

APPLICATION FORM

2026

Thank you for deciding to apply for gap insurance cover with BGAP, underwritten by Guardrisk Insurance Company Limited (Reg. 1992/001639/06, FSP No. 75). This document is an application form for cover. Please complete the form accurately and in full so that we can process your application.

Contact us

Tel: 0860 102 936, Email: info@bgapcover.co.za

What you must do

1. Please Note: You need to register on Bvalue before you can apply for BGap. To register, go to www.bvalue.co.za
2. Fill in the form.
3. Submit your application by emailing the form to us at info@bgapcover.co.za, with your Bonitas medical scheme membership certificate and proof of previous gap cover (if you are moving your cover from another insurer to us).

Once you have submitted your application form:

- If any details are missing or we need more information, we will contact you.
- We will activate your membership and we will email you a confirmation of cover, along with your policy wording.
- If you do not hear from us 2 weeks after sending us your application, please contact us on 0860 102 936 or email info@bgapcover.co.za.

By signing this application, you confirm that you have read and understood the terms and conditions of cover, and that you agree to them. You also confirm that you have read and understood the benefits included in the selected cover option.

If we receive your application after the 15th day of the month, we may make a double-deduction from your bank account.

PLEASE SELECT YOUR COVER OPTION:

Family Cover (Main member age 18-64)	BGAP – Supreme – family:	R446	BGAP – Primary – family:	R354
Single Cover (Single member age 35-64)	BGAP – Supreme – single:	R388	BGAP – Primary – single:	R311
Under 35 (Single member age 18-34)	BGAP – Supreme <35:	R289	BGAP – Primary <35:	R238
Pensioner Cover (Single member age 65+)	BGAP Supreme Pensioner:	R823	BGAP Primary Pensioner:	R778

The monthly premium is inclusive of commission, binder fees and VAT. Premiums are valid for 2026. Prices may increase from 1 January 2027.

BGAP START

Please note that you can only join BGAP Start if you are on the following Bonitas options: **BonCore, BonStart, BonStart Plus, BonEssential, BonEssential Select, and BonFit**

Cover for main member (age 0-35)	BGAP Start – single:	R140	BGAP Start – family:	R182
Cover for main member (age 34-55)	BGAP Start – single:	R220	BGAP Start – family:	R286
Cover for main member (age 56-64)	BGAP Start – single:	R350	BGAP Start – family:	R455
Cover for main member (age 65+)	BGAP Start – single:	R440	BGAP Start – family:	R572

When do you want your cover to start?

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

PERSONAL INFORMATION

Title	<input type="text"/>	Initials	<input type="text"/>	<input type="text"/>	<input type="text"/>	First name	<input type="text"/>	
Surname	<input type="text"/>							
Identity/Passport number	<input type="text"/>				Date of birth	<input type="text"/>		
Medical scheme name	<input type="text"/>				Plan option	<input type="text"/>		
Medical scheme number	<input type="text"/>				Date joined	<input type="text"/>		
Postal address	<input type="text"/>							
	<input type="text"/>						Postal code	<input type="text"/>

PROVIDE US WITH YOUR BANKING DETAILS FOR YOUR MONTHLY PREMIUM DEDUCTION AND CLAIM PAYMENT

Your premium is payable monthly in advance. This means that depending on when we receive and process your application form, we may deduct the current and next month's premium at the same time.

Deduction date	<input type="text" value="1st"/>	<input type="text" value="7th"/>	<input type="text" value="10th"/>	<input type="text" value="15th"/>	<input type="text" value="20th"/>	<input type="text" value="25th"/>
Account holder name	<input type="text"/>					
Account holder ID number	<input type="text"/>					
Name of bank	<input type="text"/>					
Account number	<input type="text"/>				Branch code	<input type="text"/>
Type of account	<input type="text" value="Cheque"/>		<input type="text" value="Savings"/>		<input type="text" value="Transmission"/>	

DEBIT ORDER MANDATE

By initialling this box, you:

