

AFFIDAVIT OF PREVIOUS GAP COVER POLICIES AND DEPENDANTS

Please complete this form in black ink and CAPITAL letters

I, the undersigned, declare the details of all previous: gap cover policies held by me and the dependants thereunder.

Details of Policyholder:						
ID number/Passport:		Mr ☐	Mrs ☐	Miss ☐	Dr ☐	Other ☐
Name:						
Surname:						
Physical address:						
					Code:	
Current Gap Cover Provider:						
Current Gap Policy Number:						

The information provided below regarding previous gap cover provider membership is true and correct and that reasonable efforts have been made to obtain documentary evidence of such periods, but that I have been unsuccessful in my efforts.

By signing this affidavit, I hereby agree that should any claim be submitted within **90** days of inception of the Sirago Gap Cover policy, that Sirago reserves the right to re-underwrite this policy, backdated to inception of this policy.

NAME OF GAP PROVIDER	NAMES & SURNAMES OF ALL DEPENDANTS COVERED ON THIS POLICY	INCEPTION DATE	TERMINATION DATE	Previous Gap Policy Number
		DD/MM/YYYY	DD/MM/YYYY	
		DD/MM/YYYY	DD/MM/YYYY	
		DD/MM/YYYY	DD/MM/YYYY	

DEPONENT/PRINCIPAL POLICYHOLDER SIGNATURE

I hereby certify that the deponent has acknowledged that he/she knows and understands the contents of this affidavit, which was signed and sworn to before me at _____ on this the _____ day of _____ **2026**, the regulations contained in government notice **GN R1258** in **GG 3619** of **21 July 1972**, as amended, and government notice no **GN R1648** in **GG 5716** of **19 August 1977**, as amended, having been complied with.

COMMISSIONER OF OATHS

First Name:					
Designation:					
Address:					
					Code: