Lifestyle Protector
Risk New Business for Single Life Assured

Liberty Group Limited is a licensed life insurer, an Authorised FSP (no.2409) and part of the Standard Bank Group. Terms and Conditions, Risks and Limitations apply.

We are required in terms of various laws and for contractual purposes to share, collect and process your Personal Information (PI). Your PI is collected and processed by our colleagues, representatives or sub-contractors and we make every effort to protect and secure your PI. You are entitled at any time to request access to the information Liberty has collected, processed and shared.

APPLICATION NUMBER(S): _____ _____ _____

Checklist

- ☐ The "Client Declaration and Consent" form, signed.
- ☐ The “Declaration of Health – Living Lifestyle Dependant Protector Benefit” form, signed (if applicable).
- ☐ The “Replacement Advice Record” form, signed by both the Financial Adviser and Policyholder (if applicable).

Full and accurate disclosure

Liberty commits to a fair assessment of the information you have disclosed. It is important to note that your duty of disclosure continues until Liberty has informed you as to whether your application has been accepted or declined.

If you are uncertain of the relevance of the information, rather disclose it to us as it may be important to us. Please answer all the questions accurately and completely.

This application form can only be used under the following circumstances:

1) 1 x Life Assured (No Second Life Assured)
2) 1 x Policyholder
3) Maximum of 4 x Beneficiaries
4) Maximum of 4 x Children for Educator

POLICY INFORMATION

Policy details

Replacement of an existing policy
Important Note: Replacement of any insurance may be to the disadvantage of the Policyholder.
Is this application to replace the whole or any part of your existing insurance with any insurer (whether replacement is to occur immediately or to replace an insurance discontinued within the past four months or within the next four months)? If “Yes”, the Financial Adviser must discuss and complete the Replacement Advice Record and attach it to this application form. ☐ Yes ☐ No

Policy language: ☐ English ☐ Afrikaans

Source (If not ordinary): ☐ Replacement ☐ Option ☐ Conversion ☐ Group continuation option

Member number _____

Policy/ies being replaced:

Policy/Application number	Insurer

_____
Signature of Policyholder

Lifestyle Protector plan details

REFER TO SIGNED QUOTE. Quote number _____

Financial Adviser details and declaration (This section should be completed by the Financial Adviser)

I hereby declare that I have requested and recorded the Policyholder's responses to the question with regard to replacement and that the Policyholder is fully aware of the possible detrimental consequences of the replacement of an insurance policy.

I further declare that, irrespective of the Policyholder's response to this replacement question, I explained the following to the Policyholder:

1. The meaning of replacement,
2. That a replacement is potentially prejudicial,
3. The levying/deduction of a termination charge, and
4. That where a replacement is considered, the Policyholder is legally entitled to comprehensive information regarding the consequences of replacement.

Personal reference (internal) _____

Initials and surname	Personal code	% Split	Liberty code	Signature

Counter-offer letter

Should underwriting contact your Financial Adviser to explain the counter-offer letter? ☐ Yes ☐ No

Financial Adviser cell phone number _____

Payer details

Account type: ☐ Cheque/Current account ☐ Savings account ☐ Transmission

Debit date _____

Name of bank _____ Account number _____

Branch code _____ Branch name _____

Full first names of account holder _____

Surname/Company name _____

ID/Passport/ Company registration number _____ Date of birth/ Company registration date _____

If passport: Country of issue _____ Date of issue _____ Date of expiry _____

If company: Country of incorporation _____

Country of residence _____ Relationship to Policyholder _____

Addresses of Policyholder

To be completed by the Financial Adviser: Do you confirm that these are the Policyholder's addresses? ☐ Yes ☐ No

Email Address _____

Postal _____ Postal code _____

Residential _____ Postal code _____

Business _____ Postal code _____

Company address details

Head office _____ Postal code _____

SA Operations _____ Postal code _____

Foreign Trading _____ Postal code _____

Trust address details

High Court where trust registered _____ Postal code _____

LIFE ASSURED

Personal information

Title _____ Full first names _____ Gender ☐ M ☐ F

Surname _____ Maiden name _____

Are you a resident of RSA? ☐ Yes ☐ No

Marital status: ☐ Single ☐ Engaged ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

ID/Passport number _____ Date of birth _____

If passport: Country of issue _____ Date of issue _____ Date of expiry _____

Primary e-mail address _____

Secondary e-mail address _____

Please note that we will use your primary email address for all future communication as the option of postal communication will no longer be available.

Contact no's: Home _____ Work _____ Cell _____ Fax _____

Residential address _____ Postal code _____

Country of residence _____ Relationship to Policyholder _____

Are you currently insolvent? ☐ Yes ☐ No If "Yes", please complete the *"Insolvency Trustee Statement".*

If "Yes" to any of the questions below, please complete Section A and B:

Individuals only: Are you a citizen of any country other than South Africa or have dual nationality? ☐ Yes ☐ No

Individuals only: Are you a tax resident in any other country other than South Africa? ☐ Yes ☐ No

Are you a United States citizen? ☐ Yes ☐ No

Section A: Please list the country(ies) of nationality/citizenship and provide details of your foreign identification document(s) and the associated Tax Identification Number(s) (TIN) in the table below:

Country of nationality/Citizenship	Identification document type (for example passport, social security, foreign identification)	Document no. (for example passport, social security, foreign identification)	Document expiry date (if applicable)	TIN
1.				
2.				
3.				
4.				
5.				

Section B: Please list the country(ies) in which you are a resident for tax purposes and provide details of your foreign identification document(s) and the associated Tax Identification Number(s) (TIN) in the table below:

Country of tax residency	Identification document type (for example passport, social security, foreign identification)	Document no. (for example passport, social security, foreign identification)	Document expiry date (if applicable)	TIN
1.				
2.				
3.				
4.				
5.				

