momentum

GUARDRISK
TAILORED RISK SOLUTIONS
Part of the Momentum Group

Individual application form – GapCover

2025

Important notes:

- Thank you for your application to join Momentum GapCover, underwritten by Guardrisk Insurance Company Limited (Reg. 1992/001639/06, FSP No. 75).
- You can only apply for Momentum GapCover via an accredited financial adviser.
- If you are applying for <30 GapCover or >65 GapCover, you may not include dependants.
- Please email the completed and signed form to us at **healthnewbusiness@momentumhealth.co.za.**
- Momentum Medical Scheme members may choose to make use of additional products available from Momentum Group Limited and its subsidiaries as well as Momentum Multiply (herein collectively referred to as Momentum). Momentum is not a medical scheme and is a separate entity to Momentum Medical Scheme. Momentum products are not medical scheme benefits. You may be a member of Momentum Medical Scheme without taking any of the products offered by Momentum.

When you sign this application, you confirm that you have read and understood the terms and conditions of cover and agree to them.

Tell us who is completing this form	Client/applicant	Yes ☐	No ☐	Please read and initial each declaration under client/applicant declaration and consent.
	Appointed financial adviser	Yes ☐	No ☐	Please read and initial each declaration under financial adviser declaration and consent.

1: Contract details

Family Cover (Main member age 18-41)	MGC Supreme <42 - family - **R426**	☐
Single member only (Main member age 30 - 41)	MGC Supreme <42 - single - **R390**	☐
Family Cover (Main member age 42 - 64)	MGC Supreme >42 - family - **R603**	☐
Single member only (Main member age 42 - 64)	MGC Supreme >42 - single - **R545**	☐
Family Cover (Main member age 18 - 41)	MGC Primary <42 - family - **R385**	☐
Single member only (Main member age 30 - 41)	MGC Primary <42 - single - **R358**	☐
Family Cover (Main member age 42 - 64)	MGC Primary >42 - family - **R549**	☐
Single member only (Main member age 42 - 64)	MGC Primary >42 - single - **R498**	☐
<30 Cover (Single member age 18 - 29)	MGC <30 years rating - **R259**	☐
>65 Cover (Single member age 65+)	MGC >65 years rating - **R734**	☐

The monthly premium is inclusive of commission and VAT.

Your cover can only start on the first day of the calendar month following your application. No requests for backdating of cover will be considered.

When do you want your cover to start? 0 1 M M Y Y Y Y

2: Personal details

Policy holder

Title ☐☐☐☐ Initials ☐☐☐☐ First name

Surname

ID/Passport number ☐☐☐☐☐☐☐☐☐☐☐☐☐ Date of birth D D M M Y Y Y Y

Country in which passport was issued

Home address

Postal code ☐☐☐☐

Postal address (if different)

Postal code ☐☐☐☐

Telephone - work ☐☐☐☐☐☐☐☐☐☐ Cellphone number ☐☐☐☐☐☐☐☐☐☐

Email address

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The Marc, Tower 2, 129 Rivonia Road, Sandton, 2146

2: Personal details (continued)

Policy holder (continued)

Momentum Medical Scheme membership number | Option

Date joined D D M M Y Y Y Y

You can only take out Momentum GapCover if you are a member of Momentum Medical Scheme, thus your gap cover policy will only become active once your medical aid is activated. Should you cancel your medical aid membership, you will be given the option to join one of Guardrisk's other gap cover products.

Spouse or partner (If spouse or partner is also applying for membership)

If you are applying for <30 GapCover or >65 GapCover, you may not include dependants.

All dependants must reflect on your Momentum GapCover Certificate of Cover and must be covered on your medical aid at the time of a claimable event.

First name

Surname

ID/Passport number | Gender Male Female

Country in which passport was issued | Date of birth D D M M Y Y Y Y

Dependants (If dependants are also applying for membership)

Dependant 1

If you are applying for <30 GapCover or >65 GapCover, you may not include dependants.

