

BENEFIT AMENDMENT FORM

Instructions:

Complete policy details and life insured details in all instances.

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

Complete a beneficiary nomination form in order to change a beneficiary on your original policy.

Complete a broker nomination form in order to change your financial advisor.

Kindly note:

Additional documentation may be requested by Hollard Life where required.

Return the completed form and supporting documentation to mypolicy@hollard.co.za or call us at 0800 9345 65 for assistance.

The policyholder is required to initial each page.

1. Policyholder details

(To be completed by the policyholder)

Policy no.			
Policyholder 1			
Name			
Identity no.			
Email address	Mandatory	Cell no.	
Residential address			
Postal address			
Employer			
Occupation			
Source of wealth			
Source of income			
Country of residence			
Policyholder 2			
Name			
Identity no.			
Email address	Mandatory	Cell no.	
Residential address			
Postal address			
Employer			
Occupation			
Source of wealth			
Source of income			
Country of residence			

2. Life insured details

(To be completed by life insured)

Name of Insured						
What is your current occupation?						
In which industry do you work?						
What is your monthly taxable income?						
What is your monthly after tax income?						
What is your current education level?	☐ No matric	☐ Matric/ Matric + 1 or 2 yr Diploma	☐ 3 or 4 yr Diploma	☐ 3 yr Degree	☐ 4 yr Degree or higher	
Give details of the qualification, e.g. BCom Marketing						
Complete the table below to total 100% of your daily tasks						

Deskbound and office bound tasks	Supervising staff within an office	Travelling (excluding travel to and from your office/place of work)	Supervising staff on site or in a factory/field work	Light manual work (standing up, e.g. hairdresser)	Moderate manual work (not involving very strenuous exercise, e.g. mechanic)	Heavy manual work (involving strenuous exercise, e.g. miner)
%	%	%	%	%	%	%
					Yes ☐	No ☐
If Yes, state the name of the professional organisation						

3. Amend my existing policy

(To be completed by life insured)

For policies with the date of commencement before 2006, you will need to upgrade the policy.

I would like to upgrade my current Hollard Life policy in its entirety to the latest Hollard Life Product range.	Yes ☐	No ☐
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Attach a signed quotation that shows:

- All new benefits to be added to the existing policy, and
- The total amount of cover required after the amendment for the existing and/or new benefits.

Indicate below the benefits that you would like to increase, decrease, remove or add from your policy:

Benefit	Version	Sum assured *	Increase	Decrease	Remove	Add	Upgrade
		R	☐	☐	☐	☐	☐
		R	☐	☐	☐	☐	☐
		R	☐	☐	☐	☐	☐
		R	☐	☐	☐	☐	☐
		R	☐	☐	☐	☐	☐
		R	☐	☐	☐	☐	☐
		R	☐	☐	☐	☐	☐
		R	☐	☐	☐	☐	☐

* If a benefit is being removed, the sum assured will be zero. If a benefit is being decreased, the sum assured needs to be the new decreased amount.

Is this Proposal to replace the whole or any part of your existing insurance with any insurer, if yes, the financial advisor must discuss and complete the replacement policy advice record and attach it to this proposal.	Yes ☐	No ☐
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Signature (life insured) _____

Date	D	D	M	M	Y	Y	Y	Y
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Signature (life insured) _____

Date	D	D	M	M	Y	Y	Y	Y
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4. Underwriting and medical information

(To be completed by life insured)

1. Have you as the insured ever been declared insolvent?	Yes ☐	No ☐
If Yes, have you been rehabilitated?		
2. Are you aware of any retrenchment process currently underway at your current employer?	Yes ☐	No ☐
3. Are you employed by a family-owned business where you are a member of the same family?	Yes ☐	☐
4. Do you have any intention of leaving South Africa (permanently or temporarily for a period of 1 month or more)?	Yes ☐	☐
If Yes, which countries do you intend to travel to?		
5. Do you participate in a high-risk occupation, sport, hobby or pastime which may expose you to a higher than average risk of injury?	Yes ☐	No ☐
If Yes, give details (e.g. motorised speed contests, aviation, diving, bungee jumping).		
6. Height (without shoes)	cm	
7. Weight (in normal clothes)	kg	
8. Alcohol units consumed per week (state type and quantity)		
9. Have you received medical advice to reduce or discontinue your liquor consumption since the original policy acceptance?	Yes ☐	No ☐
If Yes, state reason, name and telephone number of the doctor concerned.		
10. Do you currently smoke, or have you smoked in the last 12 months?	Yes ☐	No ☐
If Yes, what and how much do you smoke per day (including vaping, pipes, hubblys or cannabis)?		
11. Have you received medical advice to reduce or discontinue smoking since the original policy acceptance?	Yes ☐	No ☐
If Yes, state reason, name and telephone number of doctor concerned.		
12. Have you consumed, injected or smoked any legal or illegal narcotics since the original policy acceptance?	Yes ☐	No ☐
Do you have, or have you had, since original policy inception, trouble with, or disorders of, any of the following? If Yes, please give further information at the end of the section in the details of complaint or symptom table.		
13. Your heart or circulation (e.g. blood pressure, chest pains, heart murmur, palpitations, rheumatic arthritis, stroke, cholesterol, TIA)?	Yes ☐	No ☐
14. Your lungs (e.g. persistent cough, shortness of breath, tuberculosis, asthma, bronchitis)?	Yes ☐	No ☐
15. Your digestive system or liver (e.g. recurrent indigestion, ulcers, bleeding from the bowel, hepatitis, gallstones)?	Yes ☐	No ☐

16. Your kidneys, bladder or reproductive organs (e.g. stones, infections, bilharzia, prostate, gynaecological problems)?	Yes ☐	No ☐
17. Your nervous system (e.g. concussion, paralysis, seizures, fits, blackouts)?	Yes ☐	No ☐
18. Psychological/Psychiatric conditions (e.g. depression, anxiety, hallucinations, stress, suicide attempts)?	Yes ☐	No ☐
19. Your eyes (excluding errors of refraction), ears (e.g. deafness, ear discharge), nose or throat?	Yes ☐	No ☐
20. Your skeletal joints or muscles (e.g. rheumatism, arthritis, back or neck trouble, gout)?	Yes ☐	No ☐
21. Your glands or blood (e.g. diabetes, thyroid, spleen, bleeding disorder, leukaemia)?	Yes ☐	No ☐
22. Growths (e.g. cancer, carcinoma-in-situ, benign mole, lump or tumor of any kind)?	Yes ☐	No ☐
23. 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 test) with normal or abnormal results not mentioned above?	Yes ☐	No ☐
24. Are you taking, or have you ever taken drugs, tranquilizers or have you been prescribed any other medications in any form for a continuous period of more than two weeks?	Yes ☐	No ☐
25. 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)?	Yes ☐	No ☐
26. Have you been for any genetic testing or received counselling for genetic testing in the past 7 years?	Yes ☐	No ☐
27. Have you ever been referred to a medical specialist?	Yes ☐	No ☐
If Yes, state nature of incapacity, period and dates.		
28. Have you been seen by any allied or alternative medical professional such as a homeopath, physiotherapist, psychologist, biokineticist, chiropractor, sangoma, traditional healer, etc.?	Yes ☐	No ☐
If Yes, list these.		
29. Have you been advised to seek further medical assistance or go for further tests?	Yes ☐	No ☐
If Yes, indicate which family member and details of disease, event or procedure.		
Events include: Raised cholesterol, angina, heart attack, coronary bypass surgery, angioplasty, stent, stroke, transient ischaemic attack, hypertension or diabetes, cancer, carcinoma-in-situ (pre-cancer) or tumor of any kind, kidney disease (excluding kidney stones), Multiple Sclerosis, Huntington's chorea, motor neuron disease, Parkinson's Disease or haemochromatosis?		
30. 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?	Yes ☐	No ☐
31. Has any proposal for life, sickness, accident or disability insurance on your life been declined, deferred, withdrawn or accepted at special terms or on special rates since original policy inception?	Yes ☐	No ☐
If Yes, please provide a policy number and company name.		
32. Has any proposal for life, sickness, accident or disability insurance on your life been declined, deferred, withdrawn or accepted at special terms or on special rates since original policy inception?	Yes ☐	No ☐
If Yes, please provide a policy number and company name.		