Beneficiary details

**** Applicable to Death Income feature*** **Immediate Expenses Benefit** *(select 1 person only)*

First beneficiary for: ☐ **Life cover** ☐ **Immediate Expenses Benefit**

Title _____ Full first names _____ Gender ☐ M ☐ F

Surname _____ Beneficiary split _____ %

ID/Passport/ Company registration number _____ Date of birth/ Company registration date _____

If passport: Country of issue _____ Date of issue _____ Date of expiry _____

If company: Country of incorporation _____

Proportion allocated to income* _____ % Minimum income term* _____

Country of residence _____ Relationship to: Policyholder _____ Life Assured _____

Contact details: Cell 1 _____ Cell 2 _____ Work _____ Home _____

Beneficiary details - continued

Second beneficiary for: ☐ **Life cover** ☐ **Immediate Expenses Benefit**

Title _____ Full first names _____ Gender ☐ M ☐ F

Surname _____ Beneficiary split _____ %

ID/Passport/ Company registration number _____ Date of birth/ Company registration date _____

If passport: Country of issue _____ Date of issue _____ Date of expiry _____

If company: Country of incorporation _____

Proportion allocated to income* _____ % Minimum income term* _____

Country of residence _____ Relationship to: Policyholder _____ Life Assured _____

Contact details: Cell 1 _____ Cell 2 _____ Work _____ Home _____

Third beneficiary for: ☐ **Life cover** ☐ **Immediate Expenses Benefit**

Title _____ Full first names _____ Gender ☐ M ☐ F

Surname _____ Beneficiary split _____ %

ID/Passport/ Company registration number _____ Date of birth/ Company registration date _____

If passport: Country of issue _____ Date of issue _____ Date of expiry _____

If company: Country of incorporation _____

Proportion allocated to income* _____ % Minimum income term* _____

Country of residence _____ Relationship to: Policyholder _____ Life Assured _____

Contact details: Cell 1 _____ Cell 2 _____ Work _____ Home _____

Fourth beneficiary for: ☐ **Life cover** ☐ **Immediate Expenses Benefit**

Title _____ Full first names _____ Gender ☐ M ☐ F

Surname _____ Beneficiary split _____ %

ID/Passport/ Company registration number _____ Date of birth/ Company registration date _____

If passport: Country of issue _____ Date of issue _____ Date of expiry _____

If company: Country of incorporation _____

Proportion allocated to income* _____ % Minimum income term* _____

Country of residence _____ Relationship to: Policyholder _____ Life Assured _____

Contact details: Cell 1 _____ Cell 2 _____ Work _____ Home _____

Highest educational qualification

☐ None ☐ No matric ☐ Matric ☐ 3 or 4 year Technikon diploma or Teacher's college diploma

☐ Undergraduate university degree ☐ Post-graduate qualification ☐ Future professional

Income as per most recent income tax assessment

Source of income	Primary occupation	Commission	Secondary occupation	Commission	Other occupation	Other income for example investments	Total income
Current year	R	%	R	%	R	R	R
Previous year	R	%	R	%	R	R	R
details							

Income information for Income Protection benefits (to be completed when applying for Income Protection benefits)

Will you be insuring your Income Protector benefits using your: ☐ Pre-tax annual income[1] or ☐ Post-tax annual income[2]

Source of income	Primary occupation	Secondary occupation
Income amount	R	R
Retirement contribution[3]	R	R
Cash bonus[4] (average over last three years)	R	

Proof of income to be provided at[5]: ☐ Underwriting stage ☐ Post issue

Proof of bonus to be provided at[5]: ☐ Underwriting stage ☐ Post issue

Income information for Income Protection benefits - continued

Notes:

1. ***Pre-tax annual income***
   Salaried employees:
   For salaried employees, pre-tax income is defined as the cost to company, earned for the last 12 months. This is the total cost to the Life Assured's employer and includes all benefits associated with employment except for the following: annual bonuses (including 13th cheques), ad-hoc bonuses, gratuities, leave pay, merit award, share incentive awards, bonus/incentive amount paid to the Life Assured to retain his/her service for a specified period, pension, superannuation allowance, retirement fund lump sums, retiring allowance, dividends or stipends.

   Self-employed individuals and partnerships:
   Pre-tax income is defined as the share of the average monthly fees (and sales) earned, less the share of cost of sales, less the share of overhead expenses (where fees earned and costs incurred are shared on a pro-rata basis) earned and incurred over the last 12 months.

   Self-employed professionals:
   For professionals that charge a fee for services, pre-tax income equals the average monthly sum of the professional fee and other income from trading activities, less business overheads expenses earned and incurred over the last 12 months.

   For self-employed individuals, partnerships and professionals that provide proof of their income at the inception or reinstatement of the Income Protector benefit and whenever the sum assured is increased, Liberty will allow an increase to the pre-tax income by an amount of up to 20% of your share of monthly business expenses that will continue to be incurred in your personal capacity after a disability or permanent impairment event occurs. Expenses that are insured under any other insurance benefit that aims to cover business expenses on your disability may not be included. Personal expenses that are not related to business activities may not be included. Expenses that will not continue in your personal capacity after a disability or permanent impairment event occurs may not be included.

   Pre-tax income excludes passive income that is not related to the income being generated for the occupation being insured for example dividends, rental income etc.

2. ***Post-tax annual income***
   Post-tax income is the pre-tax annual income defined in 1 above less the tax payable on the pre-tax annual income earned on account of the life assured's employment, or any services rendered by the life assured.

3. ***Retirement contribution***
   The amount of your pre-tax annual income from you primary or secondary occupation that is contributed by you and your employer, towards your pension and provident fund and which is directly deductible from your income.

4. ***Cash bonus***
   A cash bonus is defined as remuneration paid your employer as an annual bonus (including 13th cheques) or gratuity as a consequence of services rendered in the last 12 months. It excludes all other forms of remuneration, including but not limited to salary, leave pay, wage, overtime pay, commission, fee, pension, retirement fund lump sums, superannuation allowance, retiring allowance, ad hoc bonuses, share incentives, stipends, merit awards, bonus/incentive amount paid to the Life Assured to retain his/her service for a specified period or dividends.

5. ***Post issue***
   The period before the next policy anniversary following inception or reinstatement of a new Income Protector benefit or amendments to an existing Income Protector that would warrant a request for proof of income.

6. ***Primary occupation***
   Primary occupation is your nominated occupation from which you can earn most/all of your income.

7. ***Secondary occupation***
   The secondary nominated occupation is your other nominated occupation which contributes to at least 20% of the total income of the two nominated occupations. Furthermore, you must have continually engaged in the secondary occupation for a period of at least 12 months prior to insuring this occupation, for it to qualify under Dual Occupations. Where the income earned between two occupations is the same, the Policyholder can choose which of the two occupations to nominate as the primary or secondary.

