

POLICYHOLDER FORM FOR CRITICAL ILLNESS AND DISABILITY CLAIMS

(To be completed by the policyholder, the trustees of the trust or directors of the company)

Please note that it is essential to complete this form in full to prevent unnecessary delays as a result of missing information.

The following must be included when submitting this form:

- A certified copy of the claimant's identity document (within 3 months)
- Proof of bank account details of the claimant (e.g. copy of original bank statement within 3 months)
- Proof of residence if address is not on the bank statement (within 3 months)

Return the completed form and the above documents to lifecclaims@hollard.co.za or fax to 086 659 0135.

If the policyholder is a Company, Close Corporation, Partnership, Sole Prop, Trust or Unincorporated Entity, please complete the FICA Form.

1. Life Insured details

Policy no.	_____	Identity no.	_____								
Name of Life insured	_____										
Date of birth	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y	Work tel. no.	_____
D	D	M	M	Y	Y	Y	Y				
Home tel. no.	_____	Cell no.	_____								
Email address	_____		Mandatory								
Physical address	_____	Postal code	_____								
Postal address	_____	Postal code	_____								
Country of residence	_____										
Employer's name	_____										
Occupation	_____										

2. Policyholder details

Policy no.	_____	Identity no.	_____								
Name of claimant	_____										
Date of birth	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y	Work tel. no.	_____
D	D	M	M	Y	Y	Y	Y				
Home tel. no.	_____	Cell no.	_____								
Email address	_____		Mandatory								
Physical address	_____	Postal code	_____								
Postal address	_____	Postal code	_____								
Country of residence	_____										
Employer's name	_____										
Occupation	_____										

3. Declaration by policyholder

I confirm that I legally represent the policyholder. I am aware that the life insured has submitted a claim to Hollard Life on behalf of the policyholder. I have requested the life insured to complete the claimant form and provide all the medical information required to assess the critical illness/disability claim.

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 identify (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 _____

Date

D	D	M	M	Y	Y	Y	Y
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Name & surname _____