

LOMBARD
(FSP no.1596)

Underwriter:

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

Risk and Underwriting Managers:

Turnberry Management Services (Pty) Ltd
(Reg no : 2000/031522/07) FSP no. 46964

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

Telephone: 0861 000 509
 Fax: 0861 000 508
 Physical Address: 4 Osborne Lane, Bedfordview, 2007
 Postal Address: Private Bag X2, Gardenview, 2047

Broker Code:

Commencement Date:

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

Please complete and return by fax to: 0861 000 508 | Email to: newbusiness@turnberry.co.za | Mail to: Private Bag X2, Gardenview, 2047

Title: Gender: Male Female

ID Number: Date of Birth:

Initials: First Name:

Surname:

Residential or Physical Addresses:

Postal Addresses: Code:

WorkTel No. Cellular Tel No.

Fax No. Home Tel No.

Email:

A. DEPENDANT DETAILS

Name of Dependant		Identity Number (Date of Birth if no ID No)	Gender M/F	Relationship to Policyholder	Is Child a Full Time Student?	
Surname	First Name				<input type="radio"/> YES	<input type="radio"/> NO
					<input type="radio"/> YES	<input type="radio"/> NO
					<input type="radio"/> YES	<input type="radio"/> NO
					<input type="radio"/> YES	<input type="radio"/> NO
					<input type="radio"/> YES	<input type="radio"/> NO
					<input type="radio"/> YES	<input type="radio"/> NO

B. MEDICAL AID DETAILS

Company	Option	Medical Aid Number	Date Membership Commenced

C. FAMILY DOCTOR DETAILS

Name of General Practitioner/Family Doctor	Tel No.

D. STANDARD GAP COVER 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

PREMIER	PREMIER provides the Insured persons with the following cover:	
	Private Rate Cover:	Increases the medical aid rate up to 500% for in-hospital treatment. Unlimited overall annual limit
	Co-payment Cover:	R50 000 per in-hospital admission per insured, including out-patient costs as per policy document. Unlimited overall annual limit
	Non-DSP Hospital Penalty Cover:	R8 500 per admission. Limited to 1 claim per family per annum
	Sub-limit Cover:	R20 000 per in-hospital admission per insured, including out-patient costs as per the policy document. Unlimited overall annual limit
	Biological Cancer Drug Cover:	Pays the co-payment and/or sub-limit imposed by the Medical Scheme for defined biological cancer drugs Limited to R350 000 per insured person and R1 000 000 per family per annum
	Traditional Cancer Treatment:	Pays for treatment in a private facility, including sub-limits, deductibles or co-payments related to cancer treatment. Limited to R350 000 per person per annum with a R200 000 excess
	Cancer Diagnosis Benefit:	Once off payment of R20 000 for first diagnosis of cancer, provided that the member is on an approved oncology treatment plan
Medical Scheme Contribution Waiver:	Pays a benefit of R5 000 per month for 6 months in the event of the accidental death or Permanent and Total Disability due to accidental injuries, of the medical scheme contribution payer	
Stated Cash Back Benefit:	Pays the insured person a defined lump sum benefit in the event of hospitalisation for a period of longer than 3 days/72 hours	
Casualty Benefit:	Emergency Casualty benefit for accidental injury. Limited to R7 500 per event. Unlimited events per annum	
Personal Accident Benefit:	Pays a benefit of R20 000 per insured in the event of accidental death or Permanent and Total Disability resulting from injuries sustained as a result of an accident	
<input type="radio"/> R310/month	Maximum entry age 65 next birthday.	

ENHANCE	ENHANCE provides the Insured persons with the following cover:	
	Private Rate Cover:	Increases the medical aid rate up to 500% for in-hospital treatment. Unlimited overall annual limit
	Co-payment Cover:	R50 000 per in-hospital admission per insured, including out-patient costs as per policy document. Unlimited overall annual limit
	Sub-limit Cover:	R20 000 per in-hospital admission per insured, including out-patient costs as per the policy document. Unlimited overall annual limit
	Cancer Diagnosis Benefit:	Once off payment of R20 000 for first diagnosis of cancer, provided that the member is on an approved oncology treatment plan
Casualty Benefit:	Emergency Casualty benefit for accidental injury. Limited to R7 500 per event. Unlimited events per annum	
Personal Accident Benefit:	Pays a benefit of R20 000 per insured in the event of accidental death or Permanent and Total Disability resulting from injuries sustained as a result of an accident	
<input type="radio"/> R252/month	Maximum entry age 65 next birthday.	

OPTIMAL	OPTIMAL provides the Insured persons with the following cover:	
	Private Rate Cover:	Increases the medical aid rate up to 500% for in-hospital treatment. Unlimited overall annual limit
	Co-payment Cover:	R20 000 per in-hospital admission per insured, including out-patient costs as per policy document. Unlimited overall annual limit
	Sub-limit cover for Internal Prosthesis:	R10 000 per in-hospital admission per insured, for internal prosthesis. Limited to R50 000 per family per annum
	Traditional Cancer Treatment:	Pays the co-payments related to cancer treatment, limited to 20% per admission. Limited to R250 000 per insured per annum with a R200 000 excess
Biological Cancer Drugs:	Pays the co-payment and/or sub-limit imposed by the Medical Scheme for defined biological cancer drugs. Limited to R200 000 per insured per annum with a R200 000 excess	
Casualty Benefit:	Emergency Casualty benefit for accidental injury. Limited to R6 000 per event. Unlimited events per annum	
<input type="radio"/> R233/month	Maximum entry age 65 next birthday.	

SYNERGY	SYNERGY provides the Insured persons with the following cover:	
	Private Rate Cover:	Increases the medical aid rate up to 500% for in-hospital treatment. Unlimited overall annual limit
	Co-payment Cover:	R20 000 per in-hospital admission per insured, including out-patient costs as per the policy document. Unlimited overall annual limit
	Sub-limit Cover for Internal Prosthesis:	R10 000 per in-hospital admission per insured, for internal prosthesis. Limited to R50 000 per family per annum
Casualty Benefit:	Emergency Casualty benefit for accidental injury. Limited to R6 000 per event. Unlimited events per annum	
<input type="radio"/> R178/month	Maximum entry age 65 next birthday.	

