



## TURNBERRY GAP COVER APPLICATION FORM 2026

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 Tel: 011 677 9891 | Fax: 086 676 0777 | Email: newbusiness@turnberry.co.za Address: 4 Osborne Lane, Bedfordview, 2007

Broker Name:	
Broker Code:	

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

A.		DETAIL	S OF PRINCIPAL INSURI	ED PERSON					
Title:		First Na	me:		Su	rname:			
ID Number:		Cellphone	No.						
Home Tel No		Work Tel	No.						
Residential or Physical Address:			<u>'</u>			Code:			
Postal Address:						Code:			
Email:					Medical S	cheme:			
Medical Scheme No:		Op:	tion:	Date Membe	rship Comn	nenced:			
Previous Gap Cover	(if applicable)	Gap Cover Prov	ider:	Com	nmenceme	nt date:			
Previous Gap Cover	(if applicable)	Gap Cover Prov	ider.	Com	nmenceme	nt date:			
D		MEDIC	N EVDENCE CHORTEN	L DRODUCT					
B.		MEDICA	AL EXPENSE SHORTFAL	L PRODUCTS	5				
		CATION FORM ARE NOT A MED JTE FOR A MEDICAL SCHEME			ALENT TO TH	AT OF A MEDIC	CAL SCHEME.		\
Commencement Date	e:		If you are transferring you	ır Policy from a	another pro	vider please	attach your e	xisting polic	у.
PREMI	ER	OPTIMAL	LAUNCH	DYNAMIC		DYNAM	IIC DEPENDA	ANTS	
R737/month for <	65 yrs	R558/month for < 65 yrs	R185/month for < 65 yrs		0	1	2	3	4
R1060/month for 6	55 <b>+</b>	R806/month for 65 +	R320/month for 65 +	Ages 0-29	R180	R330	R500	R600	R700
R538/month for <	65 yrs Individual	SYNERGY	MED-EXTEND	Ages 30-49	R330	R473	R605	R715	R825
R741/month for 6	55 + Individual	R494/month for < 65 yrs	R426/month for < 65 yrs	Ages 50-64	R385	R495	R616	R759	R902
R315/month for P	Premier Youth	R688/month for 65 +	R601/month for 65+	Ages 65+	R605	R770	R935	R1100	R1265
C.			DEPENDANT DETA	ILS					
		ne age of 26 years who are of tificate required) may be ac			or a studer	nt Medical Sc	cheme optior	1	
	Name of Depe	endant	Identity N			Gender	Relation	nship to Poli	cyholder
Surname	e	First Name	(Date of Birth	if no ID No)		M/F			
In the <b>event of the</b>	death of the Prin	cipal Insured person in res	 pect of the Critical Illness B	enefit or Perso	nal Accider	nt Benefit			
Beneficiary Name:		•	Beneficiary ID:			Relationship:			

## EXTENDED FAMILY COVER

Other Dependants/Extended Family registered on the Principal Insured person or Spouse/Partner's Medical Scheme may be added to the Policy for an additional premium, as detailed below. PLEASE NOTE NO EXTENDED FAMILY FOR THE DYNAMIC OPTION

Product	Ages 26	- 64 (incl)	Ages 65 - 79 (incl)		Ages 80+	
Floudet	Rate	Number	Rate	Number	Rate	Number
PREMIER	R189		R613		R781	
OPTIMAL	R178		R500		R639	
SYNERGY	R176		R495		R632	
LAUNCH	R44		R76		R115	
MED-EXTEND	R163		R616		R787	

PLEASE NOTE, a 3-month general vaccommencement date of the Policy Expense Shortfall Cover. A 10-month hysteroscopies, endometriosis, ovari tonsillectomy, myringotomy, gromme	is the same as the con n waiting period on pregn ian cysts and fibroids (my	nmencement date of the Med ancy/childbirth. A 12-month wa omectomy), muscular-skeletal	ical Schemaiting period (except in	e, no 3-month gene d on/or investigations the event of an accid	ral waiting period will apply to s, treatment or surgery for. hys ent, which occurred while on t	to Medical terectomy,
F.		BROKER FEES				
	○ R20	○ R40	R60			
This fee (Broker Fee) is an optional fee advice, which services have or will be p unhappy with the advisory services pro	rovided to you by your brok ovided by your broker, you a	er. Turnberry will collect this fee, to re entitled to cancel the payment	ogether with of the Broke	n your premium, and pa er Fee at any time by co	ay the entire amount to your brok ontacting your broker.	ker. If you are
While this notice has been prepared by or liability is or will be accepted by Turn provided by your broker. All and any such	nberry or its officers, emplo	yees or agents in relation to the	ince or unde adequacy, a	rtaking (express or importance), completenes	plied) is or will be made, and no i s or reasonableness of the advis	responsibility sory services
Signature:			Date	:		
G.	BANK DETAILS	FOR DEDUCTIONS OF MC	NTHLY P	REMIUM BY DEBI	T ORDER	
Account Holder's Name			Nam	ne of Bank		
Account Number			Bran	nch Code		
Type of account:	Cheque 🔘	Savings (	Tran	smission ()		
Date account to be debited:	1st 🔘	7th 🔘		15th 🔘	25th (	
Please note, should the collection date or public holiday. Please note that your	r debit order reference will b	e TMS HEALTH INS D followed by	y your debto	or number.		
I hereby request and authorise Turnbe transfer my account) the amount nece	rry Management Services essary for payment of the p	(Pty) Ltd to draw against my ban remiums (as well as anv renewal)	ık account v or adiustme	vith the abovemention ent premiums and Polic	ed bank (or any bank/branch to cv fees due) in respect of the afo	which I may rementioned
insurance benefits. All such withdrawa connection with this instruction and au	lls from my bank account b	y Turnberry shall be treated as the	ough they ha	ad been signed by me	personally. I agree to pay the bar	nk charges in
Bank's tariff in force at the time. I unde	erstand that: 1) the withdrav	vals hereby authorised will be pro	ocessed by	computer, and 2) detai	ils of each withdrawal will be ref	lected on my
bank statement or on the accompanyir authority and 4) that this authority may	y be ceded or assigned to a	third party, if this Policy is also ce	eded or assi	gned to the third party.	This authority shall continue in	full force and
effect until cancelled, by me, giving 31 of the Policy and it will not relieve me of the	ne liability in respect of any u	sent to Turnberry by prepaid regis Inpaid balance owing to Turnberry	stered post. y. In additior	l understand that such , I shall not be entitled t	i cancellation may result in the ca to any refund of any amount whi	ancellation of ich Turnberry
has withdrawn regarded as receipt the	reof by my bank.					
Signature of Account Holder.			_ Date:			
H.		ARATION BY THE PRINCIPA	AL INSUR	ED PERSON		
I have been informed of my rights in	DECL/ terms of the Policyholder F	ARATION BY THE PRINCIPA Protection Rules to have the follo	wing inform	ation disclosed to me	before entering into any insural	nce contract:
I have been informed of my rights in 1) The Statutory Notice; 2) Intermedian the terms and conditions of the Policy	DECLA terms of the Policyholder F y's accreditation and mand contract and I agree that th	ARATION BY THE PRINCIPA Protection Rules to have the follow ate confirmation; 3) Mandatory do nis application and declaration sh	wing inform isclosures. I all be the ba	ation disclosed to me hereby apply for the be asis of the contract bet	enefits stipulated in this docume ween me and Lombard Insuran	ent, subject to ce Company
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