Overhead Expenses (compulsory if the Overhead Expenses Benefit is selected)

If you can't work, is there an employee/s that can fulfil your primary functions, so that the business for which the Overhead Expenses Protector is being applied for continues to function? If "Yes", provide details:	☐ Yes ☐ No
If self-employed, is the business based at your home?	☐ Yes ☐ No
Details of your interest in the business	☐ Sole Proprietor ☐ CC Member ☐ Partner ☐ Shareholder
Your percentage share of the business	%
Your percentage share of overheads	%
Percentage of business turnover from sale of goods	%
Total monthly overheads	R

Occupational details

Primary occupation details			Secondary occupation details		
Primary occupation			Secondary occupation		
Employment status			**Employment status**		
Salaried employee	☐ Yes ☐ No		Salaried employee	☐ Yes ☐ No	
Self-employed or fee-based	☐ Yes ☐ No		Self-employed or fee-based	☐ Yes ☐ No	
Commission earner	☐ Yes ☐ No		Commission earner	☐ Yes ☐ No	
Contract worker	☐ Yes ☐ No		Contract worker	☐ Yes ☐ No	
Unemployed	☐ Yes ☐ No		Unemployed	☐ Yes ☐ No	
Retired	☐ Yes ☐ No		Retired	☐ Yes ☐ No	
Non-income earner	☐ Yes ☐ No		Non-income earner	☐ Yes ☐ No	
Employer name			Employer name		
Industry			Industry		

Type of employment (compulsory if the Retrenchment Protector Benefit is selected)

Are you a director, family member of the directors of the employer, contract, part time, casual, temporary, commission only or seasonal worker? ☐ Yes ☐ No

Are you currently contributing to the SA Unemployment Fund (UIF)? ☐ Yes ☐ No

Are you aware of any planned retrenchment actions by your employer? ☐ Yes ☐ No

Other than your primary and secondary occupations nominated above, do you participate in any other occupations. ☐ Yes ☐ No

If "Yes", please provide details:

Do you travel beyond the RSA borders in the course of your duties? If “Yes”, please specify countries, nature of duties and type of responsibilities: ☐ Yes ☐ No

Please indicate below how your average working time is split between the following duties (for each occupation, where applicable):

Occupational duties	Primary occupation	Secondary occupation
Administrative: Refers to administrative duties performed at a desk or within an office environment.	%	%
Travel: Refers to traveling as part of your duties excluding travelling to and from an official or fixed place of work.	%	%
Supervisory within an office environment: Refers to a person who manages, monitors, instructs and regulates people, such as employees, within an office environment.	%	%
Supervisory within a non-office environment: Refers to a person who manages, monitors, instructs and regulates people in an industrial, manufacturing, retail, agricultural or other environments outside of an office environment such as a workshop, on-site, factory or farm.	%	%
Light manual: Refers to work which involves tasks including - standing for long hours, gripping, lifting, pushing, pulling light objects or doing similar actions as part of your occupation.	%	%
Moderate/Heavy manual: Refers to work which involves tasks including - strenuous physical activities, working at heights, confined spaces or with heavy objects or machinery.	%	%
Total:	100%	100%

Recent applications for life insurance

Have you applied for life insurance with other insurance companies within the last 12 months for which medical tests or examinations were done? ☐ Yes ☐ No

What was the date of your most recent life insurance application? _____

Provide the name of the insurance company: _____

Provide the application number: _____

Medical tests at your convenience

Would you like a Liberty nurse to visit you to obtain medical requirements? ☐ Yes ☐ No

If “Yes”, please provide the physical address where you would like to be consulted:

Address _____ Postal code _____

Contact number _____ Alternate contact number _____

Preferred time of contact: ☐ Morning 08:00-12:00 ☐ Afternoon 12:00-17:00 ☐ Any time

Assurance details (to be completed by the Financial Adviser)

Please complete the table below providing the amount of cover effected with all other insurance companies, (including but not limited to Capital Alliance Individual and Group Business, Liberty Active and Liberty Corporate Benefits). **Please do not include Liberty individual life cover that is currently in force or the cover that is being applied for in this application.**

Amount of life cover effected in last 12 months including reinstated policies with **other companies**: R _____

Cover Type with other insurance companies	Life cover	Dread disease	Lump sum disability	Monthly income disability (first 24 months)	Monthly income disability (after 24 months)	Monthly overhead expenses	Monthly retrenchment cover (paying less than 12 months)	Monthly retrenchment cover (paying 12 months or more)	Bonus cover (annualised cover amount)
Existing personal	R	R	R	R	R	R	R	R	R
Concurrent personal	R	R	R	R	R	R	R	R	R
Existing partnership	R	R	R						
Concurrent partnership	R	R	R						
Existing keyman	R	R	R						
Concurrent keyman	R	R	R						
Existing contingent liability	R	R	R						
Concurrent contingent liability	R	R	R						

Lifestyle questions

Height and weight details

Height (m) _____ Weight (kg) _____

Alcohol consumption

Do you drink alcohol? ☐ Yes ☐ No If "Yes", please complete the *alcohol consumption* question below:

If "Yes", please complete the *alcohol consumption* question below:

Alcohol consumption	Spirits in tots		Amount per week	
	Beers in cans/bottles		Amount per week	
	Wine in glasses		Amount per week	

Note: *1 bottle of spirits = 21 tots, 1 bottle of wine = 6 glasses*
1 tot = 25ml, 1 glass of wine = 125ml, 1 glass of beer/cider = 250ml

Have you ever received advice, treatment, or undergone rehabilitation to reduce or discontinue alcohol consumption? ☐ Yes ☐ No

If "Yes", please provide details of the counselling, treatment/hospitalisation/rehabilitation:

Provide details	Name of the doctor, clinic, hospital, rehabilitation centre	Date

Smoking habits and nicotine tobacco use

Have you smoked nicotine/tobacco or used nicotine/tobacco products in the last 6 months? ☐ Yes ☐ No

If "Yes", have you used any of the following? Please complete the information below.

Number of cigarettes smoked per day			
Cigars	☐ Yes ☐ No	Pipe smoking	☐ Yes ☐ No
E-cigarettes/Vaping	☐ Yes ☐ No	Hookah pipe	☐ Yes ☐ No
Betel nut	☐ Yes ☐ No	Snuff	☐ Yes ☐ No

Have you ever received advice to reduce or discontinue nicotine/tobacco use relating to a specific medical condition? ☐ Yes ☐ No

If "Yes", please provide details: _____

Additional lifestyle questions

Have you ever taken any recreational drugs including cannabis (dagga), cocaine, ecstasy, anabolic steroids, etc.? ☐ Yes ☐ No

If “Yes”, please provide type of drugs:

Criminal activity/proceedings

Have you ever been involved, or implicated in or convicted of any criminal activities or proceedings, including drunken driving charges, but excluding speeding fines? If "Yes", please provide details: ☐ Yes ☐ No

Avocation details (sports, hobbies and pastime activities)

Have you participated in, do you currently participate in, or do you intend participating in any hazardous activity, hobby or pastime where there is a possible risk of accident or injury? ☐ Yes ☐ No

If "Yes", please select all that apply.

Big game hunting	☐ Yes ☐ No	Aviation related sports example paragliding	☐ Yes ☐ No
Powerboat racing	☐ Yes ☐ No	Parachuting	☐ Yes ☐ No
Skydiving	☐ Yes ☐ No	Underwater diving	☐ Yes ☐ No
Mountaineering	☐ Yes ☐ No	Rock climbing	☐ Yes ☐ No
Aviation	☐ Yes ☐ No	Other	☐ Yes ☐ No

If "Yes" to "Other", please provide details:

Medical attendant(s) details

Please provide the details of a doctor to whom reasons for a health loading or results of blood tests including an HIV test may be sent:

Initials _____ Surname _____ Tel no. _____ No. of years as a patient of this doctor _____

Address of doctor _____

_____ Postal code _____

Underwriting (only complete if you did not select tele-underwriting)

If any question is answered "Yes", details must be provided as additional information in the underwriting interview.

May a Tele-Underwriter contact you directly for additional information and/or for the completion of underwriting questionnaires? ☐ Yes ☐ No

Have you ever had symptoms, been diagnosed with, consulted a medical- and/or health- and/or alternative health practitioner, taken medication or had treatment, been given advice, been hospitalised for, had any tests, investigations or had surgery related to?

Please select all that apply:

1. Your heart or circulation? ☐ Yes ☐ No

- ☐ 1.1 Angina
- ☐ 1.2 Angioplasty/Stent
- ☐ 1.3 Coronary artery bypass graft/CABG
- ☐ 1.4 Chest pain
- ☐ 1.5 Raised cholesterol
- ☐ 1.6 Coronary heart disease
- ☐ 1.7 Heart attack/Myocardial infarction
- ☐ 1.8 Heart murmur
- ☐ 1.9 Hypertension/high blood pressure
- ☐ 1.10 Rheumatic fever
- ☐ 1.11 Varicose veins
- ☐ 1.12 Other conditions: _____

Name, telephone number and address of the attending doctor/s or the doctor/s consulted. (Please provide the information for each disclosure).

When did you last visit the doctor for this condition? _____ (mm/yyyy)

Life Assured's Initials: _____

Underwriting - continued

2. Your lungs or other breathing problems (excluding colds, influenza)? ☐ Yes ☐ No

☐ 2.1 Asthma ☐ 2.2 Bronchitis ☐ 2.3 Persistent cough

☐ 2.4 Pneumonia ☐ 2.5 Tuberculosis

☐ 2.6 Other conditions: _____

Name, telephone number and address of the attending doctor/s or the doctor/s consulted. (Please provide the information for each disclosure).

_____

_____

_____

When did you last visit the doctor for this condition? _____ (mm/yyyy)

3. Your digestive system, including stomach, small bowel, large bowel and liver? ☐ Yes ☐ No

☐ 3.1 Appendix ☐ 3.2 Hepatitis A ☐ 3.3 Hepatitis B/C/D

☐ 3.4 Gall stones/Gall bladder removed ☐ 3.5 Dyspepsia/Gastritis ☐ 3.6 Ulcer

☐ 3.7 Reflux ☐ 3.8 Hernia/Hiatus hernia

☐ 3.9 Other conditions: _____

Name, telephone number and address of the attending doctor/s or the doctor/s consulted. (Please provide the information for each disclosure).

_____

_____

_____

When did you last visit the doctor for this condition? _____ (mm/yyyy)

4. Your kidneys, bladder and reproductive organs? ☐ Yes ☐ No

☐ 4.1 Bladder infection/Cystitis ☐ 4.2 Blood in urine/Haematuria ☐ 4.3 Prostatitis

☐ 4.4 Pyelonephritis ☐ 4.5 Kidney stones recurrent

☐ 4.6 Other conditions: _____

Name, telephone number and address of the attending doctor/s or the doctor/s consulted. (Please provide the information for each disclosure).

_____

_____

_____

When did you last visit the doctor for this condition? _____ (mm/yyyy)

5. Your nervous system, and mental health conditions? ☐ Yes ☐ No

☐ 5.1 Depression/Reactive depression ☐ 5.2 Anxiety/Panic attacks ☐ 5.3 Epilepsy/Fits

☐ 5.4 Headaches ☐ 5.5 Fainting/Blackouts ☐ 5.6 Stroke

☐ 5.7 Stress ☐ 5.8 Post traumatic stress disorder

☐ 5.9 Other conditions: _____

Name, telephone number and address of the attending doctor/s or the doctor/s consulted. (Please provide the information for each disclosure).

_____

_____

_____

When did you last visit the doctor for this condition? _____ (mm/yyyy)

6. Your ears, eyes, nose or throat? ☐ Yes ☐ No

☐ 6.1 Deafness/Hearing loss ☐ 6.2 Blindness/Loss of vision ☐ 6.3 Tonsillitis/Tonsillectomy

☐ 6.4 Sinusitis ☐ 6.5 Glaucoma

☐ 6.6 Other conditions: _____

Name, telephone number and address of the attending doctor/s or the doctor/s consulted. (Please provide the information for each disclosure).

_____

_____

_____

When did you last visit the doctor for this condition? _____ (mm/yyyy)

Life Assured's Initials: _____

Underwriting - continued

7. Your skin, muscles, bones, joints, limbs and spine? ☐ Yes ☐ No

☐ 7.1 Arthritis ☐ 7.2 Gout ☐ 7.3 Knee problems

☐ 7.4 Back problem/Slipped disc/Spinal operation ☐ 7.5 Osteoporosis ☐ 7.6 Psoriasis

☐ 7.7 Whiplash ☐ 7.8 Rheumatoid arthritis

☐ 7.9 Other conditions: _____

Name, telephone number and address of the attending doctor/s or the doctor/s consulted. (Please provide the information for each disclosure).

When did you last visit the doctor for this condition? _____ (mm/yyyy)

8. Your glands or blood, including diabetes or raised blood sugar tests? ☐ Yes ☐ No

☐ 8.1 Anaemia ☐ 8.2 Thyroid disorder ☐ 8.3 Splenectomy

☐ 8.4 Diabetes mellitus/Sugar in urine

☐ 8.5 Other conditions: _____

Name, telephone number and address of the attending doctor/s or the doctor/s consulted. (Please provide the information for each disclosure).

When did you last visit the doctor for this condition? _____ (mm/yyyy)

9. Cancer, growth or tumour of any kind, including moles removed? ☐ Yes ☐ No

9.1 Please provide details: _____

Name, telephone number and address of the attending doctor/s or the doctor/s consulted. (Please provide the information for each disclosure).

When did you last visit the doctor for this condition? _____ (mm/yyyy)

10. Have you ever been diagnosed with Covid-19? ☐ Yes ☐ No

Name, telephone number and address of the attending doctor/s or the doctor/s consulted. (Please provide the information for each disclosure).

When did you last visit the doctor for this condition? _____ (mm/yyyy)

11. Do you know your current HIV/AIDS status? ☐ Yes ☐ No

If "Yes", please advise: ☐ Tested negative ☐ Tested positive

Name, telephone number and address of the attending doctor/s or the doctor/s consulted. (Please provide the information for each disclosure).

When did you last visit the doctor for this condition? _____ (mm/yyyy)

12. If not already mentioned above, have you had any other illness or tropical disease? ☐ Yes ☐ No

☐ 12.1 Bilharzia ☐ 12.2 Fibromyalgia ☐ 12.3 Chronic fatigue syndrome/Myalgic encephalomyelitis/Yuppie flu

☐ 12.4 Malaria

☐ 12.5 Other conditions: _____

Name, telephone number and address of the attending doctor/s or the doctor/s consulted. (Please provide the information for each disclosure).

When did you last visit the doctor for this condition? _____ (mm/yyyy)

Life Assured's Initials: _____

Underwriting - continued

13. **Have you ever been hospitalised or had any examinations for reasons not already mentioned including blood or genetic testing or tumour markers, or have you sought medical advice for any ongoing medical problem?** ☐ Yes ☐ No

☐ 13.1 CAT/MRI scan/X-rays ☐ 13.2 Accident ☐ 13.3 Colonoscopy/Gastroscopy

☐ 13.4 ECG (electrocardiogram)

☐ 13.5 Other conditions: _____

Name, telephone number and address of the attending doctor/s or the doctor/s consulted. (Please provide the information for each disclosure).

_____

_____

_____

When did you last visit the doctor for this condition? _____ (mm/yyyy)

14. **Do you intend consulting a medical professional in the next 8 weeks, for any medical examinations or for conditions or symptoms not already disclosed, or is any future surgery planned?** ☐ Yes ☐ No

If "Yes" to question 14, please provide a detailed response including doctor's details:

_____

_____

_____

When did you last visit the doctor for this condition? _____ (mm/yyyy)

15. ***For female applicants:*** **Are you currently pregnant?** ☐ Yes ☐ No

If "Yes", how many weeks? _____

16. ***For female applicants:*** **Have you, or have you had, any conditions or disorder of the female organs (breasts, ovaries, uterus) or any abnormality of pregnancy or confinement, dense breast tissue, lumps or cysts in the breasts or ovaries, hysterectomy, mammograms, pap smear?** ☐ Yes ☐ No

16.1 Conditions: _____

If "Yes" to question 16, please provide a detailed response including doctor's details:

_____

_____

_____

When did you last visit the doctor for this condition? _____ (mm/yyyy)

17. **Has a proposal/application for life, health, dread disease, disability or functional impairment assurance ever been declined, deferred or accepted with certain provisions example a higher premium, or with exclusions?** ☐ Yes ☐ No

17.1 Details: _____

18. **Have you been medically boarded or have you submitted claims for disability or 3rd party benefits or have you been off work for a continuous period of more than a month in the last 3 years (excluding maternity leave)?** ☐ Yes ☐ No

18.1 Details: _____

_____

19. **Family history: Do any of your relatives (mother, father, sister, brother) have or have they had any of the following medical conditions?** ☐ Yes ☐ No

Medical condition	Relationship with relative	Age at diagnosis	Current age/s	Age/s at death
Blood pressure/hypertension	Mother ☐ Yes ☐ No			
	Father ☐ Yes ☐ No			
	Brother/s and or sister/s ☐ Yes ☐ No			
Cancer - breast	Mother ☐ Yes ☐ No			
	Sister/s ☐ Yes ☐ No			
Cancer - colon/rectum	Mother ☐ Yes ☐ No			
	Father ☐ Yes ☐ No			
	Brother/s and or sister/s ☐ Yes ☐ No			
Cancer - ovarian	Mother ☐ Yes ☐ No			
	Sister/s ☐ Yes ☐ No			
Cancer - prostate	Father ☐ Yes ☐ No			
	Brother/s ☐ Yes ☐ No			
Coronary artery disease (angina/thrombosis/heart attack)	Mother ☐ Yes ☐ No			
	Father ☐ Yes ☐ No			
	Brother/s and or sister/s ☐ Yes ☐ No			

Life Assured's Initials: _____

Underwriting - continued

Medical condition	Relationship with relative	Age at diagnosis	Current age/s	Age/s at death
Diabetes/high blood sugar	Mother ☐ Yes ☐ No			
	Father ☐ Yes ☐ No			
	Brother/s and or sister/s ☐ Yes ☐ No			
Haemophilia	Mother ☐ Yes ☐ No			
	Father ☐ Yes ☐ No			
	Brother/s and or sister/s ☐ Yes ☐ No			
Haemochromatosis	Mother ☐ Yes ☐ No			
	Father ☐ Yes ☐ No			
	Brother/s and or sister/s ☐ Yes ☐ No			
Huntington's chorea	Mother ☐ Yes ☐ No			
	Father ☐ Yes ☐ No			
	Brother/s and or sister/s ☐ Yes ☐ No			
Any mental health disorders/ bipolar/schizophrenia/suicide	Mother ☐ Yes ☐ No			
	Father ☐ Yes ☐ No			
	Brother/s and or sister/s ☐ Yes ☐ No			
Natural causes/old age	Mother ☐ Yes ☐ No			
	Father ☐ Yes ☐ No			
	Brother/s and or sister/s ☐ Yes ☐ No			
Polycystic kidney disease	Mother ☐ Yes ☐ No			
	Father ☐ Yes ☐ No			
	Brother/s and or sister/s ☐ Yes ☐ No			
Porphyria	Mother ☐ Yes ☐ No			
	Father ☐ Yes ☐ No			
	Brother/s and or sister/s ☐ Yes ☐ No			
Raised cholesterol	Mother ☐ Yes ☐ No			
	Father ☐ Yes ☐ No			
	Brother/s and or sister/s ☐ Yes ☐ No			
Stroke/Cerebro vascular accident	Mother ☐ Yes ☐ No			
	Father ☐ Yes ☐ No			
	Brother/s and or sister/s ☐ Yes ☐ No			
Visual disorders/Retinitis Pigmentosa	Mother ☐ Yes ☐ No			
	Father ☐ Yes ☐ No			
	Brother/s and or sister/s ☐ Yes ☐ No			
Any other familial medical condition that affects your biological relatives that may require you doing investigations or being followed-up?	Mother ☐ Yes ☐ No			
	Father ☐ Yes ☐ No			
	Brother/s and or sister/s ☐ Yes ☐ No			

Life Assured's Initials: _____

OTHER LIVES ASSURED
(Not applicable on Loan Protection Package)

Child lives (maximum number of children per benefit is 4)

Child 1 ☐ EduCator ☐ EduCator Xtra **Institution type:** ☐ Public ☐ Independent ☐ Prime
☐ Child Living Lifestyle ☐ EduGlobal

Title _____ Full first names _____

Surname _____ Gender ☐ M ☐ F

ID/Passport number _____ Date of birth _____

If passport: Country of issue _____ Date of issue _____ Date of expiry _____

Country of residence _____ Relationship to Policyholder _____

Child 2 ☐ EduCator ☐ EduCator Xtra **Institution type:** ☐ Public ☐ Independent ☐ Prime
☐ Child Living Lifestyle ☐ EduGlobal

Title _____ Full first names _____

Surname _____ Gender ☐ M ☐ F

ID/Passport number _____ Date of birth _____

If passport: Country of issue _____ Date of issue _____ Date of expiry _____

Country of residence _____ Relationship to Policyholder _____

Child 3 ☐ EduCator ☐ EduCator Xtra **Institution type:** ☐ Public ☐ Independent ☐ Prime
☐ Child Living Lifestyle ☐ EduGlobal

Title _____ Full first names _____

Surname _____ Gender ☐ M ☐ F

ID/Passport number _____ Date of birth _____

If passport: Country of issue _____ Date of issue _____ Date of expiry _____

Country of residence _____ Relationship to Policyholder _____

Child 4 ☐ EduCator ☐ EduCator Xtra **Institution type:** ☐ Public ☐ Independent ☐ Prime
☐ Child Living Lifestyle ☐ EduGlobal

Title _____ Full first names _____

Surname _____ Gender ☐ M ☐ F

ID/Passport number _____ Date of birth _____

If passport: Country of issue _____ Date of issue _____ Date of expiry _____

Country of residence _____ Relationship to Policyholder _____

POLICYHOLDER

Policyholder details (only the Policyholder can act on the policy and make changes to the policy)

Policyholder

Title _____ Full first names _____ Gender ☐ M ☐ F

Surname/Company/Trust name _____ Maiden name _____

ID/Passport/Company registration number _____ Company registration date _____

If passport: Country of issue _____ Date of issue _____ Date of expiry _____

Policyholder details- continued

Policyholder - continued

If company: Country of incorporation _____ Trading name _____

Date of birth _____ Place of birth _____ Country of birth _____

Country of residence _____ South African resident? ☐ Yes ☐ No

Marital status: ☐ Single ☐ Engaged ☐ Married Date of marriage _____

☐ Widowed ☐ Separated ☐ Divorced Date of divorce _____

Primary e-mail address _____

Secondary e-mail address _____

Contact numbers: Home _____ Work 1 _____ Work 2 _____

Fax _____ Cell 1 _____ Cell 2 _____

Nominated occupation _____ Industry of occupation _____

Employer name _____

Insurable interest/Reason for assurance _____

Company/Employer owned policy? ☐ Yes ☐ No If "Yes", do you wish to claim an s11(w)(ii) deduction on the premium? ☐ Yes ☐ No

Tax status of Policyholder: ☐ Tax-exempt body ☐ Company/Close corporation ☐ Tax paying trust

☐ Non-tax paying trust ☐ Tax paying body ☐ Natural person

SA Income tax reference number _____ Tax office _____

Source of funds: ☐ Employment ☐ Dividends ☐ Interest ☐ Pension and annuities ☐ Other grants

☐ Royalties ☐ Scholarship ☐ Stokvel ☐ Maturity value

☐ Real property and income such as rent ☐ Distribution from a partnership

☐ Other (please specify) _____

Source of income: ☐ Employment ☐ Directorship ☐ Pension ☐ Commission

☐ Membership of a close corporation

☐ Other (please specify) _____

Source of wealth: ☐ Property sale ☐ Investment sale ☐ Inheritance ☐ Company sale ☐ Divorce settlement

☐ Savings ☐ Lottery ☐ Gambling ☐ N/A

☐ Distributable net Income of Estate

☐ Other (please specify) _____

Are you currently insolvent? If "Yes", please complete the "*Insolvency Trustee Statement*". ☐ Yes ☐ No

If "Yes" to any of the questions below, please complete Section A and B on the next page:

Individuals only: Are you a citizen of any country other than South Africa or have dual nationality? ☐ Yes ☐ No

Individuals only: Are you a tax resident in any other country other than South Africa? ☐ Yes ☐ No

Are you a United States citizen? ☐ Yes ☐ No

Entities only:* Is the entity organised, incorporated or resident for tax purposes outside of South Africa? ☐ Yes ☐ No

Entities only:* Does a foreign person/entity have an equity interest in or exercise control over the entity? ☐ Yes ☐ No

If "Yes", please complete the "Self-Certification Declaration for an Entity" form.

Country of nationality/Citizenship	Identification document type (for example passport, social security, foreign identification)	Document no. (for example passport, social security, foreign identification)	Document expiry date (if applicable)	TIN
1.				
2.				
3.				
4.				
5.				

Section B: Please list the country(ies) in which you are a resident for tax purposes and provide details of your foreign identification document(s) and the associated Tax Identification Number(s) (TIN) in the table below:

Country of tax residency	Identification document type (for example passport, social security, foreign identification)	Document no. (for example passport, social security, foreign identification)	Document expiry date (if applicable)	TIN
1.				
2.				
3.				
4.				
5.				

Other role for an authorised individual in a company for example executor, trust founder, partner, trustee, director etc.

To be completed if a company or trust is loaded as the Policyholder and by an authorised individual holding more than 25% ownership/shareholding.

Role 1

Title _____ Full first names _____

Surname _____ Gender ☐ M ☐ F

Maiden name _____ Are you a resident of RSA? ☐ Yes ☐ No

Date of birth _____ Place of birth _____ Country of birth _____

Email address _____ Country of residence _____

Are you currently insolvent? ☐ Yes ☐ No

Marital status: ☐ Single ☐ Engaged ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

ID/Passport number _____

If passport: Country of issue _____ Date of issue _____ Date of expiry _____

Contact no's: Home _____ Work _____ Cell _____ Fax _____

Residential address _____ Postal code _____

Relationship to the Policyholder _____ Designation _____

If "Yes" to any of the questions below, please complete the "*Self Certification Declaration for an Individual*" form:

Are you a citizen of any country other than South Africa or have dual nationality? ☐ Yes ☐ No

Are you a tax resident in any other country other than South Africa? ☐ Yes ☐ No

Are you a United States citizen? ☐ Yes ☐ No

Role 2

Title _____ Full first names _____

Surname _____ Gender ☐ M ☐ F

Maiden name _____ Are you a resident of RSA? ☐ Yes ☐ No

Date of birth _____ Place of birth _____ Country of birth _____

Email address _____ Country of residence _____

Are you currently insolvent? ☐ Yes ☐ No

Marital status: ☐ Single ☐ Engaged ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

ID/Passport number _____

If passport: Country of issue _____ Date of issue _____ Date of expiry _____

Contact no's: Home _____ Work _____ Cell _____ Fax _____

Residential address _____ Postal code _____

Relationship to the Policyholder _____ Designation _____

If "Yes" to any of the questions below, please complete the "*Self Certification Declaration for an Individual*" form:

Are you a citizen of any country other than South Africa or have dual nationality? ☐ Yes ☐ No

Are you a tax resident in any other country other than South Africa? ☐ Yes ☐ No

Are you a United States citizen? ☐ Yes ☐ No

Signatures

Signed at _____ on _____

_____ Life Assured/Policyholder

_____ Policyholder (if different from Life Assured)

_____ Signature of payer life/account holder (if different from Policyholder)

DECLARATION OF HEALTH
LIVING LIFESTYLE DEPENDANT PROTECTOR BENEFIT

We are required in terms of various laws and for contractual purposes to share, collect and process your Personal Information (PI). Your PI is collected and processed by our colleagues, representatives or sub-contractors and we make every effort to protect and secure your PI. You are entitled at any time to request access to the information Liberty has collected, processed and shared.

POLICY NUMBER _____

1. **If you are applying for the Living Lifestyle Dependant Protector benefit, please complete this form using a black pen once you have read and understood the contents on this form.**
2. **Please email ONLY this page to headofficeunderwriting@liberty.co.za.**

Assured	First name and initials	Relationship	Surname if different to life assured	Date of birth	ID Number
Spouse					
Child dependant					
Child dependant					
Child dependant					

The definition of child and spouse are as follows:

- "**Child**" means the Life Assured's own child, legally adopted child or stepchild. The child must be unmarried.
- "**Spouse**" includes the person you are legally married to either by civil or customary law, by civil union, by Asiatic religion or the person whom you are in the same sex or heterosexual cohabiting relationship with.

I, the Life Assured declare that the following statements are true and correct and will form part of my application for the Living Lifestyle Dependant Protector benefit.

- That my Spouse or Child dependant(s) mentioned above meet the definition of "Spouse" and/or "Child" as defined above.
- Neither my Spouse nor Child dependant(s) suffers from, have ever been diagnosed with or have been investigated for genetic or congenital abnormalities, nor are any of them expecting to be tested for such abnormalities in future.
- Neither my Spouse nor Child dependant(s) has ever made an application to any life assurer or medical aid where the application was declined, deferred or accepted on special medical terms.
- Neither my Spouse nor Child dependant(s) are currently experiencing any symptoms which may prompt them to seek medical advice within the next six months, nor do my Spouse or Child dependant(s) currently receive regular medical care (including the use of chronic medication) for any medical condition.
- Neither my Spouse nor Child dependant(s) have ever submitted any claim to Liberty or any other Life Office.
- There are no other circumstances not mentioned above which may predispose my Spouse or Child dependant(s) to hospitalisation, surgical procedures or other medical treatment.

Furthermore, I, the Life Assured understand:

That no claim will be admitted on the Living Lifestyle Dependant Protector benefit where in the opinion of Liberty's Chief Medical Officer (CMO) the condition was present at the inception of the benefit or where the condition is in any way related to conditions which are diagnosed before the inception of the benefit.

_____ _____
Signature of Policyholder (owner) Date

_____ _____
Signature of Life Assured Date

_____ _____
Signature of payer Date

Please note that in the event of any modification or variation of this standard form, Liberty will regard this form as being invalid and of no force and effect. **Do not sign blank or incomplete forms.**

CLIENT DECLARATION AND CONSENT

We are required in terms of various laws and for contractual purposes to share, collect and process your Personal Information (PI). Your PI is collected and processed by our colleagues, representatives or sub-contractors and we make every effort to protect and secure your PI. You are entitled at any time to request access to the information Liberty has collected, processed and shared.

POLICY NUMBER _____

1. **Please complete this form using a black pen once you have read and understood the contents on this form.**
2. **Please email both pages to newbusiness@liberty.co.za.**

Your Personal Information

We need to collect and process some of your Personal Information in terms of various laws and to provide products or services to you, to confirm, update and enhance our records from time to time in order to provide you with these goods or services. Acceptance of these terms is voluntary but is a requirement for the provision of products or services to you. If you do not accept these terms, we cannot activate and service your policy. As this information forms the basis of our assessment and terms we offer you, it must be correct, complete and up to date. If any information you give us is wrong, incomplete or outdated, we may cancel your policy or decline a future claim. We will comply with all relevant regulations in dealing with your information and keep it secure and confidential at all times. Where you have provided us with the Personal Information of a third party, you guarantee that such third party has given you consent to provide us with their Personal Information. You further agree to provide all documentation and information required in terms of Liberty business rules. You also confirm that all information you have provided to us is true and correct. You acknowledge and accept that Policyholder/Investor information may be provided to SARS. Further, that SARS may also exchange the information with the tax authorities of another country or countries in which the Policyholder/Investor may be a tax resident.

In terms of the Protection of Personal Information Act we are required to:

- Keep your information secure, confidential and only for as long as required.
- Only process information as permitted by law.
- Provide you with access to update or rectify any of your information.
- Notify you if any of your information has been compromised

Authorisation to collect, share and process information

You hereby authorise us, our Financial Advisers, the owner of the policy (if different to the Life Assured) and our service providers, (which may also be located outside of the Republic of South Africa), as long as required and potentially after your death, to:

- Collect any personal, medical, financial, policy and product information, any information related to your wellness programme membership, credit and other potentially relevant information about you directly from all available sources internally within the Liberty Group, as well as external sources and contracted service providers including but not limited to your medical scheme, medical practitioners, credit bureaus, pathology laboratory industry databases including those accessed by The Financial Services Exchange (Pty) Ltd trading as Astute in order to meet our regulatory obligations, for fraud detection, servicing and internal processing purposes;
- For external sources, you agree that this authorisation is considered a legally binding personal instruction to the parties concerned to provide any relevant information requested directly to us; and
- Appoint an external tracing agent and providing them with the necessary personal information to conduct tracing if Liberty becomes aware that Sums Assured are payable and after reasonable steps have been taken, we are unsuccessful in tracing those who are entitled to the Sums Assured; and
- Process and share this information internally and externally only as required in order to: continually assess risks; service your product; consider claims; provide services and products to you; meet our responsibilities to you; follow your instructions; inform you of new services and products; make sure our business suits your needs; monitor and analyse your conduct for quality control, fraud, compliance and other risk-related purposes; for security, administrative and legal purposes; carry out statistical, research and other analyses to identify potential market trends and develop new products and services; and
- Communicate any product offerings, enhancements to products and any special offers which may be to your benefit; and
- Comply with applicable contractual or regulatory requirements.

Change in information provided

- If there has been a change in any of the information provided to us which includes but is not limited to health, occupation or hobbies, since the date of the submission of the application and the issuing of underwriting terms (where applicable), you need to notify us as we may need to reassess your application. Failure to notify us could lead to the termination of your policy.
- We have a duty to take all reasonable steps to ensure your personal information is complete, accurate, not misleading and updated on a regular basis. To do this, we will always try to obtain personal information from you directly. Where we are unable to do so, we will make use of verifiable independent third-party data sources.
- Should any tax related information you have provided change in future, please complete and submit a new Self-Certification Declaration form within 30 days of such change (*contact info@liberty.co.za for the form*).

Your Right/Remedies

Should you believe that we have utilised your personal information contrary to applicable law, you will first resolve any concerns with us by contacting us on 0860 456 789/+27 (0)11 558 4871. If you are not satisfied with such process, you have the right to lodge a complaint with the information regulator.

Notes:

- **"Potentially relevant information"** includes information about your lifestyle, financial status, health, occupation and hobbies amongst others and spans a variety of potential sources, but specifically includes claims records from medical schemes, results of pathology and other blood tests conducted and details of prescription medication usage.
- **"Personal Information"** includes race, gender, nationality, marital status, age, physical or mental health, disability, language, education, identity number, telephone number, email, postal address, biometric information, and financial, criminal or employment history as defined in the Protection of Personal Information Act.
- **"Process"** means any operation or activity, whether automated or not, concerning personal information, including: collection, receipt, recording, organisation, collation, storage, updating or modification, retrieval, alteration, consultation, use, dissemination by means of transmission, distribution or making available in any other form, merging, linking, as well as blocking, degradation, erasure or destruction of information.
- **"Various laws"** pertain to, but is not limited to the following legislation: Protection of Personal Information Act of 2013 ("PoPIA"), Financial Intelligence Centre Act ("FICA"), Financial Advisory and Intermediary Services Act ("FAIS"), Tax Administration Act ("TAA").
- **"We"** refers to Liberty Holdings Limited and all its subsidiaries.

Your signature below is a confirmation that you have read, understood and agreed to the terms in this *"Client Declaration and Consent".*

Please complete all details below for your applicable role:

<table>
<tr><th rowspan="2">Role</th><th colspan="3">Liberty can share your Personal Information:</th><th rowspan="2">Signature</th><th rowspan="2">Date</th></tr>
<tr><th>Within the Liberty Group for marketing purposes and special offers?</th><th>With registered banks for marketing purposes and special offers?</th><th>With certain specially selected third parties for marketing purposes only?</th></tr>
<tr><td rowspan="2">Life Assured/ Policyholder</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td></td><td></td></tr>
<tr><td colspan="3">Full name</td><td colspan="2">ID/Registration no.</td></tr>
<tr><td rowspan="2">Policyholder (if different from Life Assured)</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td></td><td></td></tr>
<tr><td colspan="3">Full name</td><td colspan="2">ID/Registration no.</td></tr>
<tr><td rowspan="2">Payer life/ account holder (if different from Policyholder)</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td></td><td></td></tr>
<tr><td colspan="3">Full name</td><td colspan="2">ID/Registration no.</td></tr>
</table>

If you change your mind in the future about any of the above, please notify Liberty through your Financial Adviser or directly at 0860 456 789 or info@liberty.co.za.

Do not sign blank or incomplete application forms. In order to avoid any claim being repudiated due to "Non-Disclosure" it is vital that all risks (medical, financial, occupation, hobbies, or legal) are fully disclosed to ensure full underwriting assessment, so the appropriate decision on your application can be made. Please note that in the event of any modification of this form Liberty will regard this application as being invalid.