VITAL	VITAL provides the Insured persons with the following cover:	
	Private Rate Cover:	Increases the medical aid rate up to 500% for in-hospital treatment. Unlimited overall annual limit
	Casualty Benefit:	Emergency Casualty benefit for accidental injury. Limited to R6 000 per event. Unlimited events per annum
<input type="radio"/> R167/month	Maximum entry age 65 next birthday.	

SENIOR GAP COVER PRODUCTS

SENIOR	SENIOR provides the Insured persons with the following cover:	
	Private Rate Cover:	Increases the medical aid rate up to 500% for in-hospital treatment. Unlimited overall annual limit
	Co-payment Cover:	R15 000 per in-hospital admission per insured, including out-patient costs as per policy document. Unlimited overall annual limit
	Sub-limit Cover:	R15 000 per in-hospital admission per insured. Limited to R50 000 per family per annum
<input type="radio"/> R255/month	Entry ages are 65 to 80 next birthday.	

E. TRAVEL ASSIST

If you purchase any one of the products listed on page 2 of this application form, you qualify for international travel insurance for travel outside the borders of South Africa. Cover is provided by TIC, ensures end to end emergency service by air, land or sea, anywhere in the world, 24 hours a day. The maximum length of a trip is limited to 90 days. Medical expenses are covered up to an amount of R5 000 000. Notification of travel must be given to Turnberry on 0861 000 509 at least 48 hours prior to departure, during the hours 08h00 to 16h00 Monday to Friday (excluding public holidays). Maximum age is 80 years next birthday.

F. EXTENDED FAMILY COVER

A "Family" means the Principal insured person and an Eligible spouse (listed under Section A) and Eligible children (listed under Section A), who have not attained the age of 26 years unless mentally or physically disabled and unable to earn any form of income. Any dependants falling under this definition are included at no additional cost. If you have extended family or an additional dependant registered on your medical aid and they do not qualify in terms of our definition of a family as per the definition above, you may add them onto your policy. The cost per additional dependant is detailed below. Rates quoted below are per person. To calculate the additional cost for extended family you wish to cover, multiply the number of people by the rate for the applicable age category.

Product	Ages 26-64 (incl)		Ages 65-79 (incl)		Total
	Rate	Number	Rate	Number	
PREMIER	R86		N/A		
ENHANCE	R65		N/A		
OPTIMAL	R75		N/A		
SYNERGY	R72		R196		
VITAL	R36		R105		

G. WAITING PERIODS

PLEASE NOTE, a 3-month waiting period shall apply, with exception of benefits providing cover up to 500% if cover commences in line with your Medical Aid commencement. There is a 9-month waiting period on all pregnancy/childbirth benefits and a 12-month waiting period on all hysterectomy, hysteroscopies and endometrial ablations, joint replacements and spinal investigations, surgery or treatment, tonsillectomy, grommets, adenoids, hernia repairs and wisdom teeth benefits for all of the above policies. Pre-diagnosed cancer is covered provided that the Insured person is in complete remission for a period of 5 years. A 12-month exclusion will be applied to all pre-existing conditions on all policies. All rates are quoted per family.

H. DECLARATION OF HEALTH

1. Are you or any dependants under the above policies aware of any reason why hospitalisation and/or medical treatment may be required in the next 12 months from the date of application? (If yes, provide details below.) YES NO

Name	Symptoms/Diagnosis	Treatment	Date of first Diagnosis/Symptoms	Date of last Treatment

2. Have you or any dependants under the above policies been diagnosed, treated, hospitalised and/or sought medical advice for any condition within the last 12 months, from date of application? (If yes, provide details below.) YES NO

Name	Symptoms/Diagnosis	Treatment	Date of first Diagnosis/Symptoms	Date of last Treatment

3. Have you or any dependants under the above policies ever been diagnosed with and/or treated for cancer? (If yes, provide details below.) YES NO

Name	Symptoms/Diagnosis	Treatment	Date of first Diagnosis/Treatment	Date of last Treatment

SHOULD THE INFORMATION PROVIDED ABOVE BE INSUFFICIENT TO ASSESS THE RISK, ADDITIONAL MEDICAL INFORMATION WILL BE REQUESTED. SHOULD THE SPACE PROVIDED ABOVE BE INSUFFICIENT PLEASE ATTACH A SUPPORTING SCHEDULE.

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

Accountholder's Name	
Name of Bank	
Branch Name and Town	
Branch Code	
Account Number	

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 authorise Turnberry to draw against my current 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 above mentioned insurance benefits. All such withdrawals from my bank account by you 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. This authority shall continue in full force and effect until cancelled by me giving 30 days' written notice thereof sent to Turnberry by prepaid registered post, but I understand that such cancellation may result in the cancellation of the policy and will not relieve me of 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 Accountholder: _____ Date:

J. EMPLOYER AUTHORISATION FOR DEDUCTION OF MONTHLY PREMIUMS FROM SALARY

(MUST BE COMPLETED BY ALL EMPLOYEES) AUTHORISATION TO RECOVER PREMIUMS FROM MY SALARY

I, _____ I.D.No. hereby authorise my employer to deduct from my salary my portion, where applicable, of the monthly premium, future increases, arrears and any other amounts due by me to the insurer.

Signature of Accountholder: _____ Date:

K. DECLARATION BY THE POLICYHOLDER

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 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 LOA any information to assess risks or claims. Any informations 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 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.

Freedom of choice: Have you been advised of and exercised your free choice to take out insurance with the insurer and intermediary of your choice? YES NO

Has any insurer ever declined a proposal of yours or cancelled any policy or any section thereof? YES NO
 If "YES", please provide details

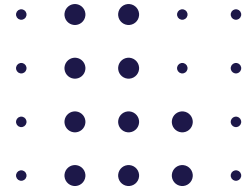
Is this policy replacing a policy of the same or similar type? YES NO

If "YES", have the product benefits and restrictions been adequately compared? YES NO

Remarks: _____

Signature: _____ Date:

PRINCIPAL MEMBERSHIP CHANGE FORM



LOMBARD

(FSP no.1596)

Current Principle Member:

Telephone: 0861 000 509

Fax: 0861 000 508

Current Principle Member ID Number:

Physical Address: 4 Osborne Lane, Bedfordview, 2007

Postal Address: Private Bag X2, Gardenview, 2047

Please complete and return by fax to: 086 649 0417 | Email to: admin@turnberry.co.za

Please note, it is not necessary to change the principle membership if spouses have elected to change principal membership on their medical aid. Principal membership should be changed in the event of a divorce or death of the principal insured person.

A. NEW PRINCIPAL MEMBER DETAILS

Title:	<input type="text"/>	Gender:	<input type="radio"/> Male	<input type="radio"/> Female	
ID Number:	<input type="text"/>	Date of Birth:	<input type="text"/>		
Initials:	<input type="text"/>	First Name:	<input type="text"/>		
Surname:	<input type="text"/>				
Residential or Physical Addresses:	<input type="text"/>				
	<input type="text"/>			Code:	<input type="text"/>
Postal Addresses:	<input type="text"/>				
	<input type="text"/>			Code:	<input type="text"/>
WorkTel No.	<input type="text"/>	Cellular Tel No.	<input type="text"/>		
Fax No.	<input type="text"/>	Home Tel No.	<input type="text"/>		
Email:	<input type="text"/>				
Medical Aid Name:	<input type="text"/>	Medical Aid No.	<input type="text"/>		

The Principal Member on the Policy has changed as stated above and we request Turnberry to amend the policy in accordance with this change. Turnberry will issue the contract in the name of the new Principal Member.

The banking details for monthly premium deduction will remain unchanged unless the New Debit Order Authority on the following page is completed and signed by the account holder.

B.

BANK DETAILS FOR DEDUCTIONS OF MONTHLY PREMIUM BY DEBIT ORDER

Accountholder's Name	
Name of Bank	
Branch Name and Town	
Branch Code	
Account Number	

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 authorise Turnberry to draw against my current 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 abovementioned insurance and lifestyle benefits. All such withdrawals from my bank account by you 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. This authority shall continue in full force and effect until cancelled by me giving 30 days' written notice thereof, sent to Turnberry by prepaid registered post, but I understand that such cancellation may result in the cancellation of the policy and will not relieve me of 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 while this authority was in force, unless I can prove that any such amounts were not legally owing to Turnberry. Receipt of this instruction by Turnberry shall be regarded as receipt thereof by my bank.

Signature: _____ Date:

C.

DECLARATION BY THE POLICYHOLDER

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 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 declaration of health and the date of acceptance of the risk 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 of the policy may render my policy null and void and all premiums paid 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 LOA 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.

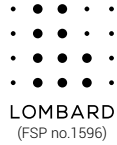
I acknowledge that should any of my personal and/or banking details change it is my responsibility to ensure that Turnberry are notified of the changes.

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

Should any of your contact details have changed, please advise us.

Signature original principal member (if not deceased) : _____

Signature New principal member: _____ Date:



APPLICATION FOR REINSTATEMENT

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

Telephone: 011 677 9891
 Fax: 0861 000 508
 Physical Address: 4 Osborne Lane, Bedfordview, 2007
 Postal Address: Private Bag X2, Gardenview, 2047

Policy Number:

Please complete and return by fax to: 086 649 0417 | Email to: admin@turnberry.co.za

I, _____ I.D.No. apply for my Policy(ies) to be reinstated and agree to pay any arrear premiums that may have resulted from the cancellation of my Policy.

A. DECLARATION OF HEALTH						
1.	Are you or any dependants under the above Policies aware of any reason why hospitalisation and/or medical treatment may be required in the next 12 months from the date of application? (If yes, provide details below.)				YES <input type="radio"/>	NO <input type="radio"/>
	Name	Symptoms/Diagnosis	Treatment	Date of first Diagnosis/Symptoms	Date of last Treatment	
2.	Have you or any dependants under the above Policies been diagnosed, treated, hospitalised and/or sought medical advice for any condition within the last 12 months, from date of application? (If yes, provide details below.)				YES <input type="radio"/>	NO <input type="radio"/>
	Name	Symptoms/Diagnosis	Treatment	Date of first Diagnosis/Symptoms	Date of last Treatment	
3.	Have you or any dependants under the above Policies ever been diagnosed with and/or treated for cancer? (If yes, provide details below.)				YES <input type="radio"/>	NO <input type="radio"/>
	Name	Symptoms/Diagnosis	Treatment	Date of first Diagnosis/Treatment	Date of last Treatment	
SHOULD THE INFORMATION PROVIDED ABOVE BE INSUFFICIENT TO ASSESS THE RISK, ADDITIONAL MEDICAL INFORMATION WILL BE REQUESTED. SHOULD THE SPACE PROVIDED ABOVE BE INSUFFICIENT PLEASE ATTACH A SUPPORTING SCHEDULE.						

B.

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 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: _____

C.

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?

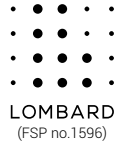
YES NO

If "YES", have the product benefits and restrictions been adequately compared and explained to you?

YES NO

Signature: _____

Date: _____



TURNBERRY DEBIT ORDER AUTHORISATION

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

Telephone: 011 677 9891
Fax: 0861 000 508
Physical Address: 4 Osborne Lane, Bedfordview, 2007
Postal Address: Private Bag X2, Gardenview, 2047

Policy No.		Debtor No.	
ID No.			

Please complete and return by fax to: 086 649 0417 | Email to: debtors@turnberry.co.za

Please note, should you change your collection date from 1st or 7th to the 15th or 25th, the collection will be for the next month and could result in a double deduction.

A. 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 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:



(FSP no. 36571)



LOMBARD
(FSP no.1596)

TURNBERRY DECLARATION OF HEALTH

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

Telephone: 011 677 9891
Fax: 0861 000 508
Physical Address: 4 Osborne Lane, Bedfordview, 2007
Postal Address: Private Bag X2, Gardenview, 2047

Policy Number:

Please complete and return by fax to: 086 649 0417 | Email to: admin@turnberry.co.za

A. DECLARATION OF HEALTH						
1.	Are you or any dependants under the above Policies aware of any reason why hospitalisation and/or medical treatment may be required in the next 12 months from the date of application? (If yes, provide details below.)				YES <input type="radio"/>	NO <input type="radio"/>
	Name	Symptoms/Diagnosis	Treatment	Date of first Diagnosis/ Symptoms	Date of last Treatment	
2.	Have you or any dependants under the above Policies been diagnosed, treated, hospitalised and/or sought medical advice for any condition within the last 12 months, from date of application? (If yes, provide details below.)				YES <input type="radio"/>	NO <input type="radio"/>
	Name	Symptoms/Diagnosis	Treatment	Date of first Diagnosis/ Symptoms	Date of last Treatment	
3.	Have you or any dependants under the above Policies ever been diagnosed with and/or treated for cancer? (If yes, provide details below.)				YES <input type="radio"/>	NO <input type="radio"/>
	Name	Symptoms/Diagnosis	Treatment	Date of first Diagnosis/ Treatment	Date of last Treatment	
SHOULD THE INFORMATION PROVIDED ABOVE BE INSUFFICIENT TO ASSESS THE RISK, ADDITIONAL MEDICAL INFORMATION WILL BE REQUESTED. SHOULD THE SPACE PROVIDED ABOVE BE INSUFFICIENT PLEASE ATTACH A SUPPORTING SCHEDULE.						