First name

Surname

ID/Passport number | Gender Male Female

Country in which passport was issued | Date of birth D D M M Y Y Y Y

Relationship to principal member

Dependant 2

First name

Surname

ID/Passport number | Gender Male Female

Country in which passport was issued | Date of birth D D M M Y Y Y Y

Relationship to principal member

Dependant 3

First name

Surname

ID/Passport number | Gender Male Female

Country in which passport was issued | Date of birth D D M M Y Y Y Y

Relationship to principal member

Dependant 4

First name

Surname

ID/Passport number | Gender Male Female

Country in which passport was issued | Date of birth D D M M Y Y Y Y

Relationship to principal member

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3: Previous gap cover details

Have you or any of your dependants previously belonged to any other gap cover? If yes, please give us the details. Yes ☐ No ☐

Name	Previous insurer	Cover option	Cover start date	Cover end date
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y

Please give us proof in the form of a membership certificate.

Please note that only a membership certificate from your current/previous gap cover provider listing all your dependants and their start date of cover will be accepted as proof of cover.

If you answered "yes" and have attached proof of previous gap cover (with a break in cover no more than 90 days), you do not need to complete Section 4.

4: Provide us with more information about your and your dependants' health

Please provide full and complete information, even if you have already done so for your Momentum Medical Scheme application for membership. If you do not disclose pre-existing medical conditions, it may limit/exclude certain benefits or result in termination of your cover.

Important to note:

- Any cancer, birth or pregnancy-related medical condition that existed within 12 months before the first day of cover will be excluded for 12 months after cover starts (this exclusion extends to any child born during this period); and
- Any other physical defect, medical condition, illness or injury that existed within 12 months before the first day of cover will be excluded for 9 months after cover starts.

Please select a "Y" or "N" for each of the below questions. Please answer honestly, accurately and completely in respect of each person to be covered:

	Applicant	Spouse or partner	Dependant 1	Dependant 2	Dependant 3	Dependant 4
Name of dependant						
Are you or any of your dependants currently pregnant or trying to become pregnant?	Y N	Y N	Y N	Y N	Y N	Y N
Have you or any of your dependants recently given birth?	Y N	Y N	Y N	Y N	Y N	Y N
Have you or any of your dependants ever been diagnosed with any form of cancer, malignant or pre-malignant tumours?	Y N	Y N	Y N	Y N	Y N	Y N
Have you or any of your dependants had any surgical procedure during the past 12 months or are you or any of your dependants planning a surgical procedure during the next 12 months?	Y N	Y N	Y N	Y N	Y N	Y N
Do you or any of your dependants take chronic or ongoing medication?	Y N	Y N	Y N	Y N	Y N	Y N

Have you or any of your dependants had or currently have, any of the medical conditions listed below, for which medical advice, diagnosis, care or treatment was recommended or received within the last 12 months?

Any bone or joint condition including ongoing back, shoulder, hip or knee problems, arthritis, rheumatism, fibromyalgia or any other musculoskeletal (back, bone and muscle) condition	Y N	Y N	Y N	Y N	Y N	Y N
High blood pressure, high cholesterol or lipids, ischaemic or coronary heart disease, chest pains, irregular heartbeat, heart murmur, heart failure, myocardial infarction, angina, peripheral vascular disease, valve lesions or any other heart-related medical condition	Y N	Y N	Y N	Y N	Y N	Y N
Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse	Y N	Y N	Y N	Y N	Y N	Y N
Stroke, spinal cord injury or any other brain, spinal or nerve condition	Y N	Y N	Y N	Y N	Y N	Y N

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Section 4: Provide us with more information about your and your dependant's health (continued)

	Applicant	Spouse or partner	Dependant 1	Dependant 2	Dependant 3	Dependant 4
Name of dependant						
Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel disease, intestinal polyps or any other abdominal condition	Y N	Y N	Y N	Y N	Y N	Y N
Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye	Y N	Y N	Y N	Y N	Y N	Y N
Any condition of the ear, nose or throat, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis, or adenoiditis	Y N	Y N	Y N	Y N	Y N	Y N
Any condition of the mouth, teeth or gums including maxillo-facial treatment or specialised dentistry	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes, thyroid disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition	Y N	Y N	Y N	Y N	Y N	Y N
Cirrhosis, liver disease or failure, cystic fibrosis or any other liver-related condition	Y N	Y N	Y N	Y N	Y N	Y N
Kidney and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycystic kidney disease or any other renal or urinary condition	Y N	Y N	Y N	Y N	Y N	Y N
Any blood condition or disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders	Y N	Y N	Y N	Y N	Y N	Y N
Any condition of the respiratory system including asthma, tuberculosis, chronic obstructive pulmonary disease (COPD), silicosis, pulmonary or cystic fibrosis or emphysema?	Y N	Y N	Y N	Y N	Y N	Y N
Any condition of the prostate including undescended testes or urinary incontinence	Y N	Y N	Y N	Y N	Y N	Y N
Any other medical condition not listed above that may require treatment or surgery	Y N	Y N	Y N	Y N	Y N	Y N

