



Application for Group Life Conversion to Absa Life @Ease

Confidential

Please note: an incomplete application form will result in delays to the application process. A signed quotation and a copy of the Identity Document ("ID") must accompany this application.

Absa employee number:

CASA number:

Policy number:

A Particulars of the person whose Life is to be Insured

Title Surname

First name(s) Initials

Maiden name (if applicable) or previous surname Marital status

Gender Male Female ID number

Date of birth (dd/mm/ccyy) Language preference English Afrikaans

Telephone (H) Telephone (W) Cellphone

Email

Who will be paying the premium? Life Assured Proposer Other

If "Other", what is the relation to the Life Assured?

Passport number Nationality

Country of residence

B Details of Proposer (If applicable)

Relationship to the Insured (financial insurable interest)

Full name(s) of the Proposer (if applicable)

Maiden name (if applicable) or previous surname

Date of birth (dd/mm/ccyy) ID number

Marital status Gender Male Female Language preference English Afrikaans

Residential address

Postal code

Telephone (H) Telephone (W) Cellphone

Email Country of residence

Passport number Nationality

Signature of Life Insured _____

Date (dd/mm/ccyy)

Signature of Proposer _____

Date (dd/mm/ccyy)

C Occupation (Life to be Insured)

Occupation status: Fulltime Self-employed Part-time Temporary employed

Future occupation (after the recent change in employer)

Do you work inside the borders of South Africa?

Yes No

If "No", provide details of work outside RSA borders: Country(ies)

Period

Please state the name of your employer

Employer's full address

Postal code

Please give a brief description of your duties

D Details of beneficiaries (Compulsory for payments of benefits not ceded)

Name and surname	ID number	Relation	Country of residence	Nationality	% Split

E Existing Insurance

Please state the current insurance you have in force from all companies (including Absa Life), including whether utilised for the business or for personal cover.

Existing Insurance	Death Benefit	Dread Disease	Lump-sum Disability	Income Protection	Accidental Death
Business					
Personal					
Simultaneous applications	Death Benefit	Dread Disease	Lump-sum Disability	Income Protection	Accidental Death
Business					
Personal					

F Premium Collection details

Accountholder's name and surname

Account to debit

Name of bank/institution

Debit frequency

Annually Monthly

Deduction date (dd/mm/ccyy)

Policy commencement date (dd/mm/ccyy)

F.1 Premium collection authorisation (complete only when paying by debit order)

- 1 Withdrawals and transfers of funds by Absa Life Limited or its nominee (jointly referred to hereafter as "Absa Life") from the account specified will be binding on the premium payer and will have the same effect as if the premium payer personally performed such act.
- 2 Absa Life will be authorised, where funds in my account are insufficient on the payment date, to make the above withdrawals and transfer at any later stage not exceeding 32 (thirty two) days when funds are available.
- 3 Absa Life will be authorised to amend the amount and/or the date of payment of debits by notifying me upfront in writing, should the amount and/or date of payment respectively be amended on the account to which the above debits are to be credited.
- 4 I/We undertake to pay any bank charges relating to this authorisation and the Bank may, at its discretion, debit my above account with such bank charges from time to time.
- 5 I/We acknowledge that the onus will rest on me/us to prove that any amount, apparently withdrawn and credited to the account, in terms of the authorisation, was not due or was effected contrary to this authorisation.
- 6 I/We confirm that I/We will have no claim against Absa Life whatsoever in respect of any damage (whether direct or indirect) I/We may suffer, should the Bank fail to collect a payment.
- 7 I/We hereby indemnify Absa Life against any losses and/or damage Absa Life may suffer in executing this authorisation.
- 8 This payment method authorisation will remain in force until it has been cancelled by me/us with 30 (thirty) days prior notice in writing.
- 9 Debit orders, in months where the collection date selected is not available, will occur on the 1st (first) following business day.

Signed at _____ on _____

Signature of Life Insured

Signature of Premium Payer

G Scheme Information (Scheme member leaving)

Scheme's name																							
Date joined Scheme (dd/mm/ccyy)													Exit date (dd/mm/ccyy)										
Current occupation																							
Any pre-existing condition(s)?																							
Any other condition(s)?																							

G.1 Reason for leaving the Scheme [Please tick (✓) the reason applicable to you]

1	Retirement	Early retirement (related to ill health)	
2	Retirement	Age related retirement	
3	Resignation	I am leaving for another employer	
4	Resignation	I am becoming self employed	
5	Resignation	I don't yet have other employment	
6	Retrenchment	I have other employment	
7	Retrenchment	I don't yet have other employment	
8	Sabbatical		
9	Dismissed		
10	Other (provide reasons)		

H Personal statement by Life to be Insured

- | | | | |
|---|---|-----|----|
| 1 | Do you take part or intend taking part in any hazardous activities? | Yes | No |
| 2 | Do you smoke or have you used any form of tobacco in the past 6 (six) months? | Yes | No |
| 3 | Does this proposal replace your existing insurance with any insurer? | Yes | No |
- (If "Yes", the adviser must discuss and complete the Replacement Policy Advice Record and attach it to this form.)

H.1 Declaration

It is hereby acknowledged that all the declarations detailed below are legally binding on the signatory(ies).

I/We accept and acknowledge that:

- I/We understand that this application is subject to the underwriting conditions of Absa Life. Based on the risk contained herein, the application may be declined or deferred, benefits may be declined, limited or excluded or the premium may be loaded due to health or other reasons.
- No representations, undertakings or agreements of any nature which are made or concluded by a representative or employee of Absa Life (whether verbally or in writing) will be binding on Absa Life, unless contained in properly authorised official policy documentation issued as a result of this application.
- By signing the application, I/We guarantee that all information that was provided is true and accurate and can be relied on and that I/We will disclose all necessary material information. Where such information is not disclosed or is incorrect, the policy may be cancelled and any amounts paid may/will be forfeited.
- All information in this application form will be treated as private and confidential.
- Answers to the questions detailed on this application are acknowledged as true, irrespective of whether completed in the handwriting of the signatory(ies) or not and form the basis of the contract between Absa Life and me/us, the Proposer(s). Wherever a representative of Absa Insurance and Financial Advisers ("AIFA") has completed this form, he/she will be deemed to have acted as an agent of the signatory(ies) and not of Absa Life.
- No material information relevant to the assessment of the risks associated with this application has been withheld.
- I/We, the Life/Lives Assured, am/are resident within South African borders.
- Should there be any change in my/our state and nature of my occupation, duties, hobbies, place of residence or any material facts relating to the risk(s) associated with this application from the date of between the date of application and the commencement date of this policy, I/we the signatory(ies) will so inform Absa Life in writing, within 30 (thirty) days of its occurrence.
- The life insured hereby curtails his/her right to privacy to facilitate assessment of the risks and the consideration of any claim for benefits, under a policy related to this or any other proposal for insurance made by the life insured, who irrevocably authorises:
 - any medical practitioner, employee(s), hospital or any other person to furnish Absa Life or its representative any details in respect of any illness, injury or any other information relating to the Life Insured as may be necessary;
 - any authorised medical practitioner or employee(s) or any other person to release confidential information to Absa Life or another person acting on their behalf and in such manner or method as Absa Life may direct; and
 - Absa Life to share with other insurers that information and any information contained in this proposal or in any related policy or other document, either directly or through a data base operated by or for insurers/reinsurers as a group, at any time (even after the death of the life insured) and in such detailed, abbreviated or coded form as may from time to time be decided by Absa Life or by the operators of such database.
- The life insured knows and understands the confidential nature of medical and other information and agrees to provide permission to Absa Life to obtain medical or any other information and evidence from or through third parties without seeing it as a breach to their right to privacy and confidentiality.
- The life insured indemnifies Absa Life and its directors, agents and employees against any claim of whatever nature, which may be made against them as a result of or arising from the furnishing of such information.
- I/We, the undersigned, confirm that I/We have read this declaration and authorisation and understand the implications and further acknowledge that this document does not constitute the full terms and conditions of the policy.

- I/We, the undersigned, have been made aware that if my policy is accepted, I/We will receive the policy terms of which I/We will read and ensure full understanding. Should I/We have any concerns or questions, I/We may refer them to the mandated financial adviser.
- I/We know and understand that upon signing this form, I/We agree to have the balance of any pre-existing clause on my group benefits to be included on the @Ease conversion policy.
- I/We, the undersigned, confirm that I/We have read this document and understand the implications thereof.

Signature of Life to be Insured

Date (dd/mm/ccyy)

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Signature of Proposer

Date (dd/mm/ccyy)

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Signature of Adviser

Date (dd/mm/ccyy)

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I Declaration by the Advisor

Broker's name	<input type="text"/>	Broker's code	<input type="text"/>
Branch code	<input type="text"/>	PRI number	<input type="text"/>
Broker's telephone	<input type="text"/>	Broker's cellphone	<input type="text"/>
Broker's email	<input type="text"/>		
ID verified?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Attach a copy of the ID document	

Commission distribution	Name:	Code:	%
	Name:	Code:	%

I, the undersigned Intermediary, hereby confirm that I have discussed the following key items with the client:

- Waiting periods that may apply on this policy (if any).
- Automatic exclusions and limitations (e.g. suicide).
- Restrictions applicable (if any).
- Full terms and conditions on the policy(ies) taken out.
- The client's eligibility to be covered under the benefits proposed.
- The client's obligations in terms of premiums and payments thereof.
- The client's cancellation rights in terms of the policy.
- Informed the client that should they wish to lodge a complaint or claim to refer to the terms and conditions for the details and process.

1 Commission percentage: 0% - 100% in increments of 10% %

2 I hereby declare that I have requested and recorded the client's response to question (H) with regard to replacement and that the client is fully aware of the possible detrimental consequences of the replacement of an insurance policy.

I further declare that, irrespective of the client's response to question (H), I explained the following to the client:

- The meaning of replacement.
- That a replacement is potentially prejudicial.
- The levying/deduction of a termination charge.
- That where a replacement is considered, the client is legally entitled to comprehensive information regarding the consequences of replacement.

3 I have disclosed any commission payable to me.

Question to the Intermediary: Does this proposal constitute replacement of an Investment policy with a recurring premium investment policy that will lead or has led to the levying/deduction of a termination charge of more than 15% of the replaced policy's fund value?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Refer to the definitions in Part 3 of the Regulations to the Long-term Insurance Act, 1998 (commission regulations).

Name of Intermediary

Signature

Signature of Adviser/Agent (Compulsory)

Date (dd/mm/ccyy)

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