Signature: _____

Date:



TURNBERRY DEPENDANT ADDITION FORM 2023

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

Policy No.	
------------	--

Please complete and return by fax to: 086 649 0417 | Email to: admin@turnberry.co.za

Principal Insured Person:		ID Number:	
Address:			
Telephone Number:		Email Address:	

A. DEPENDANT DETAILS

Spouse/Partner and children up to 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. New dependants added are underwritten and subject to Waiting Periods.

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

B. 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. New dependants added are underwritten and subject to Waiting Periods.

Product	Ages 26 - 64 (incl)		Ages 65 - 79 (incl)		Ages 80+	
	Rate	Number	Rate	Number	Rate	Number
PREMIER	R144		R466		R593	
OPTIMAL	R135		R380		R486	
SYNERGY	R134		R376		R480	
LAUNCH	R33		R57		R88	
MED-EXTEND	R124		R469		R598	

C. 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 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 declaration of health and the date of acceptance of the risk 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 of the policy may render my policy null and void and all premiums paid 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 or any interception of any communication between Turnberry and me.

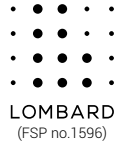
I acknowledge that should any of my personal and/or banking details change it is my responsibility to ensure that Turnberry are notified of the changes. I acknowledge that the premium is due monthly in advance on the 1st day of each calendar month and if not received by Turnberry by the 15th day of the 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.

Has any Insurer ever declined a proposal of yours or cancelled any policy or any section thereof? YES NO

If "YES", please provide details.

Remarks: _____

Signature: _____ Date: _____



HEALTH/GAP COVER CLAIM FORM 2023

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

Telephone: 011 677 9891
 Fax: 0861 000 508
 Physical Address: 4 Osborne Lane, Bedfordview, 2007
 Postal Address: Private Bag X2, Gardenview, 2047

Policy Number:

Please complete and return by fax to: 086 500 7532 or 086 673 4224 | Email to: claims@turnberry.co.za

A. DOCUMENTS REQUIRED

Turnberry must be notified in writing of any claim within five (5) months calculated from the date of treatment. Outstanding documentation needs to be submitted within 90 days from the date, outstanding documentation is requested by Turnberry. Please ensure that all documents requested below accompany your completed claim form to avoid unnecessary delays.

- Completed Claim Form
- Copy of your service provider's/doctor's account reflecting all transactions relating to the claim
- Copy of the Hospital Account (for co-payments, sub-limits, casualty benefit and shortfalls for pathology and radiology)
- Copy of your Medical Scheme's statement reflecting all transactions relating to the claim/treatment. Unfortunately an "acknowledge of payment" issued by your Medical Scheme does not provide the necessary information.

Please note, based on the information provided Turnberry may need to request additional information.

B. DETAILS OF PRINCIPAL INSURED PERSON

Title:	<input type="text"/>	Gender:	<input type="radio"/> Male	<input type="radio"/> Female
ID Number:	<input type="text"/>	Date of Birth:	<input type="text"/>	
Initials:	<input type="text"/>	First Name:	<input type="text"/>	
Surname:	<input type="text"/>			
Postal Address:	<input type="text"/>			
	<input type="text"/>			Code: <input type="text"/>
Work Tel No.	<input type="text"/>	Cellular Tel No.	<input type="text"/>	
Home Tel No.	<input type="text"/>	Email:	<input type="text"/>	

C. MEDICAL AID DETAILS

Company	Option	Medical Aid Number
<input type="text"/>	<input type="text"/>	<input type="text"/>

D. DETAILS OF PATIENT

Surname:	<input type="text"/>	Title:	<input type="text"/>
First Names:	<input type="text"/>		
ID Number (If not available Date of Birth):	<input type="text"/>		
Referring doctor/GP details (name & contact number):	<input type="text"/>		

E.

CLAIMS OF CANCER ONLY

Has the patient received treatment, consulted with a medical service provider and/or received advice in relation to the condition in the last 12 months? If so, please provide the date(s) of the consultation(s).

F.

Turnberry reserves the right to negotiate a discounted rate with your relevant medical service provider(s) in exchange for direct payment to them.

Please advise if you have paid your medical service provider(s)? Yes No

G.

BANK DETAILS OF PRINCIPAL INSURED

Accountholder's Name	
Name of Bank	
Branch Code	
Account Number	

Type of account: Cheque Savings Transmission

I declare that the banking details provided are correct, failing which, Turnberry is not liable for any losses, charges and expenses. I accept that it is my responsibility to notify Turnberry timeously of any changes in my banking details. The indemnity payment may give rise to a potential Output Tax liability under section 7(1)(a) read with section 8(8) of the Value Added Tax Act.

Signature of Principal Insured: _____ Date:

H.

DECLARATION BY THE PRINCIPAL INSURED

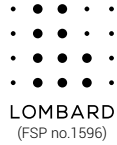
"I warrant that I am legally entitled to receive the benefits in terms of the said Policy. Turnberry shall not be liable for payment if the cause of accident/illness is related to an exception detailed in the Policy Schedule and any endorsements thereto. In support of a claim in terms of the said Policy, I declare that all statements and answers which may now or at any time be given in connection with this claim, whether in my handwriting or not, are true and complete. I understand that any misstatement or non-disclosure, which materially affects the assessment of this claim, will entitle Turnberry to declare this claim null and void. I hereby authorise the patient's Medical Scheme, any Hospital, medical service provider or any other person who has attended to or examined the patient, to furnish to Turnberry or Turnberry's authorised representative any information with respect to any illness or injury, medical history, consultations, prescriptions or treatment and copies of all hospital or medical records. A copy of this authorisation shall be considered as effective and valid as the original.

Should any benefit be paid by Turnberry and subsequently settled, in whole or part, by the patient's medical aid or the medical service provider reduced the amount they have charged, the amount of the overpayment will be refunded to Turnberry. I acknowledge and accept that for the purposes of assessing and processing this claim, effectively administering your policy and dealing with all other matters related thereto, Turnberry Management Risk Solutions may process and share my information with Lombard Insurance Company Limited, its third party service providers and/or agents who will assist in the investigation of your claim and/or the administration of your policy. During this process, my information may also be shared with your medical scheme.

On my own behalf, and on behalf of any person(s) I represent herein, I hereby consent to such information being disclosed for the aforementioned purposes with the aforementioned parties. I also acknowledge that the insurance information provided by me may be stored in a shared database and used as set out above.

Turnberry Management Risk Solutions, Lombard Insurance Company Limited and its associated parties undertake to insure that your personal information is protected as required under the Protection of Personal Information Act 4 of 2013, as amended, and that your personal information will not be shared with third parties for any purpose or in any format whatsoever, apart from the sharing of information as contemplated in the preceding paragraph.

Signature: _____ Date:



POLICY UPGRADE/ REPLACEMENT FORM 2023

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

Telephone: 011 677 9891
 Fax: 0861 000 508
 Physical Address: 4 Osborne Lane, Bedfordview, 2007
 Postal Address: Private Bag X2, Gardenview, 2047

Current Policy No	
Current Policy Type	

Principle Insured Person:	<input type="text"/>	Principal Insured ID Number:	<input type="text"/>
Replacement Policy Type:	<input type="text"/>	Replacement Policy Start Date:	<input type="text"/>

Please complete and return by fax to: 086 649 0417 | Email to: admin@turnberry.co.za

A. NOTES

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. Accidents will be covered within the 3 month general waiting period. 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), tonsillectomy, myringotomy, grommets, adenoids, wisdom teeth, hernia, cataracts, gastroscopies, colonoscopies, nasal and sinus, cancer

B. 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.

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:

REPLACEMENT COMPARISON SCHEDULE

MEDICAL EXPENSE SHORTFALL PRODUCTS			
THIS IS NOT A MEDICAL SCHEME AND THE COVER IS NOT THE SAME AS THAT OF A MEDICAL SCHEME. THIS POLICY IS NOT A SUBSTITUTE FOR MEDICAL SCHEME MEMBERSHIP.			
Please indicate your current Policy and select a new Policy		Please tick the relevant boxes below	
Vital Plus	R359 per family per month. R316 per individual per month	Current	<input type="checkbox"/>
BENEFIT SUMMARY Overall Annual Limit (OAL): R185 837.63 per person per annum • Increases the Medical Aid rate up to 500% for in-hospital treatment. Subject to OAL • Sub-limits: R4 000 per admission, per insured. Subject to OAL			
Co-Care Standard	R219 per family per month	Current	<input type="checkbox"/>
BENEFIT SUMMARY Overall Annual Limit (OAL): R185 837. per person per annum • Co-payments: R24 000 per admission, per insured. Subject to OAL			

REPLACEMENT COMPARISON SCHEDULE

MEDICAL EXPENSE SHORTFALL PRODUCTS

THIS IS NOT A MEDICAL SCHEME AND THE COVER IS NOT THE SAME AS THAT OF A MEDICAL SCHEME. THIS POLICY IS NOT A SUBSTITUTE FOR MEDICAL SCHEME MEMBERSHIP.

