TURNBERRY GAP COVER APPLICATION FORM 2026

Turnberry GAP COVER NAVIGATING THE WAY (FSP no. 36571)

LOMBARD (FSP no.1596)

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

A. DETAILS OF PRINCIPAL INSURED PERSON

Title:	First Name:	Surname:	
ID Number:	Cellphone No.		
Home Tel No	Work Tel No.		
Residential or Physical Address:		Code:	
Postal Address:		Code:	
Email:		Medical Scheme:	
Medical Scheme No:	Option:	Date Membership Commenced:	
Previous Gap Cover (if applicable)	Gap Cover Provider:	Commencement date:	
Previous Gap Cover (if applicable)	Gap Cover Provider:	Commencement date:	

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. ***Please tick your chosen option***

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

PREMIER	OPTIMAL	LAUNCH	DYNAMIC	DYNAMIC DEPENDANTS				
				0	1	2	3	4
◯ R737/month for < 65 yrs	◯ R558/month for < 65 yrs	◯ R185/month for < 65 yrs						
◯ R1060/month for 65 +	◯ 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 65 + Individual	◯ R494/month for < 65 yrs	◯ R426/month for < 65 yrs	Ages 50-64	◯ R385	◯ R495	◯ R616	◯ R759	◯ R902
◯ R315/month for Premier Youth	◯ R688/month for 65 +	◯ R601/month for 65 +	Ages 65+	◯ R605	◯ R770	◯ R935	◯ R1100	◯ R1265

C. DEPENDANT DETAILS

Spouse/Partner and children up to the age of 26 years who are registered on the Principal Insured person or a student Medical Scheme option (proof of studies and Medical Aid certificate required) 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			

In the **event of the death of the Principal Insured** person in respect of the Critical Illness Benefit or Personal Accident Benefit

Beneficiary Name: Beneficiary ID: Relationship:

D. 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+	
	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	

E. WAITING PERIODS

PLEASE NOTE, a 3-month general waiting period applies to all benefits (except in the event of an accident, which occurred while on the Policy). In the event the commencement date of the Policy is the same as the commencement date of the Medical Scheme, no 3-month general waiting period will apply to Medical Expense Shortfall Cover. A 10-month waiting period on pregnancy/childbirth. A 12-month waiting period on/or investigations, treatment or surgery for: hysterectomy, hysteroscopies, endometriosis, ovarian cysts and fibroids (myomectomy), muscular-skeletal (except in the event of an accident, which occurred while on the Policy), tonsillectomy, myringotomy, grommets, adenoids, wisdom teeth, hernia, cataracts, gastroscopies, colonoscopies, nasal and sinus, cancer.

F. BROKER FEES

◯ R20 ◯ R40 ◯ R60

This fee (Broker Fee) is an optional fee payable or owing by you, the Policyholder, to your broker, for advisory services, including, financial or risk planning and up-front and ongoing advice, which services have or will be provided to you by your broker. Turnberry will collect this fee, together with your premium, and pay the entire amount to your broker. If you are unhappy with the advisory services provided by your broker, you are entitled to cancel the payment of the Broker Fee at any time by contacting your broker.

While this notice has been prepared by Turnberry in good faith, no representation, warranty, assurance or undertaking (express or implied) is or will be made, and no responsibility or liability is or will be accepted by Turnberry or its officers, employees or agents in relation to the adequacy, accuracy, completeness or reasonableness of the advisory services provided by your broker. All and any such responsibility and liability is expressly disclaimed.

Signature: _____ Date: _____

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. Please note that your debit order reference will be TMS HEALTH INS D followed by your debtor number.

I hereby request and authorise Turnberry Management Services (Pty) Ltd to draw against my bank account with the abovementioned 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 Turnberry 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 Turnberry 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 Turnberry 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 Turnberry 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 Turnberry. In addition, I shall not be entitled to any refund of any amount which Turnberry 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 Turnberry 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 Turnberry 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 Turnberry, I accept the risks of email correspondence and shall not hold Turnberry liable for any loss or damage arising through any unauthorised access to the email correspondence with or any interception of any communication between Turnberry and me.

I acknowledge that should any of my personal and/or banking details change it is my responsibility to ensure that Turnberry 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 Turnberry 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 acknowledge and accept that for the purposes of effectively administering my policy and dealing with all other matters related thereto, Turnberry Management Risk Solutions may process and share my and the persons I represent herein private information with Lombard Insurance Company Limited and any associated party, any third party service provider, and/or agent who will assist in the administration and performance of my policy.

Have you been advised of and exercised your free choice to take out insurance with the Insurer and intermediary of your choice?	YES ◯	NO ◯
I confirm that the product benefits have been explained to me	YES ◯	NO ◯
Is this Policy replacing a Policy of the same or similar type?	YES ◯	NO ◯
If "YES", have the product benefits and restrictions been adequately compared and explained to you?	YES ◯	NO ◯

Signature: _____ Date: _____

I. DECLARATION BY BROKER FOR REPLACEMENT OF POLICY

I confirm I have fully discharged my duties as set out in section 8(d) of the General Code of Conduct

Signature: _____ Date: _____