Help to complete the application form

The following sections must be completed and signed as follows:

- Sections 1–5 to be completed by the policyholder
- Sections 6–7 to be completed by the premium payer
- Sections 8–14 to be completed by the life insured

All contracting parties are required to sign the general disclosures.

Please note, when utilising digital signatures, kindly ensure that the appropriate audit trail accompanies this application.

The policyholder must initial each page.

Where the policyholder or premium payer is a company, trust or non-natural entity, please ensure the applicable addendums are included when submitting this application.

Supporting documentation required:

- Proof of income at application stage will ensure claim payment for 24 months without proof of loss of income
- If the policy is to be ceded, provide cessionary documents
- With the implementation of FICAA Hollard Life may during the application for a policy, call for additional documentation to identify contracting parties where necessary
- Fully completed Replacement Advice Record where there is an intention to replace this policy with another

Please note, omitting to disclose information, or providing false or distorted information, at any time, either by accident or on purpose, is considered to be misrepresentation which could lead to your policy being rescinded.

DebiCheck awareness

The premium payer may be asked by their bank to DebiCheck their debit order. DebiCheck is the new safe way of approving debit orders, electronically confirmed by them, with their bank. This will be on a once-off basis at the start of the contract.

This means that the bank will now know all the details that have been agreed to regarding this debit order mandate and will not allow any debit order to be processed outside of this mandate.

Confirmation of DebiCheck may be sent to the premium payer by SMS. Alternative authorisation for DebiCheck can be given via online banking, by visiting the bank or via ATM.

To be completed by the policyholder

Section 1

If the policyholder is a company or trust, please ignore section 1 and complete the applicable addendum.

Title | Initials | First name

Former surname | Surname

Relationship to life insured | ID/passport no.

Alternative contact no. | Cell no.

Email

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Gender Male ☐ Female

Marital contract ☐ Antenuptial contract ☐ Community of property ☐ Civil union ☐ Customary

Tax status ☐ Natural person ☐ Company Country of residence

Occupation | Employer

Physical address

Postal address

Source of funds | Source of wealth

Beneficiary details

Section 2

We are unable to accept a beneficiary nomination if there is more than one policyholder or where the policyholder and life insured are different.

2.1 Should the proceeds of this policy be paid to the estate of the policyholder? ..... ☐ Y ☐ N

2.2 If your answer to 2.1 is no, please complete the table below nominating your beneficiaries. Allocate the following death benefits, where applicable, and indicate the percentage split.

First name/s	Surname	ID no.	Relationship to life insured	% split	
				Income benefits	Lump sum benefits
Total				100%	100%

Final Expense benefit (only where Life Cover is selected)

You may nominate up to one spouse and up to four children (if under 25), subject to the terms and conditions described in your quote. If you are both the sole policyholder and life insured, or if you as the policyholder are the spouse of the sole life insured, you may nominate up to one spouse (if under 65) and four children for the additional Final Expense benefit.

Policyholder and life insured

Relationship to life insured	First name/s	Surname	ID no.
Spouse			
Child 1			
Child 2			
Child 3			
Child 4			

Policyholder signature

Section 3

Correspondence details

Is the policyholder the same person any correspondence should be sent to? ..... Y N

If yes, go to section 4.

If no, please complete section 3.

All future communication will be emailed to the nominated person below and will be taken as communicated to the policyholder. Documents unavailable electronically will be posted. Please only nominate one person to receive the communication.

Title Initials

First name(s)

Surname

Cell no. Email

Postal address

Alternative contact no.

Please remember to let us know when any of your correspondence details change as quickly as possible.

Section 4

Policy details

4.1 Reason for insurance (select one)

Personal: Financial security Bond Loan Estate planning

Business: Buy and sell Other

4.2 Is this policy to be ceded? (Not available for a policy with multiple owners) ..... Y N

4.3 On what date would you like your policy to commence? Y Y Y Y / M M / D D

4.4 If this is an employer/company-owned policy, would you like to claim the Section 11(w)(ii) of the Income Tax Act deduction for the premium? ..... Y N

Section 5

Declaration by policyholder

5.1 I confirm that I am a policyholder of each application referenced by the quote number in the table below. I also confirm that I have read and understood the Policyholder and Contract Details sections of the application forms, related quotes and all related documents for each of these applications.

