Smact Funeral Benefit Application Form

VERY IMPORTANT
- Incomplete forms will not be processed.
- Please read the declaration carefully and complete all applicable sections.

Group Name:	Province:	Region:	Branch:

1. POLICYHOLDER DETAILS *(ONLY PERSONS RESIDING IN RSA WILL BE ELIGIBLE FOR INSURANCE COVER)*

			Gender	
Full Names:		Date of Birth:	M	F
Surname:		Identity Number:		
Tel work:	Tel Home:	Cell no:		
Street Address:		Postal Code:		
Postal Address:		Postal Code:		
Email Address:		Country of Residence:		
Occupation:		Employer:		

Salary: [<R5 000] [R5 000 – R10 000] [R10 000-R15 000] [R15 000-R20 000] [>R20 000] Source of Wealth: Savings [ ] Inheritance [ ]

Source of Income: Salary [ ] Business Proceeds [ ] Sales Proceeds [ ] Claim Proceeds [ ]

2. PARTNER AND DEPENDANT CHILDREN DETAILS *(ONLY PERSONS RESIDING IN RSA WILL BE ELIGIBLE FOR INSURANCE COVER)*

	Name & Surname	Relationship	Identity Number	Gender	
Partner				M	F
Child 1				M	F
Child 2				M	F
Child 3				M	F
Child 4				M	F
Child 5				M	F

3. ADDITIONAL DEPENDANTS TO BE ADDED *(ONLY PERSONS RESIDING IN RSA WILL BE ELIGIBLE FOR INSURANCE COVER)*

	Name & Surname	Benefit Amount	Relationship	Gender	Identity Number	Premium
1				M / F		
2				M / F		
3				M / F		
4				M / F		
5				M / F		
6				M / F		
7				M / F		

4. BENEFITS AND COMBINED PREMIUMS

POLICYHOLDER AND IMMEDIATE FAMILY FUNERAL BENEFIT | POLICYHOLDER ONLY				Monthly Premium
Policyholder and Immediate Family: ☐	Benefit Amount: R15 000 ☐	Benefit Amount: R30 000 ☐		R
Policyholder Only (Ages 18 to 64) ☐	Benefit Amount: R15 000 ☐	Benefit Amount: R30 000 ☐		R
Policyholder Only (Ages 65 to 74) ☐	Benefit Amount: R15 000 ☐	Benefit Amount: R30 000 ☐		R
TOMBSTONE DEPOSIT BENEFIT (Optional)				
Policyholder Only (Ages 18 to 64) ☐	Benefit Amount: R7 500 ☐	Benefit Amount: R15 000 ☐		R
Policyholder and Partner (Ages 18 to 64) ☐	Benefit Amount: R7 500 ☐	Benefit Amount: R15 000 ☐		R
BURIAL SUPPORT PLAN (Optional)	Policyholder Only (18-64) ☐	Family (18-64) ☐		R
	Policyholder Only (65-74) ☐	Family (65-74) ☐		R
AFTER BURIAL SUPPORT PLAN (Optional)	Policyholder Only (18-64) ☐	Policyholder & Partner (18-64) ☐		R
	Policyholder Only (65-74) ☐	Policyholder & Partner (65-74) ☐		R
			Additional Dependants Total Monthly Premium	R
			Total Monthly Premium	R

I hereby confirm the Total Monthly Premium Initial

Payment: Premiums received for insured people who **do not** meet the entry age criteria or where no insurable interest has been established, will be **refunded and no benefits will be payable** for that insured person.

5. PAYMENT METHOD: DEBIT ORDER AUTHORISATION & DECLARATION

Account Holder:		Account Number:	
Account Holder ID No:		Account Holder Cell No:	
Name of Bank:	Branch Code:	Account Type: Cheque ☐ Savings ☐ Transmission ☐	
Day of Deduction: 1st ☐ 5th ☐ 16th ☐ 26th ☐ 28th ☐			Initials:

I authorise Hollard Life or its assignee to debit my bank account at abovementioned bank (or any other bank / branch to which I may transfer my account) with the Total Monthly Premium indicated above. Arrears will be collected by double debit. Should that double debit collection fail, the policy and ALL Service Benefits will automatically lapse and be forfeited.

6. BENEFICIARY: *In the event of my death I nominate the following person to receive the proceeds of any benefit payable in terms of this policy or to authorise and arrange my funeral.*

Full Name & Surname	Gender	Relationship	Identity Number
	M / F		

DECLARATIONS

I, the undersigned, hereby declare and warrant that I have a duty to support all dependants listed above; I am obliged to provide for their funeral arrangements and confirm that any and all information supplied herein is true and complete. I am aware and understand that failure of a legitimate duty; any non-disclosure or misrepresentation of information material to the determination of the risk by Hollard Life may lead to non-payment of a claim or the policy being declared null and void, in which case all premiums paid may be forfeited. I understand that no analysis has been undertaken of my financial needs or position, and that no advice or representation has been given to me with regard to this product.

Terms and Conditions applicable to this policy, are explained in your Policy wording. Subject to the conditions of the Long-term Insurance Act, you have 31 days after receipt of the Policy wording, to cancel your policy by notifying Hollard Life in writing. Should there be any noncompliance with the laws governing your policy, email compliance@tbfs.co.za or alternatively fax to (011) 836 8573.

Please Note: This is an application for insurance cover only. There IS NO GUARANTEED OR IMMEDIATE ACCEPTANCE of your application - terms & conditions apply. Hollard Life will send you a printed policy certificate confirming the details of the policy and insured people. Should you not receive your policy certificate within 31 days, please contact our offices on 0860 101 003. Premiums received for insured people who do not meet the entry criteria will be refunded and no benefits will be payable for that insured person.

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.

Consent to collect and process personal information (POPI)

Please note that your personal information is being collected to process your application and to comply with regulatory requests in terms of the POPI Act. The information you supply to Hollard Life is required for purposes of completing the policy details. Should you believe that Hollard Life has used your personal information contrary to applicable law, you undertake to first try to resolve any concerns with Hollard Life. If you are not satisfied with such process, you have the right to lodge a complaint with the Information Regulator, once established in terms of POPI.

Do you agree to share your personal information with Hollard for above mentioned purposes? Yes [ ] No [ ]

Anti-Money Laundering

Money Laundering & Financing of terrorism risks (Anti-Money Laundering) are governed by relevant applicable legislation. At Hollard Life, 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 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 the 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.

SIGNATURE AS ACCEPTANCE OF TERMS AND CONDITIONS

Policyholder Signature: _____

Premium Payer Signature: _____
Complete if Premium Payer is not the Policyholder

Premium Payer ID No: _____

Premium Payer Cell No. _____

FOR OFFICE USE ONLY

INTERMEDIARY DETAILS ***(TO BE FILLED IN BY THE INTERMEDIARY OR AGENT)***	
Intermediary Name: **SMACT FINANCIAL SERVICES (PTY) LTD**	FSP Number: **46481**
Agent Name and Surname: ZAHED KAJEE (AIK BROKERS)	Agent Code: [SMACT 18]

Agent Signature: _____ Date: DD MM YYYY