33. Since the original policy inception, have you been absent from work for a continuous period of more than 1 month as a result of an accident or sickness?	Yes ☐	No ☐
If Yes, state nature of incapacity, period and dates.		
34. Are you aware of any other health or other factors that may have occurred since the original policy inception which may influence the risk attached to this policy?	Yes ☐	No ☐
If Yes, list these.		
35. Has any immediate family member, i.e. father, mother, brother, sister, been diagnosed with or died from any of the diseases, events or procedures above (under the age of 60) since inception of your original policy?	Yes ☐	No ☐
If Yes, indicate which family member and details of disease, event or procedure.		
36. Has any additional proposal for life, critical illness, accident or disability insurance on the insured's life been accepted/issued since the original policy inception?	Yes ☐	No ☐
If Yes, provide details regarding the additional cover as well as the company name.		

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

5. Details of your usual doctor

(To be completed by life insured)

Name			
Tel. no.		Fax no.	
Email			
Postal address			
Name and address of any other medical attendant who has acted in this capacity during the last 5 years			

6. Benefit amendment form – declaration of health

(To be completed by life insured)

Policy no.		Life insured	
Policyholder			

This Declaration of Health may be used provided the current medical evidence on the policy being amended is not more than 12 months old and the statements below are true.

I, the life insured, hereby declare that since the acceptance of my original policy by Hollard Life:

- I have not been referred to a specialist,
- I am not awaiting any medical test results,
- I have not had any medical tests or been recommended to have any medical tests,
- I have not been diagnosed with a new disease or disorder,
- I have not been hospitalised for more than 3 days,
- I am not currently under regular care for a medical condition or on chronic medication,
- I have not changed my occupation or taken up a hazardous pursuit,
- I am not aware of any retrenchment process currently underway at my current employer, and
- I am not employed by a family-owned business where I am not a member of the same family.

If these statements are not true, complete section C of the Benefit Amendment Form and/or Occupational Questionnaire.

Signature (life insured) _____

Date	D	D	M	M	Y	Y	Y	Y
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7. Disclosures and declarations

Please take note of the following Hollard disclosures:

Protection of Personal Information Act (POPIA)

Hollard cares about your privacy. In order to provide you with our service, we and our service providers have to process the personal information you provide us with by completing this form. We will treat this information with caution and we have put reasonable security measures in place to protect it.

Financial Intelligence Centre Amendment Act (FICAA)

In accordance with applicable anti-money laundering laws in South Africa, we are required to obtain specific information and evidence to verify your identity (and in many cases the identities of related persons, such as, but not limited to, directors, beneficial owners and persons instructing us on your behalf (where applicable)) when applying for cover and on an on-going basis. If we ask you for information or documents (including originals or certified copies) you must provide them to us as soon as possible. If we do not receive adequate information and evidence within a reasonable time of our request, we may be unable to provide you with cover or may cancel the policy in accordance with applicable law.

I hereby give consent to Hollard Life to release copies of and discuss my medical information with my doctor	Yes ☐	No ☐
I hereby give consent to Hollard Life to discuss my medical information with my financial advisor	Yes ☐	No ☐

I understand that this form and the attached signed quotation with reference no _____ shall form part of the basis of the policy contract. I further agree, that if any material information is withheld I shall forfeit the additional sum insured and related premiums paid to Hollard Life.

Signature (life insured) _____

Date	D	D	M	M	Y	Y	Y	Y
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Signature (policyholder) _____

Date	D	D	M	M	Y	Y	Y	Y
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Signature (intermediary) _____

Date	D	D	M	M	Y	Y	Y	Y
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Hollard Life Assurance Company Limited (Registration No. 1993/001405/06) a licensed Life Insurer and an authorised Financial Services Provider FSP No. 17697

Hollard Specialist Life Limited (previously Regent Life Assurance Company Limited) (Reg No. 1994/001332/06) a licensed Life Insurer and an authorised Financial Services Provider FSP No. 18146

Hollard.