Quote reference number	% policy ownership	Quote reference number	% policy ownership
	%		%
	%		%
	%		%
	%		%

I hereby confirm that all fields were completed in my presence, and I did not sign a blank form. I have read every page before signing.

Policyholder signature

Declaration by policyholder (continued)

5.2 Validity of quotation information:

- This application must be accompanied by a valid signed quotation prepared on the Hollard Life quotation system.
- Hollard Life will not be liable for any errors and omissions made by the applicant or financial advisor on the signed quotation.
- Hollard Life will not be held liable for any errors or omissions that may have occurred in the production or completion of this application.
- The policy contract will override the quotation.

5.3 I authorise Hollard Life to accept this application and the accompanying illustrative quotation on the terms of the illustrative quotation ..... Y N

5.4 I declare that the statements and responses provided by me and all documentation that I have signed or will sign in relation to each application/s are true and complete.

5.5 Where I am married in community of property, I confirm that I have written consent from my spouse to make this application.

5.6 I agree that this application and declaration, together with all relevant documents that have been or will be signed by me or any additional parties in terms of this application, shall form part of the contract between Hollard Life and myself. If any information is withheld or incorrect, I understand that the benefits will be cancelled from the inception date of the policy and all premiums that have been paid to Hollard Life will be forfeited.

5.7 I agree that should Hollard Life accept this application, the acceptance will be conditional upon there having been no change to the facts on which the acceptance was based. I agree that any changes to the health or risk status of the life insured will be communicated to Hollard Life in writing before it accepts this policy, and failure to do so may result in the rejection of any future claims.

5.8 I authorise Hollard Life to obtain and or provide any credit-related information from or to any credit bureau, life insurance institute, credit provider, industry association or other association for any industry in which Hollard Life operates.

5.9 I hereby give consent to Hollard Life to refer my details to:

- The Hollard Group for the purposes of contacting me in relation to new and existing product offerings ..... Y N
- Hollard Insurance partners for the purposes of contacting me in relation to any new or existing product offerings.... Y N

5.10 I hereby give consent to Hollard Life to send me any relevant information relating to:

a. The benefits listed on this policy ..... Y N

b. Any new or existing product offerings from Hollard Life ..... Y N

5.11 I hereby accept that this application does not create any obligation for Hollard Life until the date of policy commencement.

5.12 I understand that if the first premium is not paid on or before the first debit order date, no cover will be provided and no claims will be payable under the policy for that period until the first premium is received in full by Hollard Life.

Policyholder name

Signature

Date Y Y Y Y M M D D

Policyholder signature

Section 6

To be completed by the premium payer

If the premium payer is a company or trust, please complete the applicable addendum.

Is the policyholder the same person as the premium payer? ..... Y N

If yes, go to section 7.

If no, please complete section 6.

Title | Initials | First name

Former surname | Surname

Relationship to life insured | ID/passport no.

Alternative contact no. | Cell no.

Email

Gender Male Female

Country of residence

Occupation | Employer

Physical address

Postal address

Source of funds | Source of wealth

Section 7

Debit order authorisation

NOTE: Hollard Life only accepts applications where payment is made by debit order at any stage during the contract.

Bank | Account holder

Account no. | Branch

Branch code | Account type

Debit date

Relationship to the insured

I authorise Hollard Life to draw against this account all amounts due in terms of this policy. This authorisation is to remain in force until terminated by Hollard Life or myself. I accept that Hollard Life may debit my account on a date other than that specified. If there are insufficient funds in the nominated account to meet the premium payment due, Hollard Life is entitled to track my account and present the instruction for payment as soon as sufficient funds are available.

Bank statement reference: The transaction description on your bank statement for the deduction of your monthly premium will be 'HOL + Policy Number'.

Premium payer signature | Date Y Y Y Y M M D D

Policyholder signature

Section 8

To be completed by the life insured

Is the policyholder the same as life insured? ..... Y N

If yes, go to section 9.

