme tariff for authorised dental procedures performed in hospital or in doctor's rooms and paid from the in-hospital or major medical benefit only. The cover is limited to a percentage of the original scheme tariff, as follows: • **Adults and dependants over 18 years of age:** Treatment of impacted wisdom teeth, extractions, apicectomies or loss of teeth due to oncology or trauma ONLY. • **Dependants up to 18 years of age:** Any procedure or treatment.	Unlimited but subject to the aggregate annual limit per insured person per annum	Unlimited but subject to the aggregate annual limit per insured person per annum	Unlimited but subject to the aggregate annual limit per insured person per annum	Unlimited but subject to the aggregate annual limit per insured person per annum
Global Fee Benefit Where a global fee has been negotiated between a medical aid and service providers for a specific procedure **e.g. robotic assisted procedures using the Da Vinci Robotic (DVR) system and other robotic surgery.** (which includes ALL costs related to that procedure) and service providers charge amounts in excess of this global fee (not related to a tariff rate, co-payment or sub-limit).	No Benefit	No Benefit	Up to R13 890 per policy per annum	Up to R27 780 per policy per annum

PRODUCT		BASIC COVER 300	VITAL COVER PLUS	SUPER COVER PLUS	ABSOLUTE COVER PLUS
Oncology Gap Benefit The **shortfall** that arises after your medical aid has processed your account and is due to service providers charging above scheme tariff for medical aid approved oncology treatment plans. ***(NB: Subject to the gap cover percentage; and medical aid approved treatment plan being covered up to scheme tariff and within annual scheme oncology limit).***		Unlimited but subject to the aggregate annual limit per insured person per annum	Unlimited but subject to the aggregate annual limit per insured person per annum	Unlimited but subject to the aggregate annual limit per insured person per annum	Unlimited but subject to the aggregate annual limit per insured person per annum
Oncology Co-Payment Benefit: In Network • The co-payment or deductible that your medical aid charges you for certain in-hospital procedures. This co-payment is NOT related to the scheme tariff and service provider charge **shortfall** or designated service provider arrangements. • For claims where the medical aid will only pay a percentage for the approved treatment and the policyholder needs to pay the remaining percentage of the account. • All costs to be within the annual scheme oncology limit.		No Benefit	Up to R15 050 per policy per annum	Up to R69 460 per policy per annum	Unlimited but subject to the aggregate annual limit per insured person per annum
Oncology Co-Payment Benefit: Out of Network i.e. voluntary use of a non-designated service provider • The co-payment or deductible that your medical aid charges you for certain in-hospital procedures. This co-payment is NOT related to the scheme tariff and service provider charge **shortfall** or designated service provider arrangements. • For claims where the medical aid will only pay a percentage for the approved treatment and the policyholder needs to pay the remaining percentage of the account. • All costs to be within the annual scheme oncology limit.		No Benefit	No Benefit	1 co-payment per policy per annum. Up to R5 790	2 co-payments per policy per annum up to a combined limit of R18 520
Oncology Extender Benefit: Includes ANY approved costs above annual scheme oncology limit but subject to the medical aid scheme covering up to this limit.		No Benefit	No Benefit	Up to R40 520 per policy per annum	Unlimited but subject to the aggregate annual limit per insured person per annum
Oncology "New-Tech" Benefit Covers shortfalls / co-payments on innovative, high-cost, biological or Section 21 oncology drugs. Subject to a medical aid authorised treatment plan and use of designated service providers.		No Benefit	No Benefit	Up to R9 490 per policy per annum	Up to R19 100 per policy per annum
Oncology Gap Benefit: Breast Reconstruction Surgery The **shortfall** that arises after your medical aid has processed your account and is due to service providers charging above scheme tariff for medical aid approved oncology related breast reconstruction surgery, including the unaffected breast. ***(NB: Subject to the gap cover percentage; and medical aid approved treatment plan being covered up to scheme tariff and within the annual scheme oncology limit).***		No Benefit	No Benefit	Up to R20 840 per beneficiary per life of the policy	Up to R40 520 per beneficiary per life of the policy
Premature Birth Benefit A fixed payout is provided in the event of a baby being born before 34 completed weeks of gestation. (Excludes elective deliveries).		No Benefit	No Benefit	R15 750 per policy per annum	R21 000 per policy per annum
Maternity Follow-Up Consultations Cover for the **shortfall** on a specialist (OBGYN/Paediatrician) account related to a consultation in the rooms within 6 weeks after childbirth.		No Benefit	No Benefit	Up to R770 per consultation per policy per annum	Up to R1 380 per consultation per policy per annum
Private Ward Benefit The **shortfall** between the General Ward Rate and the Private Ward Rate for hospitalisation where an admission to a Private Ward occurred.	**For Childbirth:**	No Benefit	No Benefit	Limited to a maximum of R580 per day, for a total of 3 consecutive days	Limited to a maximum of R2 320 per day, for a total of 3 consecutive days
	For Non-Childbirth:	No Benefit	No Benefit	Limited to a maximum of R580 per day, for a total of 3 consecutive days	Limited to a maximum of R2 320 per day, for a total of 3 consecutive days