If your answer to any of the above questions is "yes" please provide details below:

Name	Details of condition and treatment undertaken	Start date	End date

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5: Your beneficiary details

Your Momentum GapCover policy has two benefits that will pay your nominated beneficiary an amount of money should you die as a result of a violent crime or an accident. The beneficiary nomination is important as, should one not be nominated, the funds will be paid into your estate.

Title		Initials	First name
Surname			
ID/Passport number		Cellphone number	
Physical address			
		Postal code	
Date of birth	D D M M Y Y Y Y	Relationship to you	

6: Banking details for collection of premiums and claim refunds payable

Name of account holder									
Account holder ID/passport number									
Company registration number, if a company account is used									
Name of bank									
Account number									
Account type	Current/Cheque		Savings		Transmission				
Branch code			Branch name						
Please choose your debit order date	1st		7th		10th		15th		20th		25th	

☐ Tick this box if we may use the same bank account details provided for your premium payments for claim refunds payable

If not, please complete the bank details below.

If a third party's account details are used, please provide a copy of their ID.

Name of account holder									
Account holder ID/passport number									
Company registration number, if a company account is used									
Name of bank									
Account number									
Account type	Current/Cheque		Savings		Transmission				
Branch code			Branch name						

By signing below you:

1. Authorise Guardrisk to debit the account specified for collection of premiums with the monthly premium due in respect of this policy.
2. Authorise Guardrisk to make claim payments to the account specified for claim refunds.
3. Acknowledge that this authorisation will remain in force and effect until cancelled by you, in writing with one calendar month's notice.
4. 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.
5. Undertake to inform Guardrisk of any change in your banking details and authorise Guardrisk to verify such banking details with your bank.
6. Confirm that Guardrisk shall not be held liable for incorrect claim payments made as a result of your failure to inform Guardrisk of a change in your banking details.
7. Accept that Guardrisk may debit your account on a date other than that specified.
8. Acknowledge that it is your responsibility to ensure that premiums are collected for cover to remain in force, notwithstanding the fact that you grant Guardrisk permission to collect premiums.

Signature of policy holder		**Date**	D D M M Y Y Y Y
Signature of third party (if applicable)		**Date**	D D M M Y Y Y Y

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7: Financial adviser

You can only apply for Momentum GapCover via an accredited financial adviser.

Brokerage name	Financial adviser's name	Cellphone number	Email address

Signature of financial adviser **Date** D D M M Y Y Y Y

8: Business/Practice consultant

Name and surname

Business/Practice consultant's code

Branch name

Telephone - work

Cellphone number

Email address

9: Financial adviser declaration and consent – only applicable when a financial adviser is completing an application form on behalf of the client

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

1. The applicant has authorised you to complete this application form on their behalf and you confirm that the information provided is true and accurate as advised by your client.
2. You can provide proof of your client's above mentioned authorisation timeously on request by Guardrisk.
3. You declare that your client has read the below client/applicant declaration and that your client accepts each declaration that you are signing on their behalf.

10: Declaration

☐ By ticking this box you confirm that your financial adviser has communicated the below to you:

1. That he/she is mandated by an authorised Financial Services Provider (FSP), as set out above, to act on behalf of that FSP as a representative.
2. That he/she is an accredited financial adviser in terms of the FAIS Act at the date of signing this application form.
3. That he/she accepts their appointment by you to provide advice and ongoing intermediary services in respect of this policy.
4. That he/she has made you aware of the commission payable by Guardrisk to him/her in respect of this policy.
5. That he/she has conducted a financial needs analysis and this insurance product is suitable to meet your insurance needs.
6. That he/she has explained the insurance product to you and you understand how the product works, what is covered and what is not covered, as well as how to claim from the policy.
7. That he/she is responsible for providing you with his/her contact details and he/she is accountable for any advice given to you about completion of this application form.

Your declaration and consent

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

1. I hereby apply for Momentum GapCover and I agree to abide by its rules.
2. I declare that the information that I have supplied is correct and complete and that this declaration shall be the basis of the contract of insurance between Guardrisk and me, which will become effective on the first day of the month for which premiums are paid.
3. I confirm my understanding that should this application be incomplete, my application may not be processed by Guardrisk.
4. I confirm my understanding that should any material information be withheld or incorrectly furnished during the application process, Guardrisk may cancel my cover and premiums paid may be used to offset expenses incurred by Guardrisk.
5. I understand that my and my dependants' cover may be subject to waiting periods and that these waiting periods have been communicated to me prior to my application for cover.
6. 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 dependants' medical scheme cover.
7. 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 cover will and will not pay.
8. I further declare my understanding that my eligibility for cover is dependent on me and my dependants remaining active members of Momentum Medical Scheme and I undertake to advise Guardrisk if I terminate my, or my dependants' medical scheme membership at any time.
9. I confirm that I have appointed the above named financial adviser as intermediary to my policy.

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10: Declaration (continued)

Your declaration and consent (continued)

10. I authorise Guardrisk to make payment of the monthly commission, calculated as per the legislated sliding scale in the Demarcation Act of 2017 to the appointed intermediary for services rendered in respect of this policy. ☐
11. I understand that in terms of the Financial Advisory and Intermediary Services Act, 2002 (“FAIS”), the financial adviser must be mandated by a licensed Financial Services Provider (“FSP”) as a representative with the necessary FAIS sub-categories to act on my behalf and that it is my responsibility to determine whether my financial adviser has the necessary authorisation. ☐
12. 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 dependants’) diagnosis, treatment and medical history. I further confirm that my dependants and/or beneficiaries have also provided the necessary authority for their medical scheme to disclose their relevant medical information to Guardrisk to assist in processing of claims under this policy. ☐
13. 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 this authorisation will endure for a maximum of five years after my death. ☐
14. I authorise Guardrisk to use, review and process any of my or my dependants’ 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 dependants and/or beneficiaries have also provided me with the authority to disclose their personal information to Guardrisk.dependants ☐
15. 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. ☐
16. 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. ☐
17. I undertake to notify Guardrisk of any change in my personal details within a reasonable time period and I indemnify Guardrisk against any liability for any loss that may result from my failure to notify Guardrisk of such change in a timeous manner. ☐
18. I authorise Guardrisk to collect, process and store my and my dependants’ personal information for the purpose of administering cover under this policy. I further confirm that my dependants and/or beneficiaries have also provided me with the authority to disclose their personal information to Guardrisk as well as for their medical scheme to disclose such personal information to assist in the processing of claims under this policy. ☐
19. I confirm that I am aware of my right to request a copy of my and my dependants’ 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 who can be contacted on 010 023 5207 or via email at POPIAComplaints@inforegulator.org.za. ☐
20. I authorise Guardrisk to disclose all relevant information to the appointed financial adviser on my policy to assist in the processing of this application form, for the purpose of administering cover and processing of all future claims under this policy. This information could include my (or one of my dependants’) medical diagnosis, treatment and history as well as personal information. I further confirm that my dependants and/or beneficiaries have also provided the necessary authority to disclose their relevant information to the appointed financial adviser to assist in the processing of this application form, administrating of this policy and any claims processed by Guardrisk on this policy. ☐
21. If I am applying for the <30 product, I declare my understanding that this cover applies only to me and that if I want to add a spouse, adult or child dependant to my cover, I will have to transfer to the <42 family rate product at the required premium, from the first of the month during which I add my dependant/s. ☐
22. If I am applying for the <30 product, I further declare my understanding that my eligibility for cover on this product is dependent on my being between 18 and 29 years old and that once I reach 30 years old, my cover will be transferred to the <42 product at the required premium on my next cover renewal date. ☐
23. If I am applying for the <42 or >42 single rate product, I declare my understanding that this cover applies only to me and that if I want to add a spouse, adult or child dependant to my cover, I will have to transfer to the <42 or >42 family rate product at the required premium, from the first of the month during which I add my dependant/s. ☐

Signed at

*Remember to inform us should any information provided on this form change between the date of signing the form and the start date.

Signature of policy holder

Date D D M M Y Y Y Y

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Momentum 268 West Avenue Centurion 0157 PO Box 7400 Centurion 0046 South Africa Call Centre 0860 11 78 59 member@momentumhealth.co.za momentummedicalscheme.co.za
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