If no, please complete section 8.

Title | Initials | First name

Surname | Former surname

Date of birth Y Y Y Y / M M / D D | ID/passport

Gender Male ☐ Female ☐ | Email

Postal address

Tel no. | Cell no.

Marital status Single ☐ Married ☐ Divorced ☐ Civil union ☐ Widowed ☐

Section 9

Employment details

9.1 Are you self-employed? ..... Y N

9.2 What is your present occupation?

9.3 Do you currently have multiple occupations? ..... Y N

If yes, please complete the Occupation Questionnaire.

9.4 Since when have you worked in this occupation? Y Y Y Y M M D D

9.5 What industry do you work in?

9.6 List the previous occupations you've had in the last five years (with dates).

9.7 What is your highest level of education?

No matric ☐ Matric ☐ Matric + 1 or 2 year diploma ☐

3 year technical diploma or higher ☐ 3 year degree ☐

4 year degree or postgraduate degree or higher ☐

9.8 Give details of your qualifications

9.9 Are you a qualified member of a professional organisation? ..... Y N

If yes, give the name of the professional organisation

Policyholder signature

Employment details (continued)

9.10 Using percentages, describe the amount of time spent performing the following duties: %

(a) Deskbound and/or office bound, for example, call centre agent or administrator

(b) Supervisory tasks within an office environment, for example, admin manager or call centre manager

(c) Supervising staff on site or in a factory/fieldwork, for example, building foreman or construction foreman

(d) Travel (excluding travelling from home to work and back), for example, driver or sales consultant

(e) Light manual work, for example, hairdresser or dental assistant

(f) Moderate manual work, for example, auto-electrician or plumber

(g) Heavy manual work, for example, diesel mechanic or carpenter

9.11 Give details of your monthly taxable earnings (confirmed on your SARS return)

Average monthly income	Current year average monthly income	Previous year average monthly income	Current year average monthly income	Previous year average monthly income
	Life insured		Spouse	
Present taxable salary	pm	pm	pm	pm
Other taxable income	pm	pm	pm	pm
Monthly after-tax income	pm	pm	pm	pm

Proof of income for disability income will be provided by me at underwriting stage ☐ claim stage ☐

Have you ever been declared insolvent or under liquidation? ..... Y N If yes, have you been rehabilitated? ..... Y N

Are you under debt management? ..... Y N

Have you applied or do you intend to apply for debt review in terms of the National Credit Act? ..... Y N

9.12 Are you aware of any retrenchment process currently underway at your current employer? ..... Y N

9.13 Are you employed by a family-owned business where you are a member of the same family? ..... Y N

Personal details

Would you like a tele-underwriter to contact you for the medical questions? ..... Y N

Please give 3 times and dates that would be most convenient for the call.

Date ☐ Time ☐ Date ☐ Time ☐ Date ☐ Time ☐

If yes, go to section 13.

If no, complete sections 10, 11 and 12.

10.1 Height (without shoes) ☐ cm

10.2 Weight (in normal clothes) ☐ kg

Policyholder signature ☐

Personal details (continued)

10.3 Has your weight decreased by more than 3 kg during the past year? Y N

If yes, what was the reason? Pregnancy ☐ Diet ☐ Exercise ☐ Illness ☐ Stress ☐ Depression ☐

Other

10.4 Have you ever received medical advice to reduce your weight? Y N

If yes, give the reason, name and telephone number of the relevant doctor.

10.5 Do you drink alcohol? Y N

If yes, how many units of the following do you drink?

Beer/spirit coolers		per week		
Wine		per week		
Spirits		per week		
Other		per week	Type	

10.6 Have you habitually drunk more in the past? Y N

If yes, give the quantity and type per week

10.7 Have you ever received medical advice to reduce or discontinue your alcohol consumption? Y N

If yes, give the reason, name and telephone number of the relevant doctor.

10.8 Have you ever been charged with drunken driving? Y N

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

If yes, how many of the following do you smoke?

