DOCTOR'S NOTIFICATION

(To be completed by the life insured)

1. Life insured's details

Policy no. _____ Identity no. _____

Name of insured _____

2. Consent to disclose medical information to a doctor

I, _____

2.1 Hereby authorise Hollard Life to forward Dr _____ the reasons for the loading/declinature of my policy.

OR

2.2 Hereby authorise Hollard Life to forward Dr _____ copies of my blood test.

Doctor's telephone no. _____

Doctor's fax no. or email address _____

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.

Signature (life insured) _____ **Date**

D	D	M	M	Y	Y	Y	Y