THE FOLLOWING BENEFITS ARE NOT SUBJECT TO THE AGGREGATE ANNUAL LIMIT

PRODUCT		BASIC COVER 300	VITAL COVER PLUS	SUPER COVER PLUS	ABSOLUTE COVER PLUS
Accidental Death Cover A lump sum payout for death due to an accident.	**Insured / Spouse:**	R8 090	R11 550	R23 100	R34 650
	Dependant:	R4 620	R6 360	R9 240	R23 100
Policy Extender The full gap cover premium is covered in the case of the **accidental** death of the main policyholder.		12 months	12 months	12 months	12 months
Medical Aid Contribution Waiver Provides cover towards a policyholder's medical aid contribution in the case of the accidental death of the main policyholder. Cover is limited to the lower of the actual medical aid contribution or the maximum amount allowed.		No Benefit	6 months. Up to a max. of R5 090 per month	6 months. Up to a max. of R6 360 per month	6 months. Up to a max. of R7 640 per month

TRA ASSIST **(powered by MobiMed)**

Home Drive A designated driver service including "Own Vehicle" OR "Uber" services.	6 trips per policy per annum. Limited to a 50km radius	6 trips per policy per annum. Limited to a 50km radius	6 trips per policy per annum. Limited to a 50km radius	6 trips per policy per annum. Limited to a 50km radius
Panic Button 24-hour access to a crisis manager who will guide you through an emergency. ***Includes Roadguard:*** *A security assistance service offered to clients that might find themselves next to the road due to a breakdown.*	Included	Included	Included	Included
Medical Health and Trauma Counselling Line Unlimited access to qualified nurses 24 hours a day for telephonic emergency medical advice, assessment of symptoms, explanation of medical terms, etc. ***Includes a COVID-19 CARE LINE.***	Included	Included	Included	Included
Submit Claim Submit your claims documents via the mobile app.	Included	Included	Included	Included

TRAVEL BENEFIT

All TRA Gap Cover policyholders, under the age of 71, have access to the benefit of comprehensive travel insurance, the cost of which is covered by TRA provided that you remain a TRA Gap Cover policyholder and ensure that premium payments thereunder are up to date. The said travel insurance is underwritten by Guardrisk Insurance Company Limited, a licensed non-life insurer, and administered by Hepstar Financial Services (Pty) Ltd, both being registered Financial Services Providers. Click HERE for full details. Should you plan to travel and have any enquiries about the cover or wish to request the documentation confirming cover, please contact Hepstar Financial Services (Pty) Ltd on +27 (0)86 144 4548 or email info@hepstar.com.

You also qualify to buy a top-up plan by clicking HERE to increase your medical and baggage related cover, as well as add cover for trip cancellation, pre-existing medical conditions, missed connections and more.