Please indicate your current Policy and select a new Policy		Please tick the relevant boxes below	
Co-Care Plus	R291 per family per month	Current <input type="radio"/>	
BENEFIT SUMMARY <i>Overall Annual Limit (OAL): R185 837.63 per person per annum</i> • Co-payments: R24 000 per admission, per insured. Subject to OAL • Sub-limits: R12 500 per admission, per insured. Subject to OAL			
Optimal Standard	R294 per family per month	Current <input type="radio"/>	
BENEFIT SUMMARY <i>Overall Annual Limit (OAL): R185 837.63 per person per annum</i> • Increases the Medical Aid rate up to 500% for in-hospital treatment. Subject to OAL • Cancer cover: Subject to OAL • Biological Cancer Drugs: Subject to OAL			
Vital 200	R213 per family per month	Current <input type="radio"/>	
BENEFIT SUMMARY <i>Overall Annual Limit (OAL): R185 837.63 per person per annum</i> • Increases the Medical Aid rate up to 500% for in-hospital treatment. Subject to OAL			
Launch	R154 per family per month, R266 per family for 65yrs	Current <input type="radio"/>	New <input type="radio"/>
BENEFIT SUMMARY <i>Overall Annual Limit (OAL): R185 837.63 per person per annum</i> • Increases the Medical Aid rate up to 350% for in-hospital treatment. Subject to OAL • Casualty Benefit: R6 000 per event. Subject to OAL • Medical Scheme Contribution Waiver: Up to R6 000 per month for 6 months; in the event of death or permanent and total disability as a result of an accident, of the Medical Scheme contribution payer. • Gap Premium Waiver: Pays the premium for your Launch Policy for 12 months; in the event of death or permanent and total disability as a result of an accident, of the contribution payer			Under 65 yrs: <input type="radio"/> 65+ yrs: <input type="radio"/>
Vital	R308 per family per month, R417 per family for 65yrs	Current <input type="radio"/>	
BENEFIT SUMMARY <i>Overall Annual Limit (OAL): R185 837.63 per person per annum</i> • Increases the Medical Aid rate up to 500% for in-hospital treatment. Subject to OAL • Accidental Casualty Benefit: R8 000 per event. Subject to OAL • Medical Scheme Contribution Waiver: Up to R6 000 per month for 6 months; in the event of death or permanent and total disability as a result of an accident, of the Medical Scheme contribution payer. • Gap Premium Waiver: Pays the premium for your Vital Policy for 12 months; in the event of death or permanent and total disability as a result of an accident, of the contribution payer			
Synergy	R334 per family per month, R465 per family for 65yrs+	Current <input type="radio"/>	New <input type="radio"/>
BENEFIT SUMMARY <i>Overall Annual Limit (OAL): R185 837.63 per person per annum</i> • Increases the Medical Aid rate up to 500%. (e.g. Specialists, GPs, Anaesthetists, Radiology, Pathology, etc.). Subject to OAL • Co-payments: Subject to OAL. • Co-payments for Scopes: R4 000 per event per insured. Limited to 2 claims per insured and subject to OAL • Non-DSP Hospital Penalty Cover: R9 000 per admission. Limited to 1 claim per family per annum, subject to OAL • Sub-limit Cover: R28 000 per admission. Limited to R70 000 per family per annum, subject to OAL • Accidental Casualty Benefit: R9 500 per event per insured. Subject to the OAL • Casualty Benefit for Illness: R3 000 per event. Limited to 2 claims per family per annum. Subject to OAL • MRI and CT Scan Cover: R4 500 per event, limited to 1 claim per family per annum and subject to OAL • Trauma Care Cover: Trauma counselling R2 000 per event. Limited to R6 000 per family and OAL • Medical Scheme Contribution Waiver: Up to R6 000 per month for 6 months; in the event of death or permanent and total disability as a result of an accident, of the Medical Scheme contribution payer • Gap Premium Waiver: Pays the premium for your Synergy Policy for 12 months; in the event of death or permanent and total disability as a result of an accident, of the contribution payer • Personal Accident Benefit: R10 000 per insured payable upon death or permanent and total disability			Under 65 yrs: <input type="radio"/> 65+ yrs: <input type="radio"/>
Optimal	R391 per family per month, R575 per family for 65yrs	Current <input type="radio"/>	New <input type="radio"/>
BENEFIT SUMMARY <i>Overall Annual Limit (OAL): R185 837.63 per person per annum</i> • Increases the Medical Aid rate up to 500% for in-hospital treatment. Subject to OAL • Co-payments: Subject to OAL • Non-DSP Hospital Penalty: R11 000 per admission. Limited to 1 claim per family per annum. Subject to OAL • Co-payments for Scopes: R4 000 per event per insured. Limited to 2 claims per insured per annum and subject to OAL • Sub-limit Cover: R28 000 per admission. Limited to R70 000 per family per annum, subject to OAL • Cancer Cover: 20% co-payment cover. Subject to OAL • Biological Cancer Drugs: Subject to formulary and OAL • Breast Cancer Prevention Cover: Increases the Medical Aid rate up to 500% for Prophylactic Mastectomy. Subject to OAL • Breast Cancer Reconstruction: After cancer, increases the Medical Aid rate up to 500%. Unaffected breast reconstruction limited to R18 000. Subject to OAL • Accidental Casualty Benefit: R10 000 per event. Subject to OAL • Casualty Benefit for Illness: R3 500 per event. Limited to 2 claims per family per annum. Subject to OAL • MRI and CT Scan Cover: R5 500 per event, limited to 2 claims per family per annum and subject to OAL • Trauma Care Cover: Trauma counselling R2 000 per event. Limited to R7 000 per family and OAL • Medical Scheme Contribution Waiver: Up to R6 000 per month for 6 months; in the event of death or permanent and total disability as a result of an accident, of the Medical Scheme contribution payer. • Gap Premium Waiver: Pays the premium for your Optimal Policy for 12 months; in the event of death or permanent and total disability as a result of an accident, of the contribution payer • Personal Accident Benefit: R15 000 per insured payable upon death or permanent and total disability • Critical Illness Benefit R 7 500 per insured payable in the event of death due to a critical illness (excludes cancer)			Under 65 yrs: <input type="radio"/> 65+ yrs: <input type="radio"/>

REPLACEMENT COMPARISON SCHEDULE

MEDICAL EXPENSE SHORTFALL PRODUCTS

THIS IS NOT A MEDICAL SCHEME AND THE COVER IS NOT THE SAME AS THAT OF A MEDICAL SCHEME. THIS POLICY IS NOT A SUBSTITUTE FOR MEDICAL SCHEME MEMBERSHIP.

Please indicate your current Policy and select a new Policy		Please tick the relevant boxes below	
Enhance	R425 per family per month, R641 per family for 65yrs+	Current <input type="radio"/>	
BENEFIT SUMMARY <i>Overall Annual Limit (OAL): R185 837.63 per person per annum</i> <ul style="list-style-type: none"> Increases the Medical Aid rate up to 500% for in-hospital treatment. Subject to OAL Co-payments: Subject to OAL Sub-limits: R23 000 per admission, per insured. Subject to OAL R20 000 payable on the first diagnosis of cancer provided that the insured is on an approved oncology treatment plan Personal Accident Benefit: R20 000 per insured payable upon death and permanent and total disability Accidental Casualty Benefit: R10 500 per event. Subject to OAL Medical Scheme Contribution Waiver: Up to R6 000 per month for 6 months; in the event of death or permanent and total disability as a result of an accident, of the Medical Scheme contribution payer. Gap Premium Waiver: Pays the premium for your Enhance Policy for 12 months; in the event of death or permanent and total disability as a result of an accident, of the contribution payer 			
Premier	R521 per family per month, R748 per family for 65yrs+	Current <input type="radio"/>	New <input type="radio"/>
BENEFIT SUMMARY <i>Overall Annual Limit (OAL): R185 837.63 per person per annum</i> <ul style="list-style-type: none"> Increases the Medical Aid rate up to 600% for in-hospital treatment. Subject to OAL Co-payments: Subject to OAL Non-DSP Hospital Penalty Cover: R14 000 per admission. Limited to 2 claims per family per annum, subject to OAL Sub-limits: R38 000 per admission, per insured. Subject to OAL Trauma Recovery Cover: Sub-limit cover of R3 000 per admission and R10 000 per family. Subject to OAL Cancer Cover: Subject to OAL Biological Cancer Drugs: Subject to OAL Breast Cancer Prevention Cover: Increases the Medical Aid rate up to 600% for Prophylactic Mastectomy. Subject to OAL Breast Cancer Reconstruction: After cancer, increases the Medical Aid rate up to 600%. Unaffected breast reconstruction limited to R25 000. Subject to OAL Accidental Casualty Benefit: R15 000 per event. Subject to OAL. Casualty Benefit for Illness: R3 500 per event. Limited to 3 claims per family per annum. Subject to OAL MRI and CT Scan Cover: R6 500 per event, limited to 2 claims per family per annum and subject to OAL Trauma Care Cover: Trauma counselling R2 000 per event. Limited to R8 000 per family and OAL Benefit payable based on Cancer Stage at time of diagnosis Medical Scheme Contribution Waiver: Up to R6 000 for 6 months, payable upon accidental death or permanent and total disability due to an accident of the Medical Scheme contribution payer Gap premium Waiver: Pays the premium for your Premier Policy for 12 months; in the event of death or permanent and total disability as a result of an accident, of the contribution payer Personal Accident Benefit: R30 000 per insured payable upon death or permanent and total disability Critical Illness Benefit R 10 000 per insured payable in the event of death due to a critical illness (excludes cancer) 			Under 65 yrs: <input type="radio"/> 65+ yrs: <input type="radio"/>
Med-Extend	R369 per family per month, R498 per family for 65yrs+	Current <input type="radio"/>	New <input type="radio"/>
BENEFIT SUMMARY <i>Overall Annual Limit (OAL): R185 837.63 per person per annum</i> <ul style="list-style-type: none"> Increases the Medical Aid rate up to 500%. Subject to OAL Defined Procedures: Procedures excluded by the Medical Scheme. Subject to specified rand value and OAL MedBoost: Lump sum benefit when you undergo a Defined procedure and have been claim free 			Under 65 yrs: <input type="radio"/> 65+ yrs: <input type="radio"/>

SENIOR GAP COVER PRODUCTS

Vital Senior Care	R342 per family per month	Current <input type="radio"/>	
BENEFIT SUMMARY <i>Overall Annual Limit (OAL): R185 837.63 per person per annum</i> <ul style="list-style-type: none"> Increases the Medical Aid rate up to 500% for in-hospital treatment. Subject to OAL 			
Co-Care Senior	R316 per family per month	Current <input type="radio"/>	
BENEFIT SUMMARY <i>Overall Annual Limit (OAL): R185 837.63 per person per annum</i> <ul style="list-style-type: none"> Co-payments: R12 500 per admission, per insured (no cover for MRI, CT and PET scans done out-of-hospital). Subject to OAL Sub-limits: R12 500 per admission, per insured. Subject to OAL 			
Senior	R499 per family per month	Current <input type="radio"/>	
BENEFIT SUMMARY <i>Overall Annual Limit (OAL): R185 837.63 per person per annum</i> <ul style="list-style-type: none"> Increases the Medical Aid rate up to 500% for in-hospital treatment. Subject to OAL Co-payments: R18 500 per admission, per insured (includes co-payment cover for MRI, CT and PET scans done out-of-hospital). Subject to OAL Sub-limit Cover: R18 500 per admission per insured. Limited to R57 000 per family per annum and subject to OAL 			

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:

DECLARATION BY PRINCIPAL INSURED

Please note the product summaries above reflect the key points for comparison between the products. These points and any other applicable points should be discussed with your broker in conjunction with your Needs Analysis.

I confirm that the representative has fully explained the consequences of the replacement of the Policy(ies) mentioned in this Replacement Policy Advice Record and I understand the consequences of such replacement(s).

Signature: _____

Date:

DECLARATION BY FSP REPRESENTATIVE

I confirm that I have taken all reasonable steps to confirm that the information in this Replacement Policy Advice Record (RPAR) is true and correct. I confirm that in pursuance of my advice to the Policyholder to replace the Policy(ies) mentioned in this RPAR, I have fully discharged my duties as set out in section 8(d) of the General Code of Conduct for authorised Financial Service Providers and their representatives (the Code) and have retained a record of such advice as required by section 3 of the said Code.

Signature of representative: _____

Date:



TURNBERRY TRAVEL INSURANCE APPLICATION FORM 2023

Insurer:
Santam Limited
FSP no. 3416

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

Telephone: 011 677 9891
 Fax: 0861 000 508
 Physical Address: 4 Osborne Lane, Bedfordview, 2007
 Postal Address: Private Bag X2, Gardenview, 2047

Policy No.		Main Member ID No.	
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Please complete and return by fax to: 086 676 0777 | Email to: gordenes@turnberry.co.za

Dear Turnberry Member,

Your Turnberry membership provides you with access to Leisure Travel Insurance. This policy will insure you and your dependants, as listed under your Turnberry policy, against emergency medical expenses that may be incurred while traveling outside of South Africa. Cover is for trips of up to 90 days only with cover starting on the date of departure from RSA.

FREE BENEFIT	TOP UP BENEFIT
<ul style="list-style-type: none"> R5,000,000 per person travelling for emergency medical expenses only – 90 days only No cover for pre-existing medical conditions (conditions that you have already been diagnosed with 6 months prior to travelling). Maximum age is 80 years next birthday 	<ul style="list-style-type: none"> Only available to policyholders under the age of 69 Cost and Benefit details on page 2 of this document The cover is offered to extend your current travel benefits, not to extend the period of travel

In order to activate this benefit, please complete the form below.

Please ensure that application forms are sent to our offices at least **48 hours (2 working days)** before departure. A policy document confirming your emergency medical cover will be issued and sent to you.

A. TRAVELLER DETAILS				
	Full Names	Surname	Title	ID number
Traveller 1				
Traveller 2				
Traveller 3				
Traveller 4				
Traveller 5				

B. ITINERARY		
Departure Date from RSA	Return date to RSA	Main destination

C. CONTACT DETAILS		
Telephone Number	Cell Number	E-mail Address to Send Certificate to

Are you applying for a Visa? YES NO If so, for which country:

TURNBERRY TOP UP TRAVEL POLICY

PRE-EXISTING CONDITIONS, LUGGAGE & FLIGHT COVER - **(Only covers policyholders up to age of 69)**. The top-up travel cover only extends benefits; it does not extend the length of cover beyond the 90 days. Please note that no pre-existing conditions, luggage or flight cover are covered on the base Travel insurance product. Should you have a pre-existing condition and require cover for it, we have a Travel Insurance Top up available for you to purchase.

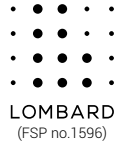
	excl. USA	incl. USA
1-14 Days	R525	R730
15 - 30 Days	R1 020	R1 410
31 - 60 Days	R1 495	R2 075
61 - 90 Days	R1 980	R2 745

Additional top up	Cover
Additional cover for medical and related expenses	R15 000 000
Daily Hospital Cash Benefit	R 7 000 (R500 per day)
Dental	R 3 000
Medical expenses relating to pre-existing medical conditions	R750 000
Accidental death	R250 000
Accidental permanent and total disablement	R1 000 000
International journey postponement	R10 000 (R500 excess)
International journey cancellation	R20 000 (R500 excess)
International journey curtailment	R20 000 (R500 excess)
International journey extension	R20 000 (R500 excess)
Missed connection	R20 000 (R500 excess)
Replacement airfare	R20 000 (R500 excess)
Travel delay	R3 000 (minimum of 6hrs)
Personal liability	R2 000 000
Weather Conditions	R10 000
Denied Visa	R15 000
Hijack & Hostage	R 37 500 (R750 per day)
Legal Expenses	R10 000
Luggage	R20 000 (R350 excess)
Single item limit	R5 000
Cash and documents	R2 500
Luggage delay	R2 000 (minimum of 6hrs)

Should you wish to apply for the top up travel policy please complete the sections below :

D. TRAVELLERS WHO REQUIRE TOP-UP TRAVEL COVER		
Names	Pre-existing conditions	Status of condition

E. PAYMENT DETAILS FOR TOP UP TRAVEL INSURANCE COVER	
<i>(not required if you only want to apply for the free travel benefit)</i>	
Method of payment:	<input type="radio"/> Credit Card (enter details below) <input type="radio"/> EFT (a quote will be issued detailing payment options)
Credit card number	<input type="text"/>
CVV number on back (3 or 4 digits)	<input type="text"/>
Expiry date	<input type="text"/>
Signature of Accountholder: _____	Date: <input type="text"/>



HEALTH / GAP COVER CLAIM FORM 2022

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

Telephone: 011 677 9891
Fax: 0861 000 508
Physical Address: 4 Osborne Lane, Bedfordview, 2007
Postal Address: Private Bag X2, Gardenview, 2047

Policy Number:

Please complete and return by fax to: 086 500 7532 or 086 673 4224 | Email to: claims@turnberry.co.za

A. DOCUMENTS REQUIRED

Turnberry must be notified in writing of any claim within five (5) months calculated from the date of treatment. Outstanding documentation needs to be submitted within 90 days from the date, outstanding documentation is requested by Turnberry. Please ensure that all documents requested below accompany your completed claim form to avoid unnecessary delays.

- Completed Claim Form
- Copy of your service provider's/doctor's account reflecting all transactions relating to the claim
- Copy of the Hospital Account
- Copy of your Medical Scheme's statement reflecting all transactions relating to the claim/treatment. Unfortunately an "acknowledge of payment" issued by your Medical Scheme does not provide the necessary information.

Please note, based on the information provided Turnberry may need to request additional information.

B. DETAILS OF PRINCIPAL INSURED PERSON

Title:	<input type="text"/>	Gender:	<input type="radio"/> Male	<input type="radio"/> Female	
ID Number:	<input type="text"/>	Date of Birth:	<input type="text"/>		
Initials:	<input type="text"/>	First Name:	<input type="text"/>		
Surname:	<input type="text"/>				
Postal Address:	<input type="text"/>				
	<input type="text"/>			Code:	<input type="text"/>
Work Tel No.	<input type="text"/>	Cellular Tel No.	<input type="text"/>		
Home Tel No.	<input type="text"/>	Email:	<input type="text"/>		

C. MEDICAL AID DETAILS

Company	Option	Medical Aid Number
<input type="text"/>	<input type="text"/>	<input type="text"/>

D. DETAILS OF PATIENT

Surname:	<input type="text"/>	Title:	<input type="text"/>
First Names:	<input type="text"/>		
ID Number (If not available Date of Birth):	<input type="text"/>		
Referring doctor/GP details (name & contact number):	<input type="text"/>		

E.

CLAIMS OF CANCER ONLY

Has the patient received treatment, consulted with a medical service provider and/or received advice in relation to the condition in the last 12 months? If so, please provide the date(s) of the consultation(s).

F.

Turnberry reserves the right to negotiate a discounted rate with your relevant medical service provider(s) in exchange for direct payment to them.

Please advise if you have paid your medical service provider(s)? Yes No

G.

BANK DETAILS OF PRINCIPAL INSURED

Accountholder's Name	
Name of Bank	
Branch Code	
Account Number	

Type of account: Cheque Savings Transmission

I declare that the banking details provided are correct, failing which, Turnberry is not liable for any losses, charges and expenses. I accept that it is my responsibility to notify Turnberry timeously of any changes in my banking details. The indemnity payment may give rise to a potential Output Tax liability under section 7(1)(a) read with section 8(8) of the Value Added Tax Act.

Signature of Principal Insured: _____ Date:

H.

DECLARATION BY THE PRINCIPAL INSURED

"I warrant that I am legally entitled to receive the benefits in terms of the said Policy. Turnberry shall not be liable for payment if the cause of accident/illness is related to an exception detailed in the Policy Schedule and any endorsements thereto. In support of a claim in terms of the said Policy, I declare that all statements and answers which may now or at any time be given in connection with this claim, whether in my handwriting or not, are true and complete. I understand that any misstatement or non-disclosure, which materially affects the assessment of this claim, will entitle Turnberry to declare this claim null and void. I hereby authorise the patient's Medical Scheme, any Hospital, medical service provider or any other person who has attended to or examined the patient, to furnish to Turnberry or Turnberry's authorised representative any information with respect to any illness or injury, medical history, consultations, prescriptions or treatment and copies of all hospital or medical records. A copy of this authorisation shall be considered as effective and valid as the original.

Should any benefit be paid by Turnberry and subsequently settled, in whole or part, by the patient's medical aid or the medical service provider reduced the amount they have charged, the amount of the overpayment will be refunded to Turnberry. I acknowledge and accept that for the purposes of assessing and processing this claim, effectively administering your policy and dealing with all other matters related thereto, Turnberry Management Risk Solutions may process and share my information with Lombard Insurance Company Limited, its third party service providers and/or agents who will assist in the investigation of your claim and/or the administration of your policy. During this process, my information may also be shared with your medical scheme.

On my own behalf, and on behalf of any person(s) I represent herein, I hereby consent to such information being disclosed for the aforementioned purposes with the aforementioned parties. I also acknowledge that the insurance information provided by me may be stored in a shared database and used as set out above.

Turnberry Management Risk Solutions, Lombard Insurance Company Limited and its associated parties undertake to insure that your personal information is protected as required under the Protection of Personal Information Act 4 of 2013, as amended, and that your personal information will not be shared with third parties for any purpose or in any format whatsoever, apart from the sharing of information as contemplated in the preceding paragraph.

Signature: _____ Date: