Education Legacy Plan Application Form

LIBERTY

INSURE INVEST HEALTH

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☐ NEW APPLICATION ☐ AMENDMENT POLICY NUMBER (For Amendments) _____

KINDLY ANSWER ALL QUESTIONS IN FULL AND ATTACH SUPPORTING DOCUMENTATION AS LISTED BELOW.

- ☐ Certified copy of document/valid passport
- ☐ Proof of a valid Lesotho bank account in Policyholder's name
- ☐ Proof of residence (must not be older than 3 months)
- ☐ Proof of source of funds / wealth / income
- ☐ Signed quotation

For Amendments only attach the document related to the required amendment

POLICYHOLDER DETAILS

First name _____ Initials _____

Surname _____

Date of birth D D - M M - Y Y Y Y Gender M F

Form of identification (tick one) ☐ Identity document ☐ Valid passport Date of issue D D - M M - Y Y Y Y

ID /Passport number _____ Country of issue _____

Marital status _____ Nationality _____

Occupation _____

Are you a foreign citizen and/or national and/or are you resident for tax purposes anywhere other than Lesotho? Y N

If 'Yes', and you are a U.S. citizen/national/resident for tax purposes in the US, please complete the 'Self-Certification Declaration for an Individual Form.

The requirement to collect this information is part of Liberty Life's obligation to comply with the U.S. Foreign Account Tax Compliance Act (FATCA). We require you to provide us with this tax information where applicable and will keep a record of such information but will only disclose this information to the relevant tax authorities if and when required to under FATCA.

CONTACT DETAILS

Telephone number (Work/ Home) _____ Mobile _____

Email address _____

Physical address _____

_____ Postal code _____

Postal address _____

_____ Postal code _____

Preferred method of communication (Tick one) ☐ Email ☐ Post ☐ SMS

CHILDREN DETAILS *(Please provide the birth certificate for each child as listed)*

FULL NAMES	DATE OF BIRTH	RELATIONSHIP	GENDER	CURRENT GRADE

POLICY DETAILS *(Only complete this section for amendments)*

Premium M

Premium Frequency (Tick one) ☐ Monthly ☐ Annual

Annual premium increase (Tick one) 0% | 5% | 10% | 15% | 20% Per annum

SOURCE OF FUNDS / WEALTH / INCOME *(Please attach proof of source of funds)*

☐ Salary ☐ Policy ☐ Donation ☐ Inheritance

☐ Savings ☐ Investment Other (please specify)

SOURCE OF FUNDS	PROOF REQUIRED
Salary	An original or certified copy of a recent payslip (not older than 3 months)
Policy, Savings, Investment	Statement from the financial institution
Donation	Written confirmation by the donor and bank statement reflecting the deposit
Inheritance	Written confirmation of inheritance signed by executor / advocate / trustee

PAYMENT DETAILS *(Always complete this section for new applications, and complete for amendment if relevant. The Policyholder and Premium payer must be the same person. Please indicate with a (✓) the selected payment method.)*

☐ Debit order ☐ Stop order

DEBIT ORDER PAYMENT DETAILS *(Complete if debit order payment is selected)*

(Please attach a copy of the latest bank statement – must not be older than 3 months, or confirmation of account details from the Policyholder's Bank on the Bank's letterhead.)

Name of accountholder

Name of bank

Branch name

Account number Branch code

Reference number (if company or trust)

Debit order date 1st | 21st | 26th

I, the undersigned authorise Liberty Life to deduct the premium for the amount as specified in this form, from this account (including any applicable premium increases I have agreed to) until the due premium on this policy is paid.

Account holder's full name and surname

Account holder's signature Date D D - M M - Y Y Y Y

STOP ORDER DETAILS *(COMPLETE IF STOP ORDER PAYMENT IS SELECTED)*

(Please attach a copy of the latest bank statement – must not be older than 3 months, or confirmation of account details from the Policyholder's Bank on the Bank's letterhead.)

Name of employer

Contact number of Employer (Landline) Employee salary reference

Gross monthly pay Net monthly pay

Current insurance deductions

I, the undersigned authorise the Employer to deduct the premium for the amount as specified in this form (including any applicable premium increases I have selected or any increases I have agreed to) from my salary and remit it to Liberty Life on a monthly basis, with effect from _____/_____/_____ until such time as I cancel this authority in writing or I substitute this with a new authority.

Policyholder's full name and surname

Policyholder's signature Date D D - M M - Y Y Y Y

NOMINATED BENEFICIARY DETAILS *(In the event of the policyholder becoming deceased, these are persons nominated by the policyholder to receive payment of the benefit. Please ensure that the % share adds up to 100% across all beneficiaries)*

I hereby instruct that any benefits in my name which shall become due under this Policy on my death should be paid to the nominated beneficiaries detailed in the proportion(s) indicated against the name of each beneficiary.

For any beneficiaries under the age of 18 years (minors), please attach a birth certificate for each minor beneficiary.

FULL NAMES	DATE OF BIRTH	RELATIONSHIP	FULL NAMES OF GUARDIAN	CONTACT DETAILS	% SHARE

COMMISSION

Specify commission percentage from 0 - 5% (if applicable) [ ] - [ ] % of each premium

DECLARATION BY THE INTERMEDIARY *(Always complete this section)*

By submitting an application, I declare that I have explained all material terms and conditions of the policy to the Policyholder. I also confirm that I have verified the identity of the Policyholder in accordance with the regulations set out in the applicable legislation, regulations and guidelines.

Brokerage / Agency name

City / Town

Intermediary full name and surname

Intermediary signature

Date D D - M M - Y Y Y Y

DECLARATION BY THE POLICYHOLDER *(Always complete this section)*

This declaration contains guarantees and undertakings that I, as the Policyholder:

Confirm that I understand the product/service

- I confirm that I understand the nature of the product/services, and that it meets my expressed and identified need and that the Intermediary has explained the relevant rules, terms and conditions, and marketing material.
- I understand that it is my responsibility to make sure that Liberty Life always has up-to-date contact information for me and anyone that I nominated to benefit from this policy.
- I acknowledge that this product does not guarantee that the actual education costs will be covered. Any projections provided are only estimates and are subject to change such as if investment returns are lower than expected or actual education costs are higher than expected.
- I understand the benefits provided by the product depend on the investment returns after any tax and charges have been deducted and that any particular benefit is not guaranteed.
- I understand that the retrenchment premium waiver will only cover me if I have been employed for at least 12 months and that I can claim for a total of 3 retrenchment claims during the life of the policy. I also confirm that:
  - I am not aware of any pending retrenchments or imminent dismissal at application stage.
  - I acknowledge that I understand that a retrenchment claim will not be valid if:
- Loss of employment is due to fraud, dishonesty, misconduct, partaking in any illegal strikes, sickness, disease, accident, injury, pregnancy, mental disorder or medical condition.
- My employment is seasonal or unemployment is a regular feature of my working life or the employment comes to an end due to expiry of a fixed-term contract, resignation, retirement or acceptance of voluntary retrenchment or if I am a partner in a partnership, a member of a Close Corporation, the director of a company, self-employed or employed by a family-owned business.
- I understand that Liberty Life will carry out checks (including but not limited to verification of identity, sanctions screening) as required by law. My personal information may be used in the detection and/or prevention of money laundering. I authorise Liberty Life to use my Personal Data and any other such information required to perform the above checks in relation to my application.
- In the event Liberty Life becomes aware of any illegal activity, Liberty Life may not be in a position to approve this application.
- I will notify Liberty Life immediately if my residency in terms of the Foreign Account Tax Compliance Act ("FATCA") or equivalent classification changes in the future, or if there are any changes in circumstances that may impact my tax residency status or FATCA classification.

Guarantee that I am giving information correctly

- Where I provide Liberty Life with personal information of a third party, e.g. beneficiary nomination, I guarantee that I have the third party's consent to provide Liberty Life with their personal information.

Authorise Liberty Life, their authorised representatives and contracted third parties (local and foreign), as well as any registered and appointed intermediaries to process my personal information as permitted by law

I, the undersigned, confirm that the information supplied on this form is to the best of my knowledge true and correct. I further acknowledge that Liberty Life and the authorised representatives accept no responsibility or liability for the accuracy of the information provided by myself.

Policyholder name and surname

Policyholder's signature

Date D D - M M - Y Y Y Y