Benefits include but are not limited to:

Emergency Medical and Related expenses	R1 000 000
Medical Evacuation, Repatriation, or Transportation to a Medical Centre	Actual expense covered when arranged by Hepstar Financial Services
Personal Accident Cover	Death: R25 000 / Permanent Disability: up to R25 000
Theft or Accidental Damage during trip	R 5 000 / Single item limit: R 1 500
Theft, Damage or loss by Airline	R5 000 / Single item limit: R 1 500
Baggage Delay *(more than 4 hours)*	R500
Baggage Delay *(more than 24 hours)*	R1 000

MONTHLY PREMIUMS

PRODUCT	BASIC COVER 300	VITAL COVER PLUS	SUPER COVER PLUS	ABSOLUTE COVER PLUS
Under 65's premium per policy per month *(Based on the age of the oldest Beneficiary)*		R420	R455	R742
Premium per Individual per policy per month	R 99			
Premium per Family per policy per month	R210			
Over 65's premium per policy per month *(Based on the age of the oldest Beneficiary)*	R421	R629	R682	R922

TOTALRISKADMINISTRATORS

APPLICATION FORM 2027

FOR OFFICE USE ONLY

Broker / Brokerage

Broker Code

Leads Company (if applicable)

Leads Code (if applicable)

Section 1: Personal Details

☐ A copy of the the valid RSA ID, or passport if there is no valid RSA ID, of the main insured

☐ A copy of the medical aid membership certificate

☐ Proof of address less than three months old (for example utility bill, Telkom account, store account statement, bank statement with address, DSTV account, municipal letter, etc.). Should you not have proof of address in your name, you may provide a declaration by a third party confirming that you share an address with them and provide the third party's proof of ID and proof of address (less than three months old.)

NB: This application will not be processed if any of the items above are not sent through with this form.

Med. Aid Membership Number

Med. Aid Inception Date (Y Y Y Y M M D D)

Med. Aid Benefit Option

Gap Cover Inception Date (Y Y Y Y M M D D)

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Prof ☐ Dr

Other (please specify)

First Names (in full)

Initials

Surname

Date of Birth (Y Y Y Y M M D D)

Cell no.

Gender (main member) ☐ M ☐ F ☐ O

Alt. Contact no.

Email Address

Postal Address

Employer

Identity No.

Passport Number (Only complete if you don't have a valid RSA ID number)

Section 2: Dependant's Details

Full Name and Surname	Contact Number	Email Address	ID Number (Passport Number if no valid RSA ID number is available)	Sex (M/F/O)	Relationship to Main Member

Common Law partners need to provide an affidavit proving 12 months of cohabitation for membership to be considered.

Section 3: Product Options (Please tick required products and options)

PRODUCT	BASIC COVER 300	VITAL COVER PLUS	SUPER COVER PLUS	ABSOLUTE COVER PLUS
Under 65's premium per policy per month *(Based on the age of the oldest Beneficiary)*		R420 ☐	R455 ☐	R742 ☐
Premium per Individual per policy per month	R 99 ☐			
Premium per Family per policy per month	R210 ☐			
Over 65's premium per policy per month *(Based on the age of the oldest Beneficiary)*	R421 ☐	R629 ☐	R682 ☐	R922 ☐
Product Choice (please tick)				

Broker fee: None ☐ R10 pm ☐ R20 pm ☐ R30 pm ☐ R40 pm ☐ R50 pm ☐

Section 4: Debit Order Details (person responsible for payment to complete)

Bank

Branch

Branch Code

Type of Account: Cheque ☐ Savings ☐ Transmission ☐ Other ☐ (please specify)

Debit order date (including December): 1st ☐ 7th ☐ 15th ☐ 25th ☐ 26th ☐

Account Number

Account Holder

The abbreviated short name TOTALRISK GAPCOVERTRA is the reference that should appear on your bank statement. Any queries relating to your debit order can be made by calling 011 372 1540.

Section 5: Gap Cover Waiting Periods

General waiting period: There is no general 3 month waiting period.
10 Month condition specific waiting period: No claims may be submitted within the first 10 months of membership for any Gap Cover policy if they relate to any of the following conditions:

- Head, neck and spinal procedures e.g. Laminectomy
- All types of hernia procedures
- Endoscopic procedures e.g. Colonoscopy, Gastroscopy
- Pregnancy and childbirth (including caesarean delivery)
- Gynaecological conditions e.g. Hysterectomy
- Joint replacement (including Arthroplasty, Arthroscopy, Metatarsal Osteotomy) but excluding treatment due to accidental trauma
- Inability to walk / move without pain
- Any renal, liver, kidney and bladder conditions
- Cardiac (relating to the heart)
- Dentistry (unless due to accidental trauma or oncology)
- Cataracts and / or eye laser surgery (including all eye and lens procedures)
- Neurological conditions and procedures
- Organ transplants (including cochlear implants)
- Reconstructive surgery as a result of an incident or condition that occurred prior to membership (including skin grafts)
- Mental health or psychiatric conditions (including depression)
- Varicose veins
- Oesophagitis, Gastroenteritis and Gastro-Intestinal Disorders
- Male genital system (including prostatectomy)
- Carpal Tunnel Syndrome
- Any Ear, Nose and Throat procedures (including nasal, sinus, tonsil and adenoid procedures)
- Diabetes and related complications
- Respiratory conditions e.g. COPD; Cystic Fibrosis (excluding viral conditions e.g. bronchitis)

All claims for these conditions received within the waiting period will be reviewed by medical management to identify pre-existing conditions.
Cancer diagnosis waiting period: If a policyholder is diagnosed with any form of cancer prior to membership, all related claims will be subject to a 9 month waiting period. If a policyholder has previously been diagnosed with cancer and is currently in remission, the policyholder needs to advise the insurer by way of medical evidence that the remission period has been for two or more consecutive years.
Pre-existing medical condition/s waiting period: NO claims relating to any pre-existing condition/s that may lead to hospitalisation (excluding cancer: see above) will be covered within the first six (6) months of membership. The Insurer reserves the right to request any clinical information from a Policyholder's doctor should a claim in this period indicate, and/or relate to, a pre-existing condition.
All claims for these conditions received within the waiting period will be reviewed by medical management to identify pre-existing conditions.

Section 6: Terms and Conditions

- **All Gap Cover policies are subject to the applicable statutory aggregate annual limit per insured person. (This is subject to regulatory amendment).**
- The monthly cut-off date for the receipt of application forms will be the 20th of each month (or closest working day to the 20th) to be effective from the 1st of the following month.
- **It is the policyholder's responsibility to monitor that monthly premiums are received by the Insurer.**
- Upgrades are only allowed once a year in January.
- There is no age limit for entry onto the Gap Cover product.
- Claims relating to any penalties incurred as a result of a policyholder voluntarily choosing a provider outside of a medical scheme approved network will be excluded.
- No osseointegrated dental implants will be covered.
- No co-payment or sub-limit amounts will be covered under the Basic Cover 300 product.
- This Gap Cover application, which may result in a policy being taken out, will not provide cover if the policyholder and dependants do not belong to a medical aid scheme registered with the Council for Medical Schemes.
- Claims to the value of R100 or less will be subject to an excess of the same amount.
- **Gap Cover is not a medical aid scheme. The cover is not the same as that of a medical scheme. The cover is not a substitute for a medical scheme membership.**
- Gap Cover is distinct from, but supplementary to medical aid cover. Should you change your medical aid scheme please advise TRA for record purposes.
- TRA requires 31 days notice of resignation from any product. Failure to advise TRA of resignation from a medical aid does not constitute a valid claim for a refund of premiums collected.
- If new and eligible Dependants are to be added to the Policy, TRA must be informed within 31 days and provided with written notice of such an addition to the Policy. Thereafter, this claim will **under no circumstances** be valid and will not be paid. If the dependant/s are registered after the 31-day period mentioned above, waiting periods and exclusions will apply.
- **Please refer to the policy document for a full list of terms and conditions.**
- **Consent for Communication:** TRA has a duty to keep policyholders updated about any offers and new products that are made available from time to time. TRA might communicate about these. As a policyholder who has accepted this policy, you accept this possible communication channel.

	FULL SIGNATURES REQUIRED	Section 7: Member Declaration and Consent
MEMBER HEALTH DECLARATION:	SIGN	Do you or dependants expect treatment within 12 months, or have ongoing symptoms, complaints or treatment in the last 12 months needing future care? ☐ Yes ☐ No If yes, provide brief details of your symptoms, medical complaints or treatment: ..... Please note that certain medical conditions and related procedures may be subject to various limitations and waiting periods (see section 5 above).
MEMBER DECLARATION:	SIGN	I have read the terms and conditions above and I am fully aware of the contents thereof.
MEMBER CONSENT:	SIGN	I hereby authorise the disclosure of relevant medical information by my medical aid to Total Risk Administrators (Pty) Ltd ("TRA"). This type of information will typically include my diagnosis and ICD-10 diagnostic code. I understand and acknowledge that my medical information will not be disclosed to any unauthorised persons.
PREMIUM BREAKDOWN:	SIGN	**SHORT TERM (ST):** Gap Cover R ..... Broker Fee (if applicable) R ..... **Total** R ..... BROKER FEE DISCLOSURE: Where applicable, the broker fee relates to the following additional services over and above regulated intermediary services: _____ This additional fee may be cancelled by the policyholder at any time.
USE OF PERSONAL INFORMATION:	SIGN	When you enter into this policy you will be giving TRA your personal information that may be protected by data protection legislation, including but not only, the Protection of Personal Information Act, 2013 (POPIA). We will take all reasonable steps to protect your personal information. You authorise us to: a. Process your personal information to: i. Communicate information to you that you ask us for. ii. Provide you with insurance services. iii. Verify the information you have given us against any source or database. iv. Compile non-personal statistical information about you. b. Transmit your personal information to any affiliate, subsidiary or re-insurer so that we can provide insurance services to you and to enable us to further our legitimate interests including statistical analysis, re-insurance and credit control. c. Transmit your personal information to any third party service provider that we may appoint to perform functions relating to your policy on your behalf. You acknowledge that this consent clause will remain in force even if your policy is cancelled or lapsed. d. Obtain access, make enquiries thereupon and request documentation in relation to your personal and medical information and that of any of your registered dependants, for the purposes of providing insurance services. You also give TRA full authority to perform these tasks as you would have done if you were personally present, with the required power of authority to perform the elected acts expressly granted in this policy. You acknowledge that this consent will remain in force even if your Policy is cancelled or lapsed. The TRA POPIA OVERVIEW can be found here: **https://totalrisksa.co.za/downloads/TRA-POPIA-Overview-2021.pdf**
MEMBER AUTHORISATION:	SIGN	I hereby authorise TRA to deduct an amount of R..... from my bank account, monthly in advance, for my premiums to the insurance products chosen by me on this application form. Premiums are subject to an annual review. The Insured needs to submit notice of resignation to the Insurer 31 days prior to resignation date and must be received in writing. Details of each withdrawal will be printed on my bank statement, with the reference TOTALRISK GAPCOVERTRA, which will enable me to identify the deduction. **Mandate:** I/We acknowledge that all payment instructions issued by you shall be treated by my/our above-mentioned Bank as if the instructions have been issued by me/us personally. **Cancellation:** I/We agree that although this Authority and Mandate may be cancelled by me/us, such cancellation will not cancel the Agreement. I/We shall not be entitled to any refund of amounts which you have withdrawn while this Authority was in force, if such amounts were legally owing to TRA. **Assignment:** I/We acknowledge that this Authority may be ceded or assigned to a third party if the Agreement is also ceded or assigned to that third party, but in the absence of such assignment of the Agreement, this Authority and Mandate cannot be assigned to any third party.
BROKER AUTHORISATION: (if applicable)	SIGN	I hereby appoint ..... as my healthcare consultant with immediate effect and understand that ..... will supply me with ongoing advisory services with regard to my healthcare solutions and has access to my personal documentation.

NAME AND SURNAME

PRINCIPAL POLICYHOLDER SIGNATURE

PREMIUM PAYER SIGNATURE (if different to Principal Policyholder)

DATE Y Y Y Y M M D D

IMPORTANT INFORMATION

Total Risk Administrators (Pty) Ltd (TRA) is an authorised financial services provider. FSP No 40815. Please send this completed form to your intermediary for submission to TRA.

Administered by:
Total Risk Administrators (Pty) Ltd (TRA), an authorised financial services provider - FSP No 40815

www.totalrisksa.co.za

Underwritten by:
Auto&General Insurance Company Limited, a licensed non-life Insurer & Financial Services Provider - Reg No 1973/016880/06