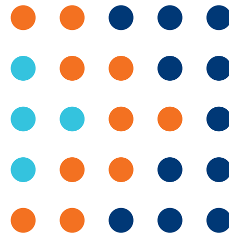

altrisk

application form

ALTRISK (PTY) LTD is an authorised financial services provider (FSP 9869) and a Hollard associate company
Tel + 27 11 329 7000 l Fax + 27 11 326 0123

vers.13

Life insured information

Title | Initials | First name
Surname | Former surname
Gender M F | Language English Afrikaans
ID no. | Date of birth
Postal address
Tel no. | E-mail
Cell no.

Life insured details

1.1 What is your present occupation?

1.2 Since when have you been in this occupation?

1.3 What industry do you work in?

1.4 Previous occupations in the last 5 years (with dates)

1.5 Please describe your duties in terms of percentages % Admin % Supervisory % Travel % Manual

1.6 Education: Not matriculated Matriculated Diploma Degree Post Grad.

1.7 Give details of qualifications

1.8 Give detals of income

Monthly taxable income	Current year	Previous year	Current year	Previous year
	Insured		Spouse	
Present occupation salary				
Present occupation commission				
Other income				

1.9 Do you have any intention of leaving (temporarily or permanently) the country in which you currently reside? Y N

If yes, which country do you intend to travel to?

1.10 Have you ever been declared insolvent? Y N

1.11 If yes, have you been rehabilitated? Y N

1.12 Do you participate in a high risk occupation, sport, hobby or pastime which may expose you to a higher than average risk of injury (e.g. motorised speed contests, aviation, diving, bungee jumping etc.)? If yes, give details. Y N

Policy owner information (if different to life insured)

Policy Owner 1 | **Policy Owner 2**

Title | Initials | Title | Initials
Name
Date of birth
ID/Reg no.
Gender M F | M F
Relationship to life insured
Postal address
Tel no. | E-mail
Cell no. | English | Afrikaans
Policy owner tax status Natural person Conforming company/CC Non-conforming company/CC

NOTE: For conforming policies, premiums are tax deductible and benefits are taxable. If the owner is a trust, the tax status of the beneficiaries of the trust should apply.

Policy information

Reason for insurance: ☐ Personal ☐ Bond cover ☐ Asset cover ☐ Buy and sell ☐ Partnership

☐ Contingent liability ☐ Loans ☐ Keyperson ☐ Estate duty ☐ Other

Please indicate if disability business endorsement is to be applied .... Y N

Is this application linked to any other application (ie. joint life, buy and sell, etc)? .... Y N

If yes, please supply the name/s of the life insured/s.

Commencement date: OR On acceptance

Beneficiary information

NOTE: If this section is left blank, benefits shall be paid to the estate of the policy owner or life insured.

First name	Surname	Date of birth	I.D. no	Relationship to life insured	%

Additional Family Funeral Benefit/Trauma Plus/Female Protector member nomination

First name	Surname	Date of birth	I.D. no	Relationship to life insured

Other insurance policies excluding any policy being replaced with this application, but including policies not yet finalised with any other insurer.

Insurance with other insurers	Life cover	Occupational disability	Functional impairment	Physical impairment	Disability income short term (payment period less than or equal to 24 months)	Disability income long term (payment period longer than 24 months)	Dread disease
Total personal cover							
Total business assurance policies							
Total group life benefits							

Protection of existing insurance

NOTE: Replacement of existing insurance is generally to the disadvantage of the owner because it involves duplication of initial costs charged to the policy. Is this proposal to replace the whole or any part of your existing insurance with any insurer (whether replacement is to occur immediately or to replace an insurance discontinued in the past four months or within the next four months)? Y N

If yes, the introducer must discuss and complete the Replacement Policy Advice Record and attach it to this proposal.

Signature of applicant

Personal details

2.1 Height (without shoes) cm

2.2 Mass (in normal clothes) kg

2.3 Has your mass changed by more than 3kg during the past year due to any of the following: Y N

Pregnancy | Diet | Exercise | Illness | Stress | Depression | Unknown

2.4 Do you consume any alcoholic liquor? If yes, state quantity and type per week. Y N

2.5 Have you habitually taken more in the past? If yes, state quantity and type per week. Y N

2.6 Have you ever received medical advice to reduce or discontinue your liquor consumption or been charged with drunken driving? Y N

If yes, state reason, name and telephone number of doctor concerned.

2.7 Do you currently smoke, or have you smoked in the last 12 months Y N

If yes, what and how much do you smoke per day?

2.8 Have you ever received medical advice to reduce or discontinue smoking? Y N

If yes, state reason, name and telephone number of the doctor concerned.

2.9 Are you a member of a medical aid? If yes, give details

2.10 Have you ever consumed, injected or smoked any illegal narcotics? Y N

Life insured information

Do you have, or have you ever had, trouble with or disorders of:

3.1 Your heart or circulation (e.g. blood pressure, chest pains, heart murmur, palpitations, rheumatic fever, stroke)? Y N

3.2 Your lungs (e.g. persistent cough, shortness of breath, tuberculosis, asthma, bronchitis)? Y N

3.3 Your digestive system or liver (e.g. recurrent indigestion, ulcers, bleeding from the bowel, hepatitis, gallstones)? Y N

3.4 Your kidneys, bladder or reproductive organs (e.g. stones, infections, bilhartzia, prostate problems)? Y N

3.5 Your nervous system (e.g. concussion, paralysis, fits, blackouts, depression, anxiety, persistent headaches)? Y N

3.6 Your eyes (excluding errors of refraction), ears, nose or throat (e.g. deafness, ear discharge)? Y N

3.7 Your skeleton joints or muscles (e.g. rheumatism, arthritis, back or neck trouble, gout)? Y N

3.8 Your glands or blood (e.g. diabetes, thyroid, spleen, bleeding disorder, leukaemia)? Y N

3.9 Growths (e.g. cancer or tumour of any kind)? Y N

3.10 Have you sought medical advice during the past five years in connection with any symptom or condition, or been a patient in a hospital or nursing home or undergone any medical examination (including ECG, X-ray examination or specialised laboratory tests) not mentioned above? Y N

3.11 Are you taking, or have you ever taken drugs, tranquillisers or any other medicines in any form for a continuous period of more than two weeks? Y N

3.12 Have you ever been tested for or received medical advice, counselling or treatment in connection with AIDS, or any infection by one of the AIDS viruses, or any sexually transmitted disease (e.g. hepatitis B, gonorrhoea, syphilis or any venereal disease)? Y N

3.13 Have you been for any genetic testing or received counseling for genetic testing in the past 5 years? Y N

3.14 Has any proposal for life, sickness, accident or disability insurance on your life ever been declined, deferred, withdrawn or accepted at special terms or on special rates? If yes, please provide a policy number and company name. Y N

3.15 Are you aware of any other health or other factors (past or present), which may influence the risk attached to this policy? Y N

3.16 In the last 2 years, have you ever been absent from work for a continuous period of more than 1 month as a result of accident or sickness? If yes, state nature of incapacity, period and dates. Y N

Signature of applicant

If you answered yes to any of the above, supply full details below

Question	Nature & duration of complaint or symptom	Date	Name & address of attending doctor/hospital	Date of last symptoms

3.17 Name, physical address and telephone number of usual medical attendant:

Tel no. Fax no. E-mail

Postal address

3.18 Name and address of any other medical attendant who has acted in this capacity during the last 5 years:

3.19 OPTIONAL: I hereby give consent for Hollard Life to release copies of my medical information to the above medical attendant and discuss details thereof with my financial advisor. Signature (Insured)

Family history

Has any immediate family member, i.e. father, mother, brother, sister, ever been diagnosed with or died from any of the diseases, events or procedures below (under the age of 60):

4.1 Raised cholesterol, angina, heart attack, coronary bypass surgery, angioplasty, stent, stroke, transient ischaemic attack, hypertension or diabetes? Y N

4.2 Cancer? Y N

4.3 Kidney disease (excl kidney stones)? Y N

4.4 Multiple sclerosis, Huntington's chorea, motor neurone disease, Parkinson's, haemocromotosis? Y N

For each family member please complete the table below where applicable

Family member	Condition diagnosed from above list	Age	Details

Product information (Please attach copy of quote)

Guarantee period ☐ Fixed guarantee ☐ Experience rated

Premium pattern ☐ Level ☐ 5% compulsory ☐ Age rated

Voluntary escalation ☐ Cover OR ☐ Premium ☐ % (max 15%)

Premium frequency ☐ Monthly OR ☐ Annually

Lump sum benefits

				Sum insured	Premium
Life cover					
Disability	☐ Own	☐ Stand alone	☐ For life		
Impairment	☐ Comprehensive		☐ For life		
Comprehensive disability	☐ Own	☐ Stand alone	☐ For life		
Disability plus	☐ Own		☐ For life		
Waiting period	☐ 7 Days	☐ 1 month	☐ 3 months		
Critical illness	☐ Basic	☐ Stand alone	☐ For life		
	☐ Core		☐ Max		
	☐ Comprehensive				
Accidental death					

Income benefits

To age ☐ 60 ☐ 65 ☐ 70

Escalation in claim ☐ Nil ☐ CPI limited to 10%

	Basic benefit (first 24 months)	Extended benefit (from 25 months)	Premium
Disability income	pm ☐ Own	pm	
Waiting period	☐ 7 days ☐ 1 month ☐ 3 months	☐ 6 months ☐ 12 months	
Disability income top-up	pm	pm	
Death income	pm	pm	
Business overhead protector		pm	
Waiting period	☐ 7 days ☐ 1 month ☐ 3 months	☐ 6 months	

Ancillary benefits

		Sum insured	Premium
Trauma plus			
Female protector			
Guaranteed insurability benefit			
Flexible cover facility	☐ Personal ☐ Business		
Disability premium waiver		Y N	
Total			

Debit order authorisation

NOTE: Altrisk will only process policies where payment is by debit order. (Payments by credit card or cash are not accepted.)

Bank ______ Account holder ______

Account no. ______ Branch ______

Branch code ______ Account type ______ Debit date ______

Relationship to life insured ______

I authorise Hollard Life to draw against this account all amounts due in terms of this application. This authorisation is to remain in force until terminated by Hollard Life or myself. I accept that Hollard may debit my account on a date other than that specified.

Signature of account holder ______ Date ______

Signature of applicant ______

Declaration by life insured and policy owner

I/We declare that the above questions have been fully considered by me/us and that the statements given in this application and all documents that have been or will be signed by me/us in connection with this application are, to the best of my/our knowledge, true and complete.

I, the life insured, declare that I am willing to undergo testing for HIV (Human Immunodeficiency Virus) and I understand the implications of a positive test and have been given the opportunity to read the counselling information. I further indemnify Hollard Life and Altrisk and their directors, consultants and employees against any claim of whatsoever nature which may be made against them as a result of such test.

I/We agree that this application and declaration together with all relevant documents that have been or will be signed by me/us or any person whose life is to be insured in terms hereof, shall be the basis of the contract between Hollard Life and myself/us, and that if any **material information is withheld the benefits and all monies paid to Hollard Life shall be forfeited.**

I/We further agree that, should this application be accepted by Hollard Life, such acceptance will be conditional upon there having been no material alteration to the facts on which the decision was based and no illness or injury to the life to be insured between the date of signing this application and the date of acceptance of the policy by Altrisk. Any such alteration to the facts must be communicated to Hollard Life in writing, and failure to do so may result in repudiation of any future claim.

I understand that if the first premium is not paid on or before the premium commencement date no cover is provided, or benefits payable for the period from the premium commencement date until the first premium is received in full by Altrisk.

Accepting that I am thereby curtailing my right of privacy, but to facilitate the assessment of the risks, and the consideration of any claim for benefits, under a policy related to this or any other proposal for insurance made by me, or in respect of me as life insured, at any time (even after my death) and in such detailed, abbreviated or coded form as may from time to time be decided by Altrisk or Hollard Life or by the operators of such data base, I irrevocably authorise Altrisk and Hollard Life -

(a) to obtain from any person, whom I hereby so authorise and request to give, any information which Altrisk or Hollard Life deems necessary, and

(b) to share with other insurers that information and any information contained in this proposal or in any related policy or other document, either directly or through a data base operated by, or for insurers as a group.

NOTE: For your protection this form should not be signed until all details have been completed.

Signed at:		on	
Signature (Insured)		Signature (Owner)	
		Signature (Owner)	

To be completed by the financial advisor

I hereby declare that I have explained the meaning and implications of the replacement question to the proposer and that I am fully aware of the possible detrimental consequences of the replacement of an insurance policy.

I confirm that I have identified the client, including the policyholder, insured life/s, premium payer and cessionary, where applicable, and verified his/ her/ their details on this contract under the requirements that section 21 of the Financial Intelligence Centre Act, No. 38 of 2001 sets out. I further confirm that, in terms of section 22 of the same act, I have stored all the verification documents.

Primary adviser		Secondary advisor	
Brokerage house		Brokerage house	
Signature		Signature	
Commission	%	Commission	%
Broker code		Broker code	
Biblife/Pri no.		Biblife/Pri no.	
Telephone no.		Telephone no.	
Broker consultant		Distribution branch	

THE LIFE OFFICES' ASSOCIATION OF SOUTH AFRICA
ASSOCIATION INCORPORATED UNDER SECTION 21

Replacement Policy Advice Record

(to be completed in consultation with your advisor - please note that this does not serve as a cancellation of the replaced policy; you must advise the insurer in writing about cancellation of a policy)

Name of policyholder

ID number of the policyholder

Name of financial advisor

Name of FSP (brokerage or insurer)

New policy

Type of policy: Investment or risk	Policy number	Insurer

Policy being replaced

Type of policy: Investment or risk	Policy number	Insurer

Question to the financial advisor

Does this proposal constitute replacement of an investment policy with a recurring premium investment policy that will lead or has led to the levying/deduction of a termination charge of more than 15% of the replaced policy's fund value? Refer to the definitions in Part 3 of the Regulations to the Long-Term Insurance Act, 1998 (commission regulations). .... Y N

Reasons why replacement may not be advisable

If you do replace any policy, we want to ensure that you make an informed choice. Please read the following information carefully and discuss with your financial advisor.

You will **pay some charges and fees twice** (e.g. commission, underwriting expenses & other initial charges levied by the insurer) - initially on the existing policy and once again on the new policy.

You may **pay higher premiums** for risk (or a bigger part of the premium) on the new policy because you are older now or your health situation might have changed.

Your new policy may not have the same **life cover or premium guarantees** as the existing policy. Check the period for which the life cover or other cover amounts are guaranteed before the insurer is entitled to change your premiums or reduce or remove cover.

Your new policy may not have the same **investment performance guarantees** as the existing policy (if applicable).

Your new policy may have **more exclusions, restrictions or waiting periods** particularly if your health has deteriorated.

The amount of money that you can withdraw under the new policy may be less (if applicable).

A new policy will usually have legal restrictions on access within the first five years. You may **lose the tax advantage** of your existing policy (if applicable).

The surrender value or paid up value of your existing policy may be as low as 65% of the policy value before the change, and could be even less than premiums paid in since **unrecovered initial expenses** must first be deducted.

Check what charges you will be paying on termination of the old policy and see whether the advantages of the new policy will make up for any such charges.

The **investment risk** under the new policy may be higher. Remember that the past performance of a fund or asset manager of a fund is not necessarily an indication of future performance.

Reasons for the change of policy/policies

Did you establish whether the existing/terminated policy could be amended to provide similar benefits to the replacement policy? If such amendment is/was possible, why do you regard it as appropriate that the terminated policy be replaced by the replacement policy?

Declaration (compulsory)

Financial advisor

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 Services Providers and their Representatives (the Code) and have retained a record of such advice as required by section 3 of the said Code.

Signature

Name

Date

Policyholder

I confirm that my financial advisor 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

Name

Date

Tel No.

E-mail