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Sanlam Life Insurance (U) Limited

Super Endowment Plus

APPLICATION FOR INSURANCE

Proposal No:

1. Principal Life to be Assured

First Name(s): sdf

Title:

Surname: sdf

ID Number: sdf

Passport No:

Marital Status: [x] Married [ ] Single

Date of Birth: Y Y Y Y M M D D

Gender: [x] Male [ ] Female

Occupation:

Pin Number:

Nationality:

Tax Identification Number (TIN):

Citizenship:

Residency:

1.1. Employment Details

Employed: [x] Yes [ ] No

Employer Code:

Employer:

Department Code:

Employee Number:

Employee terms: [x] Temporary [ ] Permanent [ ] Contract

1.2. Business Details

Business Name:

Nature of Business:

Role of proposer in business:

1.3. Telephone Numbers and Email

Cell (Pre-fix for other countries):

Home Phone:

Work Phone:

Email Address:

1.4. Postal Address

P.O. Box:

Building:

Town:

Postal Code:

1.5. Physical Address

Building / Village:

Street / Location:

Town / County:

Postal Code:

1.6. USA Physical Address (For USA citizens only)

Street:

Town / City:

Region / State:

Postal Code:

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2. Statement of Health of the Life Assured

This section covers your medical history. Please read the following questions and provide as much information as possible.

1. Has an application for life, sickness, disability, or critical illness insurance on your life ever been declined, deferred withdrawn or accepted with a loading or exclusion? Y/N ☐
2. Have you ever claimed any benefit from sickness, disability, critical illness, or accident policies? Y/N ☐
3. Have you in the last 5 years: consulted any medical professionals; had medical examinations and/or special investigations (including blood tests); taken medication or received medical treatment; been hospitalized or received medical advice to alter or discontinue your alcohol consumption? Y/N ☐
4. Have you, in the last 5 years, suffered from or been diagnosed with any form of: (Tick appropriately)

☐ blindness, hearing or speech problems asthma, tuberculosis, chronic cough.	☐ heart attack, heart disease or disorder, high blood pressure, raised cholesterol diabetes, stroke.
☐ cancer, tumors (state of benign or malignant)	☐ kidney disease, blood, or protein in the urine
☐ HIV/AIDS or HIV/AIDS related conditions, Sexually Transmitted Diseases (STDs)	☐ psychological problems or disability
☐ Body or limb defects, paralysis, physical disability	☐ any condition other than colds, flu or other minor, curable ailments

5. Are you currently experiencing health-related symptoms, or do you intend to seek medical advice or testing for any condition other than colds, flu or other minor, curable ailments in the next 6 months? Y/N ☐
6. What is your height? (Ft, Ins) ☐☐ What is your weight? (Kgs) ☐☐☐

   Is your weight ☒ Stationary? ☐ Increasing? ☐ Decreasing?
7. If you answered 'yes' to any of the questions, please give full details in the table below indicating: -

Nature of complaint or symptoms, Type of treatment or medication, Date of first symptoms or diagnosis, Date of last symptoms, Name, and telephone number of attending doctor

You may use additional Paper for more information.

You are required to tell us anything that you may know about your health that may affect our decision to insure you. If you do not provide this information, you may not be able to claim the risk benefits under this policy.
Please use the space below to provide such information

You may use additional Paper for more information.

I declare that the information I have given above is correct and a true representation of my medical history.
I understand that any medical history not mentioned may invalidate the application for life assurance or a claim.

Name: Date Y Y Y Y M M D D

3. Financial Questionnaire

Weekly Income Monthly Income Source of Income

3.1. Occupational and Recreational Hazards

Do you have any intentions of (where the answer is YES, please give details)

A) Changing the nature of your occupation? ☐
B) Engaging in hazardous occupation? (e.g., working with machinery or electricity) ☐
C) Engaging in hazardous sports or pastime? (e.g., hang gliding, sky diving, mining etc.) ☐
D) Engaging in naval, military or air services? ☐
E) Flying other than as a fare paying passenger by a recognized airline on scheduled in routes ☐

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3.2. Insurance History

Has any proposal on your life ever been made, or is now being made (excluding this application)? If YES, please state: ☐

Name of the Insurer(s)

Date of proposal Y Y Y Y M M D D Sum assured

Was it accepted at? ☒ Ordinary terms ☐ Declined or Loaded ☐ Postponed ☐ Special premium

Status ☒ Matured ☐ In-force ☐ Lapsed ☐ Surrender ☐ Cancelled ☐ Other

3.3. Plan Details

Payment Method ☒ Check-off ☐ Direct Debit ☐ Standing Order ☐ Cheques

Premium Payment Frequency ☒ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Direct Debit Instruction Date Y Y Y Y M M D D Policy Term

Premium Payable

Initial Premium Payment Account Number

Regular premium payment account number

3.4. Premium Calculator

ANB	Term	Rate	Sum Assured		Monthly Premium	Non-Monthly Premium
Discount on Non-Monthly	Q – 4%	SA – 6%	A – 8%	-		
Sub total				=		
Policy Fee				-		
Sub total				=		
0.5 % Training levy				-		
Total Premium DUE				=		

Premium in Words

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4. Beneficiaries (Note - Appointment of a minor may delay the settlement of the claim)

1. First Names:
   Surname: Date of Birth: Y Y Y Y M M D D
   Gender: ☐ Male ☒ Female Title: Relationship:
   Cell/Mobile: Benefit Share %:
   Guardian Full names:
   Guardian Birthdate: Y Y Y Y M M D D Guardian Telephone:

2. First Names:
   Surname: Date of Birth: Y Y Y Y M M D D
   Gender: ☐ Male ☒ Female Title Relationship:
   Cell/Mobile: Benefit Share %
   Guardian Full names:
   Guardian Birthdate: Y Y Y Y M M D D Guardian Telephone:

3. First Names:
   Surname: Date of Birth Y Y Y Y M M D D
   Gender: ☐ Male ☒ Female Title: Relationship:
   Cell/Mobile: Benefit Share %:
   Guardian Full names:
   Guardian Birthdate: Y Y Y Y M M D D Guardian