Cigarettes		per day		
E-cigarettes/vape		per day		
Pipes		per day		
Cannabis		per day		
Hubbly or Hookah		per week		
Other		per week	Type	

Policyholder signature

Section 10

Personal details (continued)

10.10 Have you ever consumed, smoked or injected any legal or illegal narcotics or steroids? ..... Y N

If yes, give the name/type, reason for use and name and telephone number of the relevant doctor.

If yes, please complete the Habits Questionnaire.

10.11 Are you a member of a medical aid? ..... Y N

If yes, which medical aid and what is your membership number?

10.12 Do you have any intention of leaving South Africa (permanently or temporarily for a period of one month or more)..... Y N

If yes, which countries do you intend to travel to and why?

10.13 Do you regularly participate in a high-risk occupation, sport, hobby or pastime that may expose you to a higher-than-average risk of injury? (E.g. motorised speed contests, aviation, diving, bungee jumping)? ..... Y N

If yes, give details.

If yes, please submit related questionnaire.

Section 11

Medical details

Please note, omitting to disclose information, or providing false or distorted information, at any time, either by accident or on purpose, is considered to be misrepresentation, which could lead to your policy being cancelled.

It is your duty to disclose ALL medical conditions/symptoms/health factors, you may have ever had.

Examples provided for each medical-related condition are not limited to those conditions only.

Do you have, or have you ever had, trouble with or disorders of any of the following?

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

11.2 Your lungs (e.g. persistent cough, shortness of breath, tuberculosis, asthma, bronchitis, Covid pneumonia and ventilation)? ..... Y N

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

11.4 Your kidneys, bladder or reproductive organs (e.g. stones, infections, bilharzia, prostate, gynaecological problems)..... Y N

11.5 Your nervous system (e.g. concussion, paralysis, seizure, fits, blackouts, chronic fatigue)?..... Y N

11.6 Psychological/psychiatric conditions (e.g. depression, anxiety, hallucinations, stress, suicide attempts)?..... Y N

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

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

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

11.10 Growths (e.g. cancer, carcinoma in situ, benign mole, lump or tumour of any kind)? ..... Y N

Policyholder signature

Medical details (continued)

11.11 Have you ever sought medical advice, during the past 7 years, in connection with any symptom or condition, or been a patient in a hospital or nursing home or undergone any medical examination, or routine executive medical (including ECG, X-ray examination, Pap smear, mammogram, colonoscopy, gastroscopy, ultrasound, specialised laboratory tests, hospitalisation for Covid-19) with normal or abnormal results not mentioned above? ..... Y N

11.12 Are you taking, or have you ever taken, drugs, tranquilisers or have you been prescribed any other medication in any form for a continuous period of more than two weeks? ..... Y N

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

11.14 Have you been for any genetic testing or received counselling for genetic testing in the past 7 years? ..... Y N

11.15 Have you ever been referred to a medical specialist? ..... Y N

11.16 Have you been seen by any allied or alternative medical professional such as a homeopath, physiotherapist, psychologist, biokineticist, chiropractor, sangoma, traditional healer? ..... Y N

11.17 Have you been advised to seek further medical assistance or go for further tests? ..... Y N

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

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

Q no.	Nature & duration of condition or symptom	Date of first symptom	Name & address of attending doctor/hospital including the doctor's speciality	Date of last symptom	Are you on treatment? Yes/No

11.19 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? ..... Y N

If yes, provide the policy number, name of insurer and date of application

11.20 Has a claim for any policy benefit, where you are the life insured, ever been submitted to any life insurer? ..... Y N

If yes, please provide the name of the life insurer.

Policyholder signature

Section 11

Medical details (continued)

11.21 In the last two years, have you ever been absent from work as a result of an accident or sickness for:

(a) more than two weeks? ..... Y N

(b) more than 30 non-consecutive days in a year? ..... Y N

If yes, give the reason, duration and dates.

11.22 Give the name and contact details of your usual doctor.

Full name Tel. no.

Physical address

11.23 Give the name and address of any other medical attendant who has acted in this capacity during the last five years.

11.24 Do you have an appointment with a doctor planned in the next 3 months? ..... Y N

If yes, please provide those details.

11.25 Would you like Hollard to manage any nurse bookings and laboratory test requirements on your behalf? ..... Y N

If yes, what suburb can the nurse come and see you in during the day?

NOTE: We will not be able to arrange any tests or medicals that a doctor needs to perform or complete.

Section 12

Family medical history

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

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

12.2 Cancer, carcinoma in situ (localised) or tumour of any kind? ..... Y N

12.3 Kidney disease (excluding kidney stones)? ..... Y N

12.4 Any hereditary/genetic disease, e.g. Huntington's disease, polycystic kidney disease? ..... Y N

If you answered yes to any of these questions, give full details below.

Family member	Condition diagnosed from above list	Age diagnosed	Age of death	Additional information

Policyholder signature

Other insurance details

Complete the table below with the benefit amounts of other existing insurance policies on the life insured's life with all insurers. Include any policies not yet finalised and any applications to be applied for or finalised in the next 3 months. (This excludes this current application.)

Benefit			Personal		Business		
			Individual	Group	Buy & sell	Key person	Contingent
Life cover	Lump sum						
	Income benefit	≤ 24 month payment					
		> 24 month payment					
Disability	Lump sum						
	Income benefit	≤ 24 month payment					
		> 24 month payment					
Impairment	Lump sum						
	Income benefit	≤ 24 month payment					
		> 24 month payment					
Retrenchment	Lump sum						
	Income benefit						
Critical illness	Lump sum						

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.

13.1 Is this application intended to replace the whole or any part of your existing insurance with any insurer?..... Y N

If yes, the financial advisor must discuss and complete the Replacement Policy Advice Record and attach it to this application.

Policies being replaced	
Policy number	**Insurer**

Policyholder signature

Declaration by life insured

14.1. I confirm that I am the life insured of the applications referenced by the quote number in the table below. I also confirm that I have read and understood this application form, related quotations and all other supporting documents to this application, including, but not limited to, the policy and benefit terms and conditions.

Quote reference number	% policy ownership	Quote reference number	% policy ownership
	%		%
	%		%
	%		%
	%		%
	%		%

14.2 I declare that the statements and responses provided by me and all documentation that I have signed or will sign in relation to each application/s are true and complete.

14.3 I agree that this application and declaration, together with all relevant documents that have been or will be signed by me or any additional parties in terms of this application, shall form part of the contract between Hollard Life and myself. If any information is withheld or incorrect, I understand that the benefits will be cancelled from the inception date of the policy and all premiums that have been paid to Hollard Life will be forfeited.

14.4 I agree that should Hollard Life accept this application, the acceptance will be conditional upon there having been no change to the facts on which the acceptance was based. I agree that any changes to the health or risk status of the life insured will be communicated to Hollard Life in writing before acceptance of this policy, and failure to do so may result in the rejection of any future claims.

14.5 I agree to undergo testing for HIV (human immunodeficiency virus) and understand the implications of the positive test and that I will be given the opportunity to read the counselling information.

14.6. I understand that while Hollard Life respects the confidentiality of my personal information, it is essential for insurance companies to share claims and underwriting information for the assessment and underwriting of risks and to reduce the number of fraudulent claims.

14.7 I understand that Hollard Life accesses, obtains and discloses my personal and medical information and insurance history for the assessment of this application and any claims. I therefore authorise Hollard Life to:

a. obtain from, or provide to, any person, any information it deems necessary to fulfil the terms of this application or the policy that may result from this application; and
b. share any information related to this application with other insurers either directly or through a database operated by, or for, insurers as a group.

14.8 I give Hollard Life consent to:

a. release copies of and discuss my medical results and information with my doctor/s Sign

b. discuss my medical results and information with my financial advisor/s Sign

Note: This may contain sensitive information and your signature indicates consent.

14.9 I understand that for my protection, this form should not be signed by me until all the details have been completed. This form will be deemed to have been completed by me irrespective of who completed this form.

