Health iAccess

FUNERAL PLAN APPLICATION

Replacement Form Attached [Y] [N] Application Date [D][D]/[M][M]/[Y][Y][Y][Y]

1. INTERMEDIARY/ AGENT INFORMATION

Name:

Company:

Agent Code:

Full Name:

Email:

Telephone Cell [ ][ ][ ]-[ ][ ][ ][ ][ ][ ][ ] Work Number: [ ][ ][ ]-[ ][ ][ ][ ][ ][ ][ ]

2. PRINCIPAL MEMBER INFORMATION (6 MONTHS PHASED IN WAITING PERIOD FOR NATURAL DEATH)

ID Number:

Date of Birth: [D][D]/[M][M]/[Y][Y][Y][Y] Gender: [M] [F]

Title: Initials Marital Status

First Name:

Surname:

Physical Address:

Postal Code:

Postal Address:

Postal Code:

Telephone Cell [ ][ ][ ]-[ ][ ][ ][ ][ ][ ][ ] Work Number: [ ][ ][ ]-[ ][ ][ ][ ][ ][ ][ ]

Email:

Employer (if applicable)

Employer Contact:

Employer Email:

3. BENEFICIARY INFORMATION (100%) – THE PERSON WHOM THE BENEFITS ARE PAYABLE TO ON DEATH OF THE MAIN MEMBER

ID Number: Gender: [M] [F]

First Name:

Surname:

Relation to Member:

Telephone Cell [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] Work Number:

4. MEMBERSHIP OPTION (6 MONTHS PHASED IN WAITING PERIOD FOR NATURAL DEATH)

POLICY TYPE				COVER AMOUNT	PREMIUM VALUE
1. SELECT MAIN POLICY TYPE					
	MEMBER ONLY		MEMBER + CHILDREN		
	FAMILY (SPOUSE+ CHILDREN)				
	EXTENDED M+5		EXTENDED M+9		
1.1 SELECT THE ADDITIONS TO MAIN POLICY					
	EXTENDED FAMILY		PARENTS		
			TOTAL MONTHLY PREMIUM PAYABLE		

5. DECLARATION

I hereby apply for this Policy and accept the terms and conditions, exclusions and applicable waiting periods of the Policy. I have not been coerced into this Policy and make application of my own volition on the basis that this Policy meets my needs, is affordable, and is necessary to enhance my current insurance portfolio. I understand, consent to and accept that a full policy document will be sent to me within 31 (thirty-one) days from acceptance of this application form including a Policy Schedule which shall confirm my personal details, chosen benefits and claims procedures (as intended in section 48 of the Long-Term Insurance Act) will be e-mailed to me. In accordance with Rule 4 of the Policyholder Protection Rules, I understand that I will have a cooling-off period of 31 (thirty-one) days from receipt of the section 48 summary to cancel this policy. If this policy is cancelled within 31 days, any payment that has been received will be refunded provided no claim has been lodged or any benefit paid. I am aware of the waiting periods applicable to this policy and I understand that if I am replacing existing cover that has been active in the 31 (thirty-one) day period before this application, and where such waiting period on the existing policy has expired that I will have the waiting period for natural death on this policy waived. I confirm I am able to provide proof of such existing cover that has been active and is being replaced with this policy.

I, the undersigned, hereby declare and warrant that all information supplied herein is true and complete. I am aware and understand that any non-disclosure or misrepresentation of information, which is material to the determination of the risk by DAPT LIFE, may lead to the policy being declared null and void. I can confirm that this Policy for which I am applying meets my needs and feel that I have all the necessary information in order to make an informed decision in respect of the purchase thereof. I understand that this Policy is underwritten by Smart Life Insurance Company Limited is an authorised financial services provider (FSP) 51259 and Administrated by DAPT LIFE Insurance
Financial Service & Projects (Pty) Ltd is an authorized Financial Service Provider (FSP) 45983

I further understand that my privacy is of utmost importance to Health iAccess and that Health iAccess will take the necessary measures to ensure that any and all information, including my Personal Information (as defined in the Protection of Personal Information Act 4 of 2013) provided by myself or which is collected by Health iAccess, DAPT LIFE and SMART LIFE is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and will be stored in a safe and secure manner.
I therefore hereby agree to give honest, accurate and up-to-date Personal Information and to maintain and update such information when necessary. I further accept that my Personal Information collected by Health iAccess and DAPT LIFE may be used for the following reasons:
1. To establish and verify my identity in terms of the Applicable Laws;
2. To enable Health iAccess to fulfil its obligations in terms of this Policy;
3. To enable Health iAccess to take the necessary measures to prevent any suspicious or fraudulent activity in terms of the Applicable Laws; and
4. To report to the relevant Regulatory Authority/Body, in terms of the Applicable Laws.

I acknowledge that any Personal Information supplied to Health iAccess in terms of this Policy is provided according to the Applicable Laws. By accepting this Policy, I further ac[1]knowledge that such conduct constitutes an unconditional, specific and voluntary consent to the processing of my information by Health iAccess under the Applicable Laws in the manner contemplated above, which consent shall, in the absence of any written objection issued by myself, be definite and/or for the period otherwise required in terms of any Applicable Laws. Unless consented to by myself, Health iAccess will not sell, exchange, transfer, rent or otherwise make available my Personal Information (such as my name, address, email address, telephone, cell or other detail, including any banking details) to any other parties except DAPT LIFE and SMART LIFE and I indemnify Health iAccess from any unintentional disclosures of such information to any unauthorized persons. I understand that if Health iAccess has utilized my Personal Information contrary to the Applicable Laws, I have the right to lodge a complaint with Health iAccess within 10 (ten) days. Should Health iAccess not resolve my complaint to my satisfaction, I accept and understand that I have the right to then escalate a complaint to the Information Regulator.

PROCESSING OF PERSONAL INFORMATION IN TERMS OF THE PROTECTION OF PERSONAL INFORMATION ACT 4 OF 2013
We've always undertaken to treat our client's information with the utmost care, keeping personal details confidential. With the Protection of Personal Information Act (POPIA) now in full effect, we are even more committed to protect your information.
POPIA promotes the fair and transparent use of personal information. This means if we use your personal information, we must safeguard it appropriately.
WHAT IS PERSONAL INFORMATION?
Personal information is defined by POPIA as any information that can be used to identify you as an individual. Examples include your identity number, account number, telephone number, email address, physical address and other unique identifiers.
OUR PROMISE
We undertake to maintain the privacy, safety and integrity of your personal information.

Should we have new products , can we contact you in the future? Y ☐ N ☐

6. NOMINATED DEPENDANTS OF MAIN POLICY (SPOUSE AND CHILDREN)

	SURNAME	NAME	ID NUMBER	GENDER
SPOUSE 1				M ☐ F ☐
CHILD 1				M ☐ F ☐
CHILD 2				M ☐ F ☐
CHILD 3				M ☐ F ☐
CHILD 4				M ☐ F ☐
CHILD 5				M ☐ F ☐
CHILD 6				M ☐ F ☐
			SUB TOTAL MONTHLY PREMIUM PAYABLE	

Cover available for dependent children up to the age of 21 and up to 26 years if they dependent full-time students.

7. DETAILS OF ADDITIONAL CHILDREN AND/OR EXTENDED FAMILY & PARENTS

Six (6) months waiting period for natural death for all dependents unless existing cover being replaced with this policy and existing waiting period already expired.

	SURNAME	NAME	RELATION TO MEMBER	ID NUMBER	GENDER	PREMIUM
EXTENDED 1					M ☐ F ☐	
EXTENDED 2					M ☐ F ☐	
EXTENDED 3					M ☐ F ☐	
EXTENDED 4					M ☐ F ☐	
EXTENDED 5					M ☐ F ☐	
EXTENDED 6					M ☐ F ☐	
EXTENDED 7					M ☐ F ☐	
EXTENDED 8					M ☐ F ☐	
EXTENDED 9					M ☐ F ☐	
				SUB TOTAL MONTHLY PREMIUM PAYABLE		

8. EXTENDED FAMILY COVER OPTIONS (EXTENDED MEMBER COVER MAY NOT EXCEED THE COVER AMOUNT OF THE MAIN MEMBER)

	SURNAME	NAME	RELATION TO MEMBER	ID NUMBER	GENDER	PREMIUM
EXTENDED 1					M F	
EXTENDED 2					M F	
EXTENDED 3					M F	
EXTENDED 4					M F	
EXTENDED 5					M F	
EXTENDED 6					M F	
EXTENDED 7					M F	
EXTENDED 8					M F	
EXTENDED 9					M F	
				SUB TOTAL MONTHLY PREMIUM PAYABLE		

9. GENERAL INFORMATION (TERMS AND CONDITIONS)

You have an initial 31 (thirty-one) day cooling-off period in which to cancel the Policy and be refunded any paid premium provided no Claim Event has occurred or any benefit paid.

