APPLICATION FOR GROUP SCHEME MEMBERSHIP WITH EXTENDED FAMILY BENEFITS

SAFRICAN
SWAZILAND INSURANCE COMPANY
Preparing for tomorrow, today

Tick the appropriate box:
New Application ☐ Amendment to Existing Policy ☐

Membership Inception date: ____/____/____.

Name of Company or Funeral Scheme: ____**LUKHOTSE**_____**Scheme No:**_____

PRINCIPAL MEMBER'S DETAILS

SURNAME:	FIRSTNAMES:	DATE JOINED COMPANY	STAFF NUMBER:
DATE OF BIRTH:	IDENTITY NO:	MARITIAL STATUS:	TELEPHONE NO:
PHYSICAL ADDRESS:			CODE
POSTAL ADDRESS:			CODE

SPOUSE'S DETAILS

SURNAME:	FIRST NAMES:	IDENTITY NUMBER	DATE OF BIRTH:

PRINCIPAL MEMBER'S CHILDREN

NAME AND SURNAME	ID NUMBER / DATE OF BIRTH	NAME AND SURNAME	ID NUMBER / DATE OF BIRTH
1		2	
3		4	
5		6	
7		8	

WIDER CHILDREN'S COVER

NAME AND SURNAME	ID NUMBER / DATE OF BIRTH	NAME AND SURNAME	ID NUMBER / DATE OF BIRTH
1		2	
3		4	
5		6	
7		8	

EXTENDED FAMILY DETAILS

NAME AND SURNAME	ID NUMBER	RELATIONSHIP	PREMIUM AMOUNT
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

PLEASE NOTE:

- Option to join must be within 6 (six) months of joining the Company
- Where a premium is underpaid, the benefit payable in respect of a claim will be reduced in proportion to the under payment

EXTENDED FAMILY PREMIUMS	**E**
PLUS: BASIC FUNERAL PREMIUM	**E**
WIDER CHILDREN PREMIUMS	**E**
TOTAL PREMIUM	**E**

BENEFICIARY NOMINATION:

I hereby nominate the following person/s, who is/are my dependant/s or nominee/s for any benefits due to be paid from the scheme in the event of my death.

SURNAME & TITLE	FIRST NAME AND INITIALS	RELATIONSHIP TO MEMBER	ID NUMBER

Debit order Authority:

Name of Bank:_____ Branch Code:_____

Branch: _____ Account No:_____

Name of accountholder:_____

Account type: ☐ Cheque ☐ Savings ☐ Transmission

I hereby authorize Safrican Insurance Company Limited to commence debit order withdrawal from my account on: (tick appropriate date of the month).☐**1st** ☐**15th** ☐**20th** ☐**25th** ☐**31st** day of the month and monthly thereafter for the premium applicable for the cover selected. I grant this authority on the condition that, should I decide to cancel the policy within 30 days of signing the application, by advising Safrican in writing of my intent to cancel, all payments made from this account towards the Funeral Benefit Plan will be refunded in full. I understand that the debit order will be run on the date selected. In the event of this run being dishonored the policy will lapse, subject to the grace period as stipulated under the terms and conditions. I understand that this signed document is required in the Safrican Office 10 working days prior to the elected deduction date, if not; the deduction will only qualify for the following calendar month's deductions.

DECLARATION:

I declare to the best of my knowledge and belief that the particulars given above are true and correct. I understand and agree that any willful misrepresentation in this application will invalidate any benefit under this Policy and that I undertake to abide by the terms and conditions of the Policy. Safrican Insurance Company Limited shall not be liable for any amount until it has accepted this application and first premium.

****NB: If the participant is over the age limit when joining, the claim will be repudiated and premiums refunded.**

_____ _____

PRINCIPAL MEMBER'S SIGNATURE **DATE**

For Office Use only

POLICY NO:	**DATE:**	**MEMBER GROUP NO:**