

NB: Section 1 and Section 8 of this form are compulsory. Complete any other sections for 2024 relevant updates where applicable.

For Office Use Only

Broker / Brokerage	
Broker Code	
Leads Company (if applicable)	
Leads Code (if applicable)	

Section 1: Personal Details (COMPULSORY FOR PRINCIPAL POLICYHOLDER TO COMPLETE)

First Names (in full)																	
Surname																	
Existing TRA Policy Number						Existing TRA Option											
Identity Number						Date of Birth	Y	Y	M	M	D	D					
Passport Number (Only complete if you don't have a valid RSA ID number)																	

**Section 2: Personal Details Updates of Principal Policyholder (if applicable)
(ONLY COMPLETE WHAT IS BEING UPDATED / CHANGED)**

Title	Mr	Mrs	Ms	Prof	Dr	Other (please specify)											
First Names (in full)											Initials						
Surname																	
Date of Birth	Y	Y	M	M	D	D	Cell no.										
Gender (main member)	M	F	O	Alt. Contact no.													
Email Address																	
Postal Address																	
Employer																	

NB: Attach new copy of ID if applicable. Attach proof of new address if applicable (for example, a utility bill, Telkom account, store account statement, bank statement with address, DSTV account, municipal letter, etc.).

Section 3: Medical Aid Scheme Updates (ONLY COMPLETE IF YOU HAVE CHANGED ANY MEDICAL AID DETAILS)

New Med. Aid Membership Number						New Med. Aid Inception Date	Y	Y	M	M	D	D
New Med. Aid Benefit Option												

NB: Attach your new Medical Aid Membership Certificate.

Section 4: Dependant's Details Updates (ONLY COMPLETE IF YOU ARE ADDING A NEW DEPENDANT TO YOUR POLICY OR IF YOUR DEPENDANT'S DETAILS HAVE CHANGED)

Name	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. NB: Attach your new Medical Aid Membership Certificate showing the new or changed dependants above.

**Section 5: Debit Order Details Updates (ONLY COMPLETE IF YOUR BANKING DETAILS FOR DEBIT ORDERS HAVE CHANGED)
Person responsible for payment to complete**

Bank						Debit order date (including December)	1st	7th	15th	25th	26th
Branch						Account Number					
Branch Code						Account Holder					
Type of Account	Cheque	Savings	Transmission	Other	(please specify)						

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.

NB: Attach your new Bank Statement.

Section 6: Claims Refund Banking Details Updates (ACCOUNT WHERE REFUNDS FOR CLAIMS NEED TO BE PAID INTO - ONLY COMPLETE IF THIS HAS CHANGED) Person responsible for account to complete

Bank																								
Branch									Account Number															
Branch Code									Account Holder															
Type of Account	Cheque	Savings	Transmission	Other	(please specify)																			

The abbreviated short name TRAGAPayments is the reference that should appear on your bank statement. Any queries relating to your claim refund can be made by calling 011 372 1540.

NB: Attach your new Bank Statement.

Section 7: Terms and Conditions

- All Gap Cover policies are subject to an aggregate gap cover annual limit of R198 660 per insured person per annum. (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.

Section 8: Member Declaration and Consent

(COMPULSORY FOR PRINCIPAL POLICYHOLDER TO COMPLETE)

	FULL SIGNATURES REQUIRED	
MEMBER HEALTH DECLARATION: (ONLY COMPULSORY TO COMPLETE IF ADDING A DEPENDANT/S)	SIGN	Are you or any of your dependant/s expecting surgery or planning hospitalisation or treatment in the next 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide brief details of your planned treatment or hospitalisation: _____ 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
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.

Y	Y	Y	Y	M	M	D	D
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NAME AND SURNAME

SIGNATURE

DATE

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



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