2. DAPT LIFE may immediately cancel this Policy or place it on hold, refuse any transaction or instructions, or take any other action considered necessary in order to comply with the law and prevent or stop any undesir able or criminal activity.

3. Joining age between 18 & 94 (Family Plans) and Joining age between 0 & 85 (Traditional Plans)

4. Waiting Period: No waiting period - Accidental (Unnatural death) / 6 Months waiting period for natural death / 12 Months for Suicide

5. All dependents must be related to main member (Family Plans).

6. Up to 6 children (Family Plans)

7. All family members covered must be nominated at onset of cover (Family Plans).

8. Children covered up to age 21, or up to 26, if full-time student

9. Only 1 stillborn claim per member

10. Cover till death as long as premium is paid.

11. All members covered must be nominated at onset of cover.

12. A nominated beneficiary must be nominated on this application form.

10. NEEDS ANALYSIS & RECORD OF ADVICE

FAIS Act requires providers to maintain and record the advice furnished to clients, which records must reflect the basis on which the advice was given.
Have you had previous funeral insurance? YES NO
If **yes**, please give details.

Has any insurance policy or funeral scheme /portfolio, been declined, or cancelled? YES NO
If **yes**, please give details.

Description of the need identified. (Why and what funeral cover does the client need)

I, the policyholder, acknowledge that I have read, accepted, and received a copy of the terms and conditions of this funeral policy application. :

Full Name :

Surname:

Signature

Date: D D / M M / Y Y Y Y

11. BANK DETAILS AND MANDATE

Please indicate the payment method and complete the relevant information applicable to the Payment Method				
Debit Order	Employee Stop Order	Cash	EFT/Bank Deposit	EasyPay

DEBIT ORDER DETAILS - ACCOUNT TYPE				
Cheque/Current	Savings	Transmission	SASSA	EasyPay

BANKING DETAILS

Debit Date	1st	15th	25th	Last Day

Total Premium: **R**

Account Holder:

Bank Name:

Account Number:

Branch Name:

Branch Code:

1. All premiums are payable monthly by the due date.
2. Any arrear premium may be deducted from any benefit payable upon approval of a claim.
3. A premium is due on the debit date. Failure to pay a premium, subject to grace period of 30 (thirty) days, will result in cover lapsing and the policy being cancelled.
4. Your premiums are guaranteed for the first 12 months. Any increase to the premium will be advised to the Policyholder 31 (thirty-one) days prior to the increase taking place.

Signature:

Date: D D / M M / Y Y Y Y

OUR CONTRACT ("the Agreement")

1. I/We hereby authorize you to issue and deliver payment instructions to NuPay for collection against my/our abovementioned account at my/our abovementioned bank on condition that the sum of such payment instructions will never exceed my/our obligations as agreed to in the Agreement.
2. The individual payment instructions so authorized to be issued must be issued and delivered monthly (interval) on or after the dates when the obligation in terms of the Agreement is due and the amount of each individual payment instruction may not be more or less than the obligation due.
3. The payment instructions so authorized to be issued must carry a number, which number must be included in the said payment instructions and if provided to you should enable you to identify the Agreement.
4. I/we agree that the first payment instruction will be issued and delivered on or after the issue date. Subsequent payment instructions will continue to be delivered in terms of this authority until the obligations in terms of the Agreement have been paid or until this authority is cancelled by me/us by giving you notice in writing of not less than the interval (as indicated in clause 2 above) and sent by prepaid registered post, electronic communication or delivered to your address indicated above.

5. MANDATE

I/we acknowledge that all payment instructions issued by you shall be treated by my/our abovementioned bank as if the instructions had been issued by me/us personally.

6. CANCELLATION

I/we agree that although this authority and mandate may be cancelled by me/us, such cancellation will not cancel the Agreement. I/we also understand that I/we cannot reclaim amounts, which have been withdrawn from my/our account (paid) in terms of this authority and mandate if such amounts were legally owing to you.

7. ASSIGNMENT:

I/We acknowledge that the party hereby authorized to effect the drawing(s) against my/our account may not cede or assign any of its rights to any third party without my/our written consent and that I/we may not delegate any of my/our obligations in terms of this contract/authority to any third party without prior written consent of the authorized party.

8. AGREEMENT REFERENCE NUMBER

The agreement reference number is your policy number

12. PRINCIPAL/ MAIN MEMBER/ POLICYHOLDER

First Name:

Surname:

Signature

Date: D D / M M / Y Y Y Y

Health iAccess

WhatsApp 082 289 1681

sales@healthiaccess.co.za| www.healthiaccess.co.za

smartlife always there for you

DAPT life