COMPLIMED GAP COVER APPLICATION | 2025

CompliMed®

...for the GAP in your medical aid

Insurer:
Lombard Insurance Company Limited
(Reg. No. 1990/001253/06) FSP no. 1596

Risk and Underwriting Managers:
Turnberry Management Risk Solutions (Pty) Ltd
(Reg no : 2007/026488/07) FSP no. 36571

Broker Name:	Brett Daniel
Broker Code:	CIM 01

FOR OFFICE USE ONLY				
	Application No.		Client No.	
	Policy No.		Debtor No.	

Tel: 032 815 2969 | Email: admin@complimed.co.za

A. DETAILS OF PRINCIPAL INSURED PERSON

Title: | First Name: | Surname:

ID Number: | Cellphone No.

Home Tel No. | Work Tel No.

Residential or Physical Addresses: | Code:

Postal Addresses: | Code:

Email: | Medical Scheme:

Medical Scheme No: | Option: | Date Membership Commenced:

B. MEDICAL EXPENSE SHORTFALL PRODUCTS

THE PRODUCTS OFFERED IN THIS APPLICATION FORM ARE NOT A MEDICAL SCHEME AND THE COVER IS NOT EQUIVALENT TO THAT OF A MEDICAL SCHEME. THESE PRODUCTS ARE NOT A SUBSTITUTE FOR A MEDICAL SCHEME MEMBERSHIP.

If you are transferring your Policy from another provider please attach your existing policy.

Please tick your chosen option:

LEGACY SERIES				Commencement Date:
◯ R496	per Individual per month	for under 65 yrs	◯ R538 per family per month for under 65 yrs	
◯ R677	per Individual per month	for 65 +	◯ R770 per family per month for 65 +	

C. DEPENDANT DETAILS

Spouse/Partner and children under the age of 26 years who are registered on the Principal Insured person or Spouse/ Partner's Medical Scheme may be added to the Policy at no additional cost

Name of Dependant		Identity Number (Date of Birth if no ID No)	Gender M/F	Relationship to Policyholder
Surname	First Name			

D. EXTENDED FAMILY COVER

Other Dependents/Extended Family registered on the Principal Insured person or Spouse/Partner's Medical Schememay be added to the Policy for an additional premium, as detailed below.

Product	Ages 26 - 64 (incl)		Ages 65 - 79 (incl)		Ages 80+	
	Rate	Number	Rate	Number	Rate	Number
LEGACY SERIES	R174		R562		R716	

E. WAITING PERIODS

PLEASE NOTE, A 3-month general waiting period applies to all benefits, with exception of benefits providing cover up to 600% should the commencement of the Policy be in line with the commencement date of the Medical Scheme. A 10-month waiting period on pregnancy/ childbirth. A 12-month waiting period on / investigations, treatment or surgery for: hysterectomy, hysteroscopies, endometriosis, ovarian cysts and fibroids (myomectomy), muscular-skeletal (except in the event of a motor vehicle collision), tonsillectomy, myringotomy, grommets, adenoids, wisdom teeth, hernia, cataracts, gastroscopies, colonoscopies, cancer, nasal and sinus

G. BANK DETAILS FOR DEDUCTIONS OF MONTHLY PREMIUM BY DEBIT ORDER

Account Holder's Name		Name of Bank	
Account Number		Branch Code	

Type of account: Cheque ◯ Savings ◯ Transmission ◯

Date account to be debited: 1st ◯ 7th ◯ 15th ◯ 25th ◯

Please note, should the collection date selected fall on a weekend or public holiday, a debit will be processed against your account on the first working day following the weekend or public holiday