Life insured signature

Date Y Y Y Y M M D D

Policyholder signature

To be completed by the financial advisor

I hereby declare that I have explained the benefits and obligations arising from this application to the applicant and that they fully understand the consequences of any incorrect information provided in this application.

I hereby declare that the completed application was signed with no blank spaces by the applicant, in my presence.

I further declare that I have explained the meaning and implication of the replacement question to the applicant and that the client is fully aware of the possible detrimental consequences of the replacement of an insurance policy. I have also explained the meaning of replacement; that a replacement is potentially prejudicial; the levying/deduction of a termination charge; and that when a replacement is considered, the applicant is legally entitled to comprehensive information regarding the consequences of a replacement.

I confirm that I have identified the policyholders, life insureds, premium payer and cessionary (where applicable) and verified their details for this contract.

	Primary advisor		Secondary advisor
Full name		Full name	
Brokerage house		Brokerage house	
Commission split %		Commission split %	
Advisor ID no.		Advisor ID no.	
FSP no.		FSP no.	
Biblife/Pri no.		Biblife/Pri no.	
Tel. no.		Tel. no.	
Cell no.		Cell no.	
Email address		Email address	
Broker consultant		Broker consultant	
Distribution branch		Distribution branch	
Signature		Signature	
Date	Y Y Y Y M M D D	Date	Y Y Y Y M M D D

Policyholder signature

Disclosure of your personal information

We care about the privacy, security and online safety of your personal information and we take responsibility to protect this information. By completing this form, you consent to the processing and disclosure of your personal information for the application of this policy. We will share your personal information with other insurers, industry bodies, credit agencies, service providers, any regulatory body, tax authority and to comply with anti-money laundering legislation. This includes information about your insurance, claims and premium payments. We do this to provide insurance services, prevent fraud, assess claims and conduct surveys. You are welcome to request access to any of your personal information that we hold.

Anti-money laundering

Money laundering and financing of terrorism risks (anti-money laundering) are governed by relevant applicable legislation.
At Hollard, we've taken the necessary steps to implement the anti-money laundering legislation that deals with preventing money laundering and combatting the financing of terrorism. We are required by anti-money laundering legislation to obtain specific information from you and certain related parties, to enable us to establish and verify your and related parties' identity.
You understand that different information will be required depending on the type of client and related party, and we may require supporting documentation. This requirement applies when we receive the application, on an ongoing basis while the policy is in force and when a claim is made under the policy.

By signing this declaration:

1. You agree to co-operate fully with us and to provide us with all such information and documentation requested as soon as possible.
2. You understand that there may be different information and documentation requirements, depending on the type of the owner of the policy and the related parties. Related parties include but are not limited to, the owner of the policy, the premium payer, claimant and beneficiaries.
3. You understand and accept the information and documentation requirements, which are set out in your application form, may be changed from time to time without notice.
4. You understand that if we do not receive the information and documentation as soon as possible or within a timeframe that will be communicated to you, we may be unable to provide you with insurance cover and we may have to cancel your existing policies immediately.
5. You consent to the processing and disclosure of your personal information for the application of this policy, to any regulatory body, tax authority and to comply with anti-money laundering legislation.
6. You consent to us conducting ongoing monitoring of your transactions and activities related to your business relationship with us, as required by anti-money laundering legislation and understand that we are not required to disclose our monitoring activities to you.
7. If we are unable, for whatever reason, to conduct ongoing monitoring of your transactions and activities we may be unable to provide you with insurance cover, and we may have to cancel your existing policies immediately.
8. You understand and accept that we will require documentation and information from the claimant, including the beneficiary, in order to process a claim. We will therefore not be able to process a claim before the claimant and beneficiary have provided us with the required information and documents for us to establish and verify their identity.
9. All the information you provide to us, including the information requested from you in this application form, is true and correct and you indemnify us against any damages we may suffer due to the provision of false or inaccurate information.

Policyholder		Signature		Date	Y Y Y Y M M D D
Life insured		Signature		Date	Y Y Y Y M M D D
Premium payer		Signature		Date	Y Y Y Y M M D D
Financial advisor		Signature		Date	Y Y Y Y M M D D