1. Authorise Guardrisk to debit your account with the monthly premium due in respect of this policy.
2. Acknowledge that this authorisation will remain in force and effect until cancelled by you, in writing with one calendar months' notice.
3. Understand that cancelling the Mandate does not cancel the Agreement. Agreement that the account holder is not entitled to refund for when the Mandate was still active, if such amounts were owed to them.
4. Acknowledge that this Authority may be assigned to a third party if this agreement is also assigned to a third party.
5. 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.
6. Undertake to inform Guardrisk of any change in your banking details and you authorise Guardrisk to verify such banking details with your bank.
7. Confirm that Guardrisk shall not be held liable for incorrect claim payments made as a result of your failure to inform Guardrisk of your change in banking details
8. Accept that Guardrisk may debit your account on a date other than that specified.
9. Notwithstanding the fact that you grant Guardrisk permission to collect premiums, you acknowledge that it is your responsibility to ensure that premiums are collected for cover to remain in force.
10. Acknowledge that the first payment date will be the first selected date of the month in which your cover starts.
11. Acknowledge that in the event that the payment day falls on a Sunday, or recognised South African public holiday, the payment day will automatically be the very next ordinary business day.
12. Acknowledge that payment instructions issued from this Mandate will be treated as payment instructions issued personally by the account holder.
13. Understand that the agreement reference number will be your membership number which will only be issued once your application form has been captured.
14. Understand that the debit order transaction on your bank statement will reflect as 'BGAP Cover'.

Signature of bank account holder

Date signed

TELL US WHO IS COMPLETING THIS FORM

Client/Applicant	<input type="text" value="Yes"/>	<input type="text" value="No"/>	<i>Please read and initial each declaration under Client/Applicant declaration and consent</i>
Appointed Broker	<input type="text" value="Yes"/>	<input type="text" value="No"/>	<i>Please read and initial each declaration under Broker declaration and consent</i>

PROVIDE US WITH YOUR BROKER'S DETAILS

Intermediary details

Consultant name	<input type="text"/>		
Brokerage	<input type="text"/>	FSP No.	<input type="text"/>
Email address	<input type="text"/>		
Mobile number	<input type="text"/>		

PROVIDE US WITH YOUR BROKER'S DETAILS (continued)

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.

Broker/Intermediary Signature

Date signed

YOUR DECLARATION AND CONSENT

1. I hereby apply for the BGAP product 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 Insurance Company Limited (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 and my dependants' cover will and will not pay.
8. I further declare that I understand my and my dependants' eligibility for cover depends on us remaining active members of a registered medical scheme. I undertake to inform Guardrisk if I, or any of my dependants, terminate our medical scheme membership at any time.
9. I confirm that I have appointed the above named financial advisor as intermediary to my policy.
10. I authorise Guardrisk to make payment of the monthly commission, calculated according to a scale of 20% of the first R299, and 15% of the remaining monthly premium, to the appointed intermediary for services rendered in respect of this policy.
11. I authorise the disclosure of relevant medical information by my medical scheme to Guardrisk to assist in the processing of claims under this policy. I understand that in terms of the Financial Advisory and Intermediary Services Act, 2002 ("FAIS"), the financial advisor must be mandated by a licensed Financial Services Provider ("FSP") as a representative with the necessary FAIS.
12. 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 the 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.
15. 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.
16. I authorise Guardrisk, or its appointed service provider, to negotiate on my or my dependants' 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 (prescribed minimum benefits).
17. I authorise Guardrisk to negotiate discounts on my or my dependants' 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.
18. 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.

YOUR DECLARATION AND CONSENT (continued)

19. I authorise Guardrisk to disclose all relevant information to the appointed broker 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 broker to assist in the processing of this application form, administering of this policy and any claims processed by Guardrisk on this policy.
20. I declare my understanding that a binder holder has been appointed to the group policy and payment of a monthly binder fee is made by Guardrisk, to such appointed binder holder.

By signing below you confirm:

1. That the intermediary 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 the intermediary is an accredited financial adviser in terms of the FAIS Act at the date of signing this application form.
3. That the intermediary accepts their appointment by you to provide advice and ongoing intermediary services in respect of this policy.
4. That the intermediary has made you aware of the commission payable by Guardrisk to him/her in respect of this policy.
5. That the intermediary has conducted a financial needs analysis and this insurance product is suitable to meet your insurance needs.
6. That the intermediary 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 the intermediary 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.

Signature of Applicant

Date signed

D	D	M	M	Y	Y	Y	Y
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