Platinum Life Plan Application Form

LIBERTY

INSURE INVEST HEALTH

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☐ NEW APPLICATION ☐ AMENDMENT POLICY NUMBER (For Amendments)

POLICYHOLDER DETAILS

(Always complete this section. This individual is the owner and the principal life assured under the policy terms and conditions. This individual is entitled to receive all benefits ascribed to this policy.)

Surname

First names Gender M F

ID /Passport number Date of birth D D - M M - Y Y Y Y

Telephone Mobile number

Email address

Postal address

Postal code

Occupation

BENEFICIARY / NEXT OF KIN DETAILS

(In the event of the Policyholder becoming deceased, these are persons nominated by the Policyholder to receive payment of benefits. Please ensure that %share adds up to 100% across all beneficiaries)

FIRST NAME	SURNAME	DATE OF BIRTH	CONTACT NUMBER	RELATIONSHIP	% SHARE

BENEFIT SELECTION *(Always complete this section)*

Occupation

Gross monthly income Do you have tertiary school qualification? ✓ ✓

MEDICAL QUESTIONS (Please indicate with a (✓) the applicable answer)	Y	N
1. Has a policy for life cover ever been declined or accepted at a higher premium?[1]		
2. Have you been hospitalized more than once for longer than 5 consecutive days, in the past 2 years (other than for pregnancy, sterilization, tonsillectomy, appendisectomy, sinus operation, vasectomy, flu, or bronchitis, or as a result of an accident FROM WHICH YOU HAVE FULLY RECOVERED)?[1]		
3. Is there any injury or illness that is preventing you from being at work currently from which you have been or anticipate being off work for longer than 5 days?[1]		
4. Do you have any current physical impairment or permanent disability?[1]		
5. Have you ever suffered from, or have you been told that you have diabetes/sugar in the urine, heart attack, heart bypass, chest pains, stroke, cancer or any growth, rheumatoid arthritis, lupus erythematosis, TB?[1]		
6. Have you ever been told that you have or that you suffer from high blood pressure, high cholesterol, kidney disease, lung disease, asthma, epilepsy or fits, or mental illness requiring hospitalization?		
7. Do you have any problems with your speech, hearing or vision except for wearing glasses to correct minor vision issues?[2]		
8. Have you consulted a doctor on more than three occasions over the past two years for backache, or have you had any back operations?[2]		
9. Have you smoked or used any tobacco products in the past 12 months?		

Note: [1] Yes response to any of these – Decline Platinum Life product and offer an alternative product

Note: [2] Yes response to any of these –A relevant exclusion clause to apply on Permanent Total Disability and Physical Impairment

PLATINUM LIFE BENEFIT DETAILS

Sum assured selected | Premium

OPTIONAL SIMPLE LIFE BENEFITS ***(Please indicate with a (✓) the optional benefit(s) selected). Additional premium is payable for optional benefits.***

☐ Permanent disability	Sum assured selected[3]		Premium	
☐ Critical illness	Sum assured selected[3]		Premium	
☐ Physical impairment	Sum assured selected[3]		Premium	
☐ Funeral expenses	Sum assured selected[3]		Premium	

[3]Sum assured amount cannot be higher than Platinum Life sum assured selected

Total premium payable for Simple Life Plan (incl. Optional benefits)[4]

*****Please note that premiums indicated are inclusive of all charges applicable within the regulatory framework. For a detailed breakdown, please contact your financial advisor.*

Annual benefit increase (ABI) for Simple Life Plan ☐ 0% ☐ 5% ☐ 10%

ABI does not apply to Immediate Expenses benefit

[4]Please note that premiums indicated are inclusive of all fees and charges applicable within the regulatory requirements. For a detailed breakdown, please contact your financial advisor.

Benefits and rates reflected in this application are based on the information provided by you. All applications for Platinum Life are subject to underwriting. If the specified information is incorrect based on medical evidence, rates will be automatically adjusted without further notice i.e. if after medical underwriting your smoker status as initially indicated changes, your rates will be amended accordingly.

The Insured Person undertakes that he/she has disclosed all known material information relating to his/her health that would impact on the Insurers acceptance of the risk/insured event. Failure to disclose any known material information by the Insured Person will declare the Policy invalid from the outset and the Insurer and will not pay any claim or benefits.

DOCTOR'S DETAILS FOR PLATINUM LIFE PLAN

Indicate below the name of the Doctor to whom reasons for a substandard underwriting decision may be sent.

Doctor's full name

Telephone | Mobile number

Postal address

Postal code

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.

Accountholder's full name and surname

Accountholder'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

Name of bank | 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

DECLARATION BY THE AUTHORISED REPRESENTATIVE *(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 related legislation, regulations or guidelines. I have loaded copies of all required documents on the Liberty system.

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 and the Principal Life Assured agree to.

I confirm that I understand the product and policy:

☐ I confirm that I understand the nature of the product and that the authorised representative has explained the product rules, Terms and Conditions, and relevant marketing material.

☐ I confirm that Terms and Conditions have been explained and issued to me by the authorised representative

I guarantee that I am giving information correctly:

☐ All information given to the Underwriter in respect of any transaction is true and accurate and can be relied on for contracting.

☐ Where any material information is not fully disclosed, or is found to be untrue, the Underwriter will declare the Policy invalid from the outset and will not pay any claim or benefits.

I guarantee to keep my details up to date:

☐ I undertake to keep the Underwriter informed of any changes to the information supplied on this application, which includes but is not limited to my contact details to enable the Underwriter to communicate with me.

I authorise the Underwriter and the authorised representative:

☐ To collect and process certain personal and financial information from me if relevant to my policy.

I authorize the Underwriter to collect and share information:

I accept that with this authorisation I am limiting my right to privacy. However to assess the insurance risk, I irreversibly authorize the Underwriter to:

☐ a. Obtain from any person, whom I hereby permit and request to give any information which the Underwriter needs, and

☐ b. Share with other insurers that information and any information in this application or any related source at any time, in a form approved by the Underwriter or the Regulator.

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 the Underwriter 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

Guardian's name and surname (if applicable)

Guardian's Signature

Date D D - M M - Y Y Y Y