Application for your Hollard Life Policy

Section 1

To be completed by the Life Insured

Is the Policyholder the same as Life Insured? ..... Y N

If yes, you do not need to complete this section 1.

If no, please complete section 1.

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 2

Employment details

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

2.2 What is your present occupation?

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

If yes, please complete the occupation questionnaire

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

2.5 What industry do you work in?

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

2.7 What is your highest level of education? ☐ No Matric ☐ Matric ☐ Matric + 1 or 2 yr Diploma ☐ 3 yr Technical Diploma or higher ☐ 3 yr Degree ☐ 4 yr Degree or Post Graduate Degree or higher

2.8 Give details of qualifications.

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

If yes, give the name of the professional organisation

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

(a) Desk bound 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*

Policyholder signature

Employment details (continued)

2.11 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

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 intend to apply for debt review in terms of the National Credit Act? ..... Y N

Proof of income for disability income benefits will be provided by me at: ☐ Underwriting stage ☐ Claims stage

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

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

Personal details

3.1 Height (without shoes) _____ cm

3.2 Weight (in normal clothes) _____ kg

3.3 Has your weight changed by more than 3 kg during the past year? ..... Y N

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

3.4 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. _____

_____

3.5 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 _____

3.6 Have you habitually drunk more in the past? ..... Y N

If yes, give the quantity and type per week _____

3.7 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. _____

3.8 Have you ever been charged with drunken driving? ..... Y N

3.9 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 3

Personal details (continued)

3.10 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.

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

If yes, which medical aid? Membership no.

3.12 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?

3.13 Do you regularly participate in a high-risk occupation, sport, hobby or past-time which 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 4

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?

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

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

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

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

4.5 Your nervous system (e.g. concussion, paralysis, seizure, fits, blackouts) ..... Y N

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

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

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

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

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

4.11 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) with normal or abnormal results not mentioned above? ..... Y N

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

4.13 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

Please provide results in grid below.

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

Policyholder signature

Medical details (continued)

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

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

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

4.18 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
					☐ ☐
					☐ ☐
					☐ ☐
					☐ ☐
					☐ ☐
					☐ ☐
					☐ ☐
					☐ ☐
					☐ ☐
					☐ ☐

4.19 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

4.20 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

4.21 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.

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

Full name Tel. no.

Physical address

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

Policyholder signature

Section 4

Medical details (continued)

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

If yes, please provide those details

4.25 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 5

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?

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

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

(If yes, specify the site and type of cancer in the table below)

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

5.4 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.

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.

6.1 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

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
	%		%
	%		%
	%		%
	%		%
	%		%

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.
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.
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.
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.
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.
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 authorize 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.
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.
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 _____

General Disclosures

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 & 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 inforce 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 is 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 is 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 has 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