

2. Details of applicant (Complete only if applicant is not the life insured)

Sanlam Life planholder? Existing plan number (If "Yes", the Personal Client Details (per plan) can be attached to this application. It is then not necessary to complete the life insured's details here.)

Has the applicant ever been declared insolvent? Yes No (only if Matrix/Cobalt for Professionals/Glacier Cover, not applicable to Income Protector)

If "Yes", what was the reason for sequestration

Has the applicant been rehabilitated yet? Yes No

If "Yes", please complete date of rehabilitation D D M M C C Y Y

If "No", please supply a fully completed AE2015 (Financial questionnaire)

NATURAL PERSON

Surname

Maiden name

Full first names

Preferred name

Date of birth Type of identification Number

Tax status Country of issue (of above-mentioned document)

Passport expiry date Marital status Gender

Home language

Title

LEGAL ENTITY

Name of legal entity

Legal entity type

Registration number Country of registration

Legal entity: job title/title, surname and initials of contact person

CONTACT DETAILS

Postal address (Start each line on the left)

Postal/Zip code

Residential/Physical address (If different from postal address) (Start each line on the left)

Postal/Zip code Correspondence language

e-mail address

2. Details of applicant (continued from page 3)

Contact numbers (As dialled from South Africa)			
	International dialling code	Area code	Number
Telephone (Work)			
Telephone (Home)			
Fax (Work)			
Fax (Home)			
Cell/Mobile		n.a.	

3. Reality (applicable to life insured (if RA) / applicant)

I would like to join the Sanlam lifestyle programme Reality?

OR

Please contact me with more information

Important: If you choose to join Reality, a Reality Call Centre agent will contact you for further registration. I agree that my Reality fee can be paid simultaneously with my Sanlam plan.

For more information about the detail and benefits please contact the Reality Call Centre on 082 233 5000.

4. Market segment, income and employer of life insured (if RA) / applicant

• Is the applicant/life insured a legal entity (e.g. company/financial institution)? 99

• Is the applicant an individual?

If the applicant/life insured is an individual,

• **Market segment of applicant/life insured**

Self-employed

Self-employed – Business owner / Entrepreneur 32 Self-employed – Farmer 33 Self-employed – Professional 36

Employed

Salaried employee – paid by someone 31 Salaried professional – paid by someone 37

Other

Home executive 34 Minor / Scholar 35 Retired 38 Student 39 Unemployed 40

• **Income** – Regular salary or taxable earnings from occupation(s)

Applicant/ Life insured R p.m. Spouse (if applicant/ life insured is married) R p.m. Annual taxable income from other sources R

• **Employer's details**

Employer:

Town/City/Suburb: Worksite/ Niche code

• **If employer scheme:** Is the applicant a legal entity (e.g. company/financial institution)? 99

5. Tax dispensation

NB: This paragraph must always be completed.

Is the planholder:

• a natural person?

• a trust?

• a taxpaying institution?

• a tax-exempt institution?

• a retirement fund?

***If the planholder is a trust, is any of the trust beneficiaries or eventual, direct or indirect, trust beneficiaries:**

• a taxpaying institution?

• a natural person?

• a tax-exempt institution?

****If retirement fund is marked, the FSB number must always be completed.**

FSB number (non-Sanlam Funds) 1 2 / 8

6. Notice : Cession of plan (not applicable to RA's and Income Protector)

Has the plan been ceded? Yes If "Yes", fill in cession form, (AE2170).

Life insured number

7. ► Revocable beneficiary(ies)/nominee(s) (not applicable to the Income Protector)

Beneficiary : 1

Title															
Mr	Mrs	Miss	Ms	Rev	Dr	Prof	Adv	Judge							
Surname															
<input type="text"/>															
Maiden name															
<input type="text"/>															
Full first names															
<input type="text"/>															
Type of identification				Number											
Identification document	Passport	Foreign ID		<input type="text"/>											
Country of issue <i>(of above-mentioned document)</i>			Date of birth			Gender		Correspondence language		Relationship					
<input type="text"/>			D	D	M	M	C	C	Y	Y	Male	Female	Eng	Afr	<input type="text"/>
Postal address <i>(Start each line on the left)</i>															
<input type="text"/>															
<input type="text"/>															
<input type="text"/>															
<input type="text"/>															
Postal/Zip code															
<input type="text"/>															
Percentage of benefit for Stratus:				Percentage of benefit for Matrix/Cobalt for Professionals/Glacier Cover:				Death (DS)		or First death (DS80)					
<input type="text"/> %				<input type="text"/> %				<input type="text"/> %		<input type="text"/> %					
							Final expenses (DSF1)		Accidental death						
							<input type="text"/> %		<input type="text"/> %						