I hereby request and authorize Turnberry Management Services (Pty) Ltd ("Administrator") to draw against my bank account with the above mentioned bank (or any bank/branch to which I may transfer my account) the amount necessary for payment of the premiums (as well as any renewal or adjustment premiums and Policy fees due) in respect of the aforementioned insurance benefits. All such withdrawals from my bank account by the Administrator shall be treated as though they had been signed by me personally. I agree to pay the bank charges in connection with this instruction and authorise the Administrator to increase the amount of each withdrawal so as to recover the costs thereof in accordance with the South African Clearing Bank's tariff in force at the time. I understand that: 1) the withdrawals hereby authorised will be processed by computer, and 2) details of each withdrawal will be reflected on my bank statement or on the accompanying voucher, and 3) the obligation to ensure that my monthly payments are received remains with me despite the granting to the Administrator of this authority and 4) that this authority may be ceded or assigned to a third party, if this Policy is also ceded or assigned to the third party. This authority shall continue in full force and effect until cancelled, by me, giving 31 days' written notice thereof sent to the Administrator by prepaid registered post. I understand that such cancellation may result in the cancellation of the Policy and it will not relieve me of the liability in respect of any unpaid balance owing to the Administrator. In addition, I shall not be entitled to any refund of any amount which Administrator has withdrawn regarded as receipt thereof by my bank.

Signature of Account Holder: _____ Date:

H. DECLARATION BY THE PRINCIPAL INSURED PERSON

I have been informed of my rights in terms of the Policyholder Protection Rules to have the following information disclosed to me before entering into any insurance contract:1) The Statutory Notice; 2) Intermediary's accreditation and mandate confirmation; 3) Mandatory disclosures. I hereby apply for the benefits stipulated in this document, subject to the terms and conditions of the Policy contract and I agree that this application and declaration shall be the basis of the contract between me and Lombard Insurance Company Limited ("Insurer"). I hereby warrant that the answers and statements provided in the application form are true and correct in every particular and that I have withheld no information whatsoever, which is material to or is likely to affect the assessment of the risk under the proposed insurance. I undertake to advise the Administrator in writing if a change takes place in the health of the Insured person/persons between the date of signing the application and the date of acceptance of the risk or the date of commencement of the Policy whichever occurs last. I understand that any inaccurate and untrue statements or failure to notify the Administrator of a change in health prior to the acceptance and/or commencement of the Policy may render my Policy null and void and all premiums paid will be forfeited to the Insurer. I acknowledge that no representation made to me by any agent or employee of the Insurer shall in any way bind the Insurer unless it is thereafter confirmed in writing by the Insurer. I hereby irrevocably authorise a) the Insurer to obtain from any person any information the Insurer needs to which this application relates; b) the person concerned to give the Insurer the information it requests under the authorisation in (a); the Insurer to share with other insurers and the ASISA any information to assess risks or claims. Any information may, under this authorisation, be obtained or given at any time, even after death. I agree that a photocopy or fax of this application form is as effective and valid as the original. If I have an email address for correspondence with the Administrator, I accept the risks of email correspondence and shall not hold the Administrator liable for any loss or damage arising through any unauthorised access to the email correspondence with or any interception of any communication between the Administrator and me.

I acknowledge that should any of my personal and/or banking details change it is my responsibility to ensure that the Administrator are notified of the changes.

I acknowledge that the premium is due monthly in advance on the first day of each calendar month ("due date") and if not received by the Administrator by the 15th day of the following calendar month, then this Policy shall be deemed to have been cancelled at midnight on the due date.

I understand and have exercised my right to take out a product with an intermediary and Insurer of my own choice? YES ◯ NO ◯

I confirm that I am satisfied that I understand the benefits, limitations and waiting periods that may apply to my policy? YES ◯ NO ◯

Is this Policy replacing a Policy of the same or similar type? YES ◯ NO ◯

If "Yes", I am satisfied that I understand the difference, if any, in the product benefits and restrictions between the two Policies? YES ◯ NO ◯

Signature: _____ Date:

I. FINANCIAL ADVICE

CompliMed is an authorized financial services provider marketing Short Term Insurance products underwritten by Lombard and administered by Turnberry. CompliMed does not offer Financial Advisory and Intermediary Services Act (FAIS) on any products sold via the website.