Beneficiary : 2

Title															
Mr	Mrs	Miss	Ms	Rev	Dr	Prof	Adv	Judge							
Surname															
<input type="text"/>															
Maiden name															
<input type="text"/>															
Full first names															
<input type="text"/>															
Type of identification				Number											
Identification document	Passport	Foreign ID		<input type="text"/>											
Country of issue <i>(of above-mentioned document)</i>			Date of birth			Gender		Correspondence language		Relationship					
<input type="text"/>			D	D	M	M	C	C	Y	Y	Male	Female	Eng	Afr	<input type="text"/>
Postal address <i>(Start each line on the left)</i>															
<input type="text"/>															
<input type="text"/>															
<input type="text"/>															
<input type="text"/>															
Postal/Zip code															
<input type="text"/>															
Percentage of benefit for Stratus:				Percentage of benefit for Matrix/Cobalt for Professionals/Glacier Cover:				Death (DS)		or First death (DS80)					
<input type="text"/> %				<input type="text"/> %				<input type="text"/> %		<input type="text"/> %					
							Final expenses (DSF1)		Accidental death						
							<input type="text"/> %		<input type="text"/> %						

Note

- If applicant is married in community of property and the spouse is not the only beneficiary, complete form AE3000 (not applicable to retirement annuities).
- Make copies if more beneficiaries are needed.
- Sanlam Guardian Trust manages monies for the benefit of minor beneficiaries – see AE3000.

8. ► Nomination for plan-ownership *(Only if applicant is an individual and not a life insured or the only life insured.)
(not applicable to RA's and Income Protector)*

Title																	
Mr		Mrs		Miss		Ms		Rev		Dr		Prof		Adv		Judge	
Surname																	
Full first names																	
Type of identification																	
Identification document			Passport			Foreign ID			Number								
Country of issue <i>(of above-mentioned document)</i>			Date of birth			Gender			Correspondence language			Relationship					
			D D M M C C Y Y			Male Female			Eng Afr								
Postal address <i>(Start each line on the left)</i>																	
Postal/Zip code																	

9. Authorised correspondent *(If a child between the ages of 1 day and 18 years, is the life insured and/or applicant, the name and address particulars of the parent/guardian must be filled in here.)*

Title																	
Mr		Mrs		Miss		Ms		Rev		Dr		Prof		Adv		Judge	
Surname																	
Full first names																	
Type of identification																	
Identification document			Passport			Foreign ID			Number								
Country of issue <i>(of above-mentioned document)</i>			Date of birth			Gender			Correspondence language			Relationship					
			D D M M C C Y Y			Male Female			Eng Afr								
Postal address <i>(Start each line on the left)</i>																	
Postal/Zip code																	

Life insured number

14. Option details (applicable to Matrix/Cobalt for Professionals/Glacier Cover)
(Supplement 1 and 2 must not be completed if the option amount is equal to the cover amount)

• **Option** Yes No

Plan number

Option type/name

Benefit type		Event type	Proof-free amount	
FutureCover (FS1)	FutureCover (FS2)		FutureCover (FS1)	FutureCover (FS2)
<input type="checkbox"/>	<input type="checkbox"/>	Regular <input type="checkbox"/>	R/c <input type="text"/>	R/c <input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Marriage <input type="checkbox"/>	R/c <input type="text"/>	R/c <input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Childbirth/Adoption <input type="checkbox"/>	R/c <input type="text"/>	R/c <input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Mortgage <input type="checkbox"/>	R/c <input type="text"/>	R/c <input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	First employment <input type="checkbox"/>	R/c <input type="text"/>	R/c <input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Education <input type="checkbox"/>	R/c <input type="text"/>	R/c <input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Personal liability <input type="checkbox"/>	R/c <input type="text"/>	R/c <input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Partnership interest <input type="checkbox"/>	R/c <input type="text"/>	R/c <input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Key value <input type="checkbox"/>	R/c <input type="text"/>	R/c <input type="text"/>

• **Group option** Compulsory Non-compulsory

• **Source** (if group option compulsory) Employee Benefits Other (Complete number of Employee Benefit scheme if Employee Benefits)

• Number of Employee Benefit scheme/fund

• Name of scheme/fund

NB: Please enclose a copy of the option letter.

Note: • Make copies if more lives insured are needed – maximum 10. Adjust page number for additional page(s), for example, Page 9.1, etc. and mark clearly the life insured number(s).

15. Declaration by life insured (if RA)/applicant

The life insured/applicant applies for the plan indicated herein ("this plan") – subject to the following:

1. If this is an application for more than one plan, all references to the singular will also include the plural.
2. If, where applicable, this plan is cancelled, Sanlam Life will have the right to refund less than the amount paid up to date of cancellation, if, owing to a change in investment conditions the units in the investment fund in which such amount was invested, have decreased in value during the period up to the date of cancellation.
3. This plan will be issued in the RSA. All amounts relating to this plan – in particular payments, benefits, and where applicable, surrender payments and loan payments will be expressed, calculated and paid in RSA currency. Payment will be made in the RSA.
4. I accept full responsibility for informing Sanlam Life of any changes in current identification information provided (e.g. address change, surname change, contact particulars, etc.)
5. I am aware that in terms of the Financial Advisory and Intermediary Services Act, 37 of 2002 (FAIS), I may request a copy of any document that I or someone on my behalf submitted to Sanlam Life that pertains to this application.
6. In terms of the Prevention of Organised Crime Act (number 121 of 1998), I confirm that the funds with which any payment is or will be made to Sanlam Life, in terms of this plan, are derived from a lawful source. In addition, I declare myself willing to answer any questions with regard to the origin of such funds and to provide additional information as and when it may be required by Sanlam Life.
7. I understand that all information in this application will be recorded electronically in Sanlam Life's computer system. No physical records will therefore be kept and this transaction will be regarded as having been carried out during the normal course of Sanlam Life's business. The electronic records of Sanlam Life's computer system will form the record of this plan for all purposes and may be used as evidence at any proceedings.
8. I guarantee that the paragraph, Replacement of a financial product has been filled in correctly and also that all other information herein, is complete and correct. This guarantee applies also to information which in Sanlam Life's reasonable opinion is relevant to the insurance risk, where applicable, and which is contained in other documents signed or provided by me or a life insured. If any of the aforesaid information is not complete or correct, Sanlam Life may cancel this plan. If this happens, all money paid in terms of this plan will be forfeited.
9. Sanlam Life's obligations under this plan come into effect on the last of (a) the date of Sanlam Life's written acceptance of this application; (b) this plan's start date as mentioned in the plan document; and (c) the date on which Sanlam Life receives the one-off or first payment in terms of this plan or the date on which arrangements, to Sanlam Life's reasonable satisfaction, have been made for the payment to Sanlam Life.
10. Investment advice agreement between the life insured and the Fund: *(only applicable to RA's)*
 - I want to receive ongoing investment advice for my retirement investment.
 - I understand that this advice is an optional service that is in addition to and not part of other services rendered for my retirement annuity plan.
 - I request the Fund to pay a fund-based fee to the intermediary, nominated by me, who provides this advice.
 - I understand that I may instruct the Fund at any time to change this fee, or to stop paying it.
 - I understand that Sanlam Life, as the administrator of the Fund and on instruction of the Fund, will pay this fee on a monthly basis on behalf of the Fund.
 - I understand that this fee is deducted monthly from the fund value of my plan by means of a withdrawal to the value of the monthly fee.
 - I understand that this fee is linked to and fluctuates with the fund value of my plan.
 - I understand that the Fund is not responsible for the correctness, completeness or quality of this advice.
 - I agree that until I instruct the Fund otherwise, the fee payable, expressed as a yearly fee, is the percentage of the fund value specified below.

%	(0 – 100%: e.g. if maximum – fill in 100%) of 1.14% (including VAT, if applicable) per year of fund value
---	---

Note: No fee will be payable if "Nil" is filled in or the box is left blank.
11. If this is an application for cover and you have selected that the underwriting questions for such cover should be asked by telephone, Sanlam Life will consider the application for cover on the basis of what information was supplied during this telephone conversation.
12. Should the insurance risk, where applicable, deteriorate before Sanlam Life's obligations in terms of this plan take effect, Sanlam Life may cancel this plan.
13. In any rider benefit applied for herein cannot be granted in accordance with Sanlam Life's normal practice from time to time, Sanlam Life may, with my prior consent, limit or exclude the rider benefit or load the payment and may then also adjust the main benefits of this plan in so far as it is necessary to leave unchanged the total payment indicated herein for this plan.
14. If this application is for a retirement annuity, I apply for it on behalf of the RA fund concerned. If I am not yet a member of the fund, this application also serves as my application for such membership, and the rules to the fund will be binding.
15. All insurers who are members of the Association for Savings and Investment South Africa (ASISA) share policy information on a central Register to keep track of and ensure proper handling of replacement of financial products, whether it concerns this proposal now or in future. This information is protected and can only be accessed by authorised persons. To enable such authorised persons to access my policy information, I hereby give consent that my information may be used on the Register of ASISA.

Always complete the following

I declare that (i) the documents indicated below have been given to me, (ii) I have read them and understand their contents, (iii) the application form (of which this declaration forms part) has been fully completed:

Health statement <small>(if rider benefits are applicable)</small>	<input type="checkbox"/>	Intermediary's Permit	<input type="checkbox"/>	Product Quotation	<input type="checkbox"/>	Quotation number(s)	<input style="width: 100%;" type="text"/>
							<input style="width: 100%;" type="text"/>

Note: The above declaration will be validated by the required signature(s) at paragraph 17.

16. Declaration by life insured (If someone other than the applicant)

I confirm that I am aware that the application form as well as any additional information that was documented during tele-underwriting, and which includes information about my health, will be returned to the applicant by Sanlam Life who will not be liable to me or others for any matter arising from such return.

Note: The above declaration will be validated by the required signature(s) at paragraph 17.

17. Signature(s)

Signature of/for applicant _____ Place _____ Date (DMMCCYY): _____

Note: Here the applicant confirms the declaration above and Supplement 2(A) as well as particulars provided elsewhere in this form by/on behalf of the applicant. If the applicant is also a life insured, he/she confirms, in addition, the statement of health in Supplement 1(A); (B) and declaration in Supplement 2(B).

Signature of legal guardian/
spouse – *only* if someone
other than the applicant _____ Place _____ Date (DMMCCYY): _____

Nature of relationship if legal guardian: _____

Note: As far as is required by law with regard to any person and/or aspect herein, the guardian/spouse grants the necessary consent and/or assistance or, depending on the case, acts in a representative capacity.

Signature of/on behalf of life
insured no _____ Place: _____ Date (DDMMCCYY): _____

Nature of relationship of signatory to life insured if life insured a minor: _____

Signature of/on behalf of life
insured no _____ Place: _____ Date (DDMMCCYY): _____

Nature of relationship of signatory to life insured if life insured a minor: _____

Signature of/on behalf of life
insured no _____ Place: _____ Date (DDMMCCYY): _____

Nature of relationship of signatory to life insured if life insured a minor: _____

Signature of/on behalf of life
insured no _____ Place: _____ Date (DDMMCCYY): _____

Nature of relationship of signatory to life insured if life insured a minor: _____

Signature of/on behalf of life
insured no _____ Place: _____ Date (DDMMCCYY): _____

Nature of relationship of signatory to life insured if life insured a minor: _____

Signature of/on behalf of life
insured no _____ Place: _____ Date (DDMMCCYY): _____

Nature of relationship of signatory to life insured if life insured a minor: _____

Signature of/on behalf of life
insured no _____ Place: _____ Date (DDMMCCYY): _____

Nature of relationship of signatory to life insured if life insured a minor: _____

Signature of/on behalf of life
insured no _____ Place: _____ Date (DDMMCCYY): _____

Nature of relationship of signatory to life insured if life insured a minor: _____

Signature of/on behalf of life
insured no _____ Place: _____ Date (DDMMCCYY): _____

Nature of relationship of signatory to life insured if life insured a minor: _____

Signature of/on behalf of life
insured no _____ Place: _____ Date (DDMMCCYY): _____

Nature of relationship of signatory to life insured if life insured a minor: _____

Note:

- Here a life insured confirms the statement of health in Supplement 1(A); (B) and declaration in Supplement 2(B) and also confirms particulars with regard to him/her, contained elsewhere in this form. **(This note is applicable to all the above lives insured.)**
- Where a life insured is a minor and the applicant is not the guardian/parent of such life insured, the guardian/parent must sign on behalf of the life insured

18. Further information supplied by intermediary(ies)

Name of intermediary who completed the application form.

Race (*life insured*) Asian Black Coloured White (*for statistic purposes*)

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| • Are you fully conversant with the “S” referencing system embodied in the ASISA intermediaries’ register agreement and do you accept the consequences thereof? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Did you see the RSA identity document or passport (<i>if applicable</i>) of the life(lives) insured and do you declare that the information in it agrees with the information on this application form? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Have you identified and verified the information of the applicant or the person acting on behalf of the applicant, if applicable, where the one-off payment exceeds R50 000 or the recurring payment exceeds R25 000 p.a.? (<i>Not applicable to Retirement Annuities and Topaz/Cobalt for Professionals/Glacier Cover</i>) | <input type="checkbox"/> | <input type="checkbox"/> |

If “Yes”: Source of income Source of funds for this investment
 Capacity of applicable party:

SA citizen(s)/resident(s) acting on own behalf <input type="checkbox"/>	Natural person acting on behalf of SA citizen/resident <input type="checkbox"/>	Foreign national acting on own behalf <input type="checkbox"/>	Person acting on behalf of Foreign national <input type="checkbox"/>
Natural person/legal person/partners for partnership/trustee for trust holding > 25% shares in RSA/foreign company <input type="checkbox"/>	Trust beneficiary <input type="checkbox"/>	Founder of Trust <input type="checkbox"/>	Trustee <input type="checkbox"/>
Partner in a partnership <input type="checkbox"/>	Close corporation member <input type="checkbox"/>	Representative of other legal person <input type="checkbox"/>	Other capacity (<i>please specify</i>) <input style="width: 100px;" type="text"/>

- To whom must the plan documents be posted: the planholder or intermediary?

Other requests by intermediary: _____

Name of broker’s consultant

Initials and surname of intermediary(ies)	Code	Bank brokers		Splitting of commission %					
		Man code	Reference number	Recurring payment			One-off payment	Fund-based fee	
				Upfront commission	Initial commission	Payment-based commission	Initial commission		
1.									
2.									
3.									
4.									

Note: • *The intermediary whose name appears next to “1” above, will be regarded as the one responsible for advice to the applicant/life insured.*

Declaration by intermediary:

- I hereby declare that, if applicable, I have explained the meaning and possible detrimental consequences of replacement of a financial product to the applicant/life insured.
- I hereby declare that I have disclosed the intermediary’s permit, health statement (*if applicable*) and product quotation to the applicant/life insured.
- I understand and accept that if this plan is cancelled within 30 days after the applicant/life insured received the notice of acceptance of the application, the advisory fee paid to me will be reversed on my remuneration account.
- I hereby declare that I have identified and verified all the applicable parties in terms of Section 21(1) of FICA, if applicable.
- I have read point 10 of paragraph 15 (page 10) of this application form and understand the meaning of it. I agree that if Sanlam Life complies with an instruction as stated, I will have no right of recovery or any other rights or claims against either the life insured or Sanlam Life for the payment of any money to me.

.....
 Date (DDMMCCYY)

▶ Co-signature of key individual where the intermediary is a Sanlam adviser who must still provide proof of the required product skills

▶ Signature of intermediary

19. Occupation and activities of life insured *(applicable if risk benefits are taken)*

• **Occupation and description of activities**
 Description of activities of primary occupation/rank

 Secondary occupation/Rank

State the % work per day that consists of (total % must sum to 100%)

Administrative work* %
 Manual labour %
 Supervision extramurally, or over travelling working teams, or over machinery %
 Travel, including field work %

**(Administrative work is any work not falling in the other categories, and includes the supervision of administrative personnel, or factory or workshop workers.)*

Description of activities

• **Do you smoke or have you been smoking during the preceding 12 months?** Yes No

Have you during the past 3 years participated in, or do you intend in the future to participate in, any hazardous occupation(s), for example, **flying/gliding activities, diving, professional sports, mining, motorsport, security forces, explosives handler, taxi industry, security industry/protection services, microlender industry or any other occupation with a risk of accidents or risk to health**, which you have not already disclosed above? Yes No

If "Yes", please state the occupation:

• **Disability income and Temporary disability income only**
 • Have you been following your present occupation, working for the same employer, for more than 12 months? Yes No

• **Academic qualifications** *In the case of a pre-school child/scholar/student, that of legal guardian/bread-winner*
 School grade Std. Post matric qualification(s) (e.g. ND of B.Sc) Duration of course years

• **Employer's details**
 Employer:

• **Income – Regular salary or taxable earnings from occupation(s)**
 In determining the total income, any form of income from the following is excluded: overtime pay, non-taxable fringe benefits, interest, dividends, rental income.

Life insured	Spouse (if life insured is married)	Guardian	State annual taxable income from sources other than your full-time occupation	State the other sources/Defence force unit
R <input type="text"/> p.m.	R <input type="text"/> p.m.	R <input type="text"/> p.m.	R <input type="text"/>	<input type="text"/>

• **Part-time/other activities**
 Have you in the past participated in, do you currently participate in or do you intend in the future to participate in, any hobbies/activities that could be hazardous in any way, for example, **flying/gliding activities, diving, professional sports, motorsport, bungy jumping or any other hobby/activity with a risk of accidents and/or risk to health?** Yes No

If "Yes", please state the hobby/activity and give full particulars.

Indicate the status of the above-mentioned hobby/activity.
 Past Present Future

If "past", please state the last participation date. C C Y Y

Please complete the specific forms indicated below if you are currently participating in the following activities:
Motorsport (AE96); Flying (AE97): Aviation/parachuting/gliding/paragliding/hang-gliding/wing-gliding; Diving (AE98).

Note: • *Make copies if more lives insured are needed – maximum 10. Adjust page number for additional page(s), for example, Page 13.1, etc. and mark clearly the life insured number(s).*

20. ► Additional underwriting information (per life insured)

20.1 INSURABLE INTEREST

Nature of relationship/insurable interest to the applicant (*i.e. financial loss to applicant at death of life insured*)

Spouse	<input type="checkbox"/>	Guardian	<input type="checkbox"/>	Child	<input type="checkbox"/>	Key person	<input type="checkbox"/>	Employee replacement	<input type="checkbox"/>	Other	<input type="checkbox"/>	Specify other	<input type="text"/>
--------	--------------------------	----------	--------------------------	-------	--------------------------	------------	--------------------------	----------------------	--------------------------	-------	--------------------------	---------------	----------------------

If Key person insurance, complete the AE4005 and provide existing key person insurance cover amount at other companies

R

If Employee replacement insurance, provide existing employee replacement insurance cover amount at other companies

R

(applicable to Matrix/Cobalt for Professionals/Glacier Cover only)

(Please answer Business Insurance questions at paragraph 12).

20.2 OTHER APPLICATIONS

• Have you submitted any other application(s) for (a) risk plan(s) together with this one? Yes No If "Yes", give total number of such applications i.r.o. this life. Plan number(s) (if available)

20.3 RESIDENCE OUTSIDE RSA

Do you live outside the boundaries of the RSA or Namibia, or are you planning to do so for a period in excess of 6 months within the following 12 months? Yes No

If "Yes", please fill in special form. (*Residence outside RSA – EVL07*)

20.4 BUY AND SELL INSURANCE (applicable to Matrix/Cobalt for Professionals/Glacier Cover only)

• Is this life insured also a life insured on another Matrix/Cobalt for Professionals/Glacier Cover plan? Yes No

• If "Yes", please provide the relevant plan number(s):

<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

• What is the post-tax profit of the company? R

• Is the Buy and Sell agreement in place? Yes No

20.5 FINANCIAL UNDERWRITING (only if Matrix/Cobalt for Professionals/Glacier Cover, not applicable to Income Protector)

Personal cover

If cover applied for is more than R7 million, please complete the following:

Total assets	Total liabilities	Total net worth
R <input type="text"/>	R <input type="text"/>	R <input type="text"/>

20.6 TELE-UNDERWRITING (Please give the informaton sheet for tele-underwriting (TU0001E) to the client)

Length cm Weight kg

Preferred language

Eng Afr

Contact details

Any time between 8h00 and 20h00

or

Between and

Note: The call times may not be before 8h00 or after 20h00.

Contact numbers	Area code	Number
Telephone (Work)		
Telephone (Home)		
Fax (Work)	n.a.	

Note: • Make copies if more lives insured are needed – maximum 10. Adjust page number for additional page(s), for example, Page 14.1, etc. and mark clearly the life insured number(s).

21. Existing insurance with other insurers (per life insured) (applicable to Matrix/Cobalt for Professionals/Glacier Cover only)

Note: Incomplete applications for insurance must be included, but replacements and Sanlam Life insurance must be excluded.

• Disability cover	Lump sum:	R
• Functional impairment plus disability	Lump sum:	R
• Disability income (less than 24 month waiting period)	Monthly income:	R
• Disability income (24 month waiting period)	Monthly income:	R
• Temporary disability income	Monthly income:	R
• Overhead expenses protector	Monthly overhead expenses:	R
• Life cover		R
• Dread disease (Trauma)		R
• Death income	Monthly income:	R
• Sickness	Monthly income:	R

Note: • Make copies if more lives insured are needed – maximum 10. Adjust page number for additional page(s), for example, page 15.1, etc. and mark clearly the life insured number(s).

► Supplement 1(A) Statement of health by life insured (applicable if risk benefits are taken)

Life insured number

Date of birth

Initials and surname

NB: If the answer to any question (excluding questions 9, 10, 13, 15 and 16) is "Yes", please give question number and full details on page 16 and/or 17.

- | | Yes | No | | | | | | | | |
|---|--------------------------|--------------------------|--|---------|----------|--|---------|----------|--|--|
| 1. 1.1 Has an application for life, medical, disability or dread disease insurance (e.g. heart attack) on your life ever been declined, postponed, withdrawn or accepted on special terms or at special rates? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 1.2 Have you ever submitted a disability benefits, accident benefits or trauma benefits claim (the latter as a result of a dread disease) to any insurer or fund? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 2. Do you have, or have you ever had any of the following | | | | | | | | | | |
| 2.1 (a) Any disorder of the heart, blood vessels or circulatory system (e.g. high blood pressure, chest pain, heart murmurs, palpitations, coronary thrombosis, shortness of breath, tightness of chest, stroke or raised cholesterol)? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| (b) Any disorder of the heart, blood vessels or circulatory system including calf cramps during light or moderate exercise or walking? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 2.2 Respiratory or lung trouble (e.g. asthma, recurrent bronchitis, persistent cough, tuberculosis (TB), blood vomiting or tightness of chest)? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 2.3 Disorder of the digestive system and liver (e.g. gastric or duodenal ulcer, recurrent indigestion, jaundice, hepatitis, liver disease or rectal bleeding)? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 2.4 Disease or disorder of kidneys, bladder or reproductive organs (e.g. kidney-stones, infections, blood or albumin in urine, prostatitis, trouble to pass urine or venereal disease)? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 2.5 Any nervous or mental complaint (e.g. fits, depression, anxiety or stress related disorders, persistent headaches, blackouts, epilepsy or paralysis)? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 2.6 Eye, ear, nose or throat disorders (e.g. defective vision, deafness, recurrent ear infections, balance disturbance, impaired speech or hoarseness)? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 2.7 (a) Any disorder or disease of spine, joints, muscles, bones, limbs (e.g. backache, slipped vertebrae/disc prolapse or any other back or neck trouble, rheumatism, arthritis, gout)? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| (b) Any disorder or disease of the skin including porphyria, psoriasis or dermatitis? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 2.8 Diabetes, sugar in urine, insulin resistance, leukaemia, bleeding disorders, spleen, thyroid or any other glandular and blood disease? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 2.9 Cancer, growths or tumours of any kind? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 2.10 Congenital mental insufficiency, essential defect of memory/concentration or minimal brain dysfunction? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 2.11 Any disorder which affects or may affect your ability to practise your occupation (e.g. chronic fatigue, joints or skeletal problems)? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 2.12 Any other disease, injury or disorder which necessitated treatment or bed rest for more than 6 days or prevented you from practising your occupation for more than a month in the past 3 years? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 3. Have you ever been tested for Aids or an Aids-related illness (excluding for insurance purposes), for Hepatitis B or any other sexually transmitted disease or have you received any medical advice, counselling or treatment in respect thereof? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 4. During the past 5 years have you been to any hospital, clinic, or medical institution or undergone any medical investigations (including ECG's, X-rays or pathological tests) for other reasons than the above-mentioned? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 5. Did you receive any medication or other treatment uninterruptedly for longer than six days within the past 5 years, or is this the case now, for conditions NOT already mentioned? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 6. Did you consult any medical practitioner or other person who renders health services (e.g. nursing sister, herbalist, traditional healer/sangoma) during the past 12 months, for conditions NOT already mentioned? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 7. Have you taken any drugs like mandrax, dagga, etc. during the past 5 years? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 8. Has any member of your immediate family (e.g. parents, brothers or sisters) suffered from diabetes, heart disease, high-blood pressure, raised cholesterol, porphyria, cancer or any other hereditary disease? If "Yes", state which relative, as well as age and type of disease. | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 9. Have you been smoking during the past 12 months? If "Yes", state daily use of tobacco here: | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| Quantity per day | | | | | | | | | | |
| Cigarettes <input type="text"/> Cigars <input type="text"/> Pipe <input type="text"/> | | | | | | | | | | |
| 10. Do you consume alcohol? If "Yes", state type and quantity per day or per week here: | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2" style="width: 30%;">Type</th> <th colspan="2" style="text-align: center;">Quantity</th> </tr> <tr> <th style="width: 35%; text-align: center;">per day</th> <th style="width: 35%; text-align: center;">per week</th> </tr> </thead> <tbody> <tr> <td style="height: 20px;"> </td> <td style="text-align: center;">per day</td> <td style="text-align: center;">per week</td> </tr> </tbody> </table> | Type | Quantity | | per day | per week | | per day | per week | | |
| Type | | Quantity | | | | | | | | |
| | per day | per week | | | | | | | | |
| | per day | per week | | | | | | | | |
| 11. Did you drink more regularly in the past or did you have an alcohol problem – whether or not you received treatment for it? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 12. Has your mass changed by more than 5 kg during the past year? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 13. Height and mass: <input type="text"/> cm <input type="text"/> kg | | | | | | | | | | |
| 14. Have you undergone any medical examinations during the past 6 months for the purposes of a previous insurance application with Sanlam Life? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |

Note:

- This statement of health will be validated by the required signature(s) at paragraph 17 on page 11.
- Make copies if more lives insured are needed – maximum 10. Adjust page number for additional page(s), for example, Page 16.1, etc. and mark clearly the life insured number(s).

Life insured number

Date of birth

Initials and surname

D	D	M	M	C	C	Y	Y
---	---	---	---	---	---	---	---

NB: Please complete in full if any of the following benefits are applied for:

- Sickness benefit
- All disability income and overheads protector benefits with waiting periods less than 12 months.

15. Sick leave records Yes No
 During the past two years, were you medically booked off work for longer than two consecutive days?
 If "Yes", please provide details:

When (MMCCYY)	Number of days absent	Reason / diagnosis	Name of treating doctor

16. Are you aware of any condition that may need surgery and/or hospitalisation in the next two years? If so, please provide details. Yes No

17. Do you have, or have you ever had, any of the following?
 If "Yes", give full details on page 18 of each instance. **It is not necessary to repeat information already mentioned** on the previous page of the health declaration. Yes No
 17.1 Any chronic condition of the joints, limbs or spine, that may need medical intervention, e.g. bunions, unstable knee ligaments, recurrent shoulder dislocations, rotator cuff problems or frozen shoulders etc.?
 17.2 Any of the following chronic or repetitive conditions:

	Yes	No		Yes	No
(a) Migraines	<input type="checkbox"/>	<input type="checkbox"/>	(f) Poor bladder control	<input type="checkbox"/>	<input type="checkbox"/>
(b) Tremor	<input type="checkbox"/>	<input type="checkbox"/>	(g) Gallstones	<input type="checkbox"/>	<input type="checkbox"/>
(c) Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	(h) Herniae: umbilical or inguinal	<input type="checkbox"/>	<input type="checkbox"/>
(d) Visual disturbance	<input type="checkbox"/>	<input type="checkbox"/>	(i) Hiatus hernia	<input type="checkbox"/>	<input type="checkbox"/>
(e) Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>			

18. Please complete if you are a female applicant applying for:
 • Sickness benefit
 • All disability income and overheads protector benefits with waiting periods less than 12 months
 • Dread disease benefit
 Do you have, or have you ever had, any of the following?
 If "Yes", give full details on page 18 of each instance. **It is not necessary to repeat information already mentioned** on the previous page of the health declaration. Yes No
 18.1 Any condition or abnormality of the female reproductive system or breasts? This may include abnormal PAP smears, abnormal or excessive menstruations, enlarged uterus or fibroids/myoma of the uterus, ovarian cysts, any nodule/tumour/cyst of the breast or fibroadenosis, or other similar condition.
 18.2 Are you pregnant at present, or did you have a caesarean section in the past? Yes No

Note: This statement of health will be validated by the required signature(s) at paragraph 17 on page 11.

If the answer to question 1.2 above is "Yes", provide details in the spaces below.

Claim	Date of claim (DDMMCCYY)	Reason for claim	Company(ies) claimed from	Have you sustained permanent disablement or injuries?

Note: • Make copies if more lives insured are needed – maximum 10. Adjust page number for additional page(s), for example, Page 17.1, etc. and mark clearly the life insured number(s).

► Supplement 1(A) (continued from page 17)

If the answer to any of the questions on the previous page(s) (excluding questions 1.2, 9, 10, 13, 15 and 16) is "Yes", enter (in the spaces below) the number(s) of the relevant question(s) and provide the full details with regard to such question(s).

Question number	Date of diagnosis AND latest symptoms (DDMMCCYY)	Describe the nature of the condition and treatment received	Still on treatment? (Yes / No)	Initials, surname and contact number of doctor/Name and contact number of medical institution	Have you recovered in full? (If not, describe)

(B) Details of family doctor

Initials and surname of family doctor

Since when has he/she been your family doctor?

Telephone number ()

Fax number ()

Postal address of family doctor

 Postal code:

Initials, surname and postal address of previous family doctor

 Postal code:

Note: • Make copies if more lives insured are needed – maximum 10. Adjust page number for additional page(s), for example, Page 18.1, etc. and mark clearly the life insured number(s).

► Supplement 2

(A). Declaration by applicant in respect of HIV/other tests *(Not applicable if only accidental benefits are taken)*

I understand and accept that

- the life insured(s) has/have to understand and agree to all the terms and conditions set out in the life insured(s) declaration in Supplement 2(B), which must also be signed by him/her;
- if Sanlam Life requires the life insured(s) to undergo an HIV blood test:
- the life insured(s) must undergo an HIV test before this application will be processed;
- Sanlam Life reserves the right to require the life insured(s) to undergo (an)other blood test(s) in order to continue with the processing of this application;
- Sanlam Life will refuse to accept this application unless the life insured(s) undergoes/undergo an HIV test and/or (an)other blood test(s) required by Sanlam Life and such test(s) renders a negative/required test result.

Note: *This declaration will be validated by the required signature(s) at paragraph 17 on page 11.*

(B). Declaration by life insured number in respect of HIV/other tests and/or other insurance information *(Not applicable if only accidental benefits are taken)*

1. I understand and hereby agree that if, for purposes of processing this application, Sanlam Life requires me to undergo an HIV blood test and/or another blood test
 - I will undergo such a test. (I understand the importance of being fully informed about my having to undergo an HIV blood test and I fully understand the implications thereof);
 - any such HIV blood test must be done only according to the Association for Savings and Investment South Africa (ASISA) prescribed rules;
 - Sanlam Life reserves the right to require that I undergo other blood tests and also reserves the right to require that further tests be done on the sample of my blood. If Sanlam Life requires me to undergo other blood tests, I agree to do so.
2. I agree to undergo a cotinine test to measure serum nicotine levels, if Sanlam Life requests it.
3. If, in complying with a requirement by Sanlam Life, I should undergo any HIV test and/or other blood test, I indemnify Sanlam Life and its directors, agents, intermediaries and employees, as well as the person who takes the sample of my blood and the person who performs such test on that sample, against any claim of whatever nature which may be brought against Sanlam Life and/or against any of these persons as a direct or indirect result of any such test. The particulars of the medical doctor to whom the result of any such blood test must be disclosed, are as follows: *(complete only if someone other than family doctor)*

Initials and surname of doctor

Postal address of doctor

			Tel. nr. ()		
				Post code:	<input type="text"/>

4. Accepting that I am curtailing my right of privacy, but to facilitate the assessment of the risks, and the consideration of any claim for benefits under a plan related to this or any other application made in respect of me as a life insured, I irrevocably authorise Sanlam Life, for insurance purposes, to:
 - obtain from any person or institution, whom I hereby so authorise and request to give to Sanlam Life, any information which Sanlam Life deems necessary, and
 - share, at any time (even after my death), with other insurers – either directly or through a data base operated by or for insurers as a group, and in such detailed, abbreviated or coded form as may from time to time be decided by Sanlam Life or by the operators of such data base – that information and any information contained in this application or in any related plan or other document.

I indemnify Sanlam Life and its directors, agents, intermediaries and employees, as well as any other person, against any claim arising from the provision and/or disclosure of such information.

5. Sanlam Life has specific risk products for HIV positive lives. If your HIV test result is positive, you can contact Sanlam Life at 0860 000 121, or your intermediary.

Alternatively, would you prefer Sanlam Life to contact you? Yes No Please initial if you require direct contact

Note: *This declaration will be validated by the required signature(s) at paragraph 17 on page 11.*

Note: • *Make copies if more lives insured are needed – maximum 10. Adjust page number for additional page(s), for example, Page 19.1, etc. and mark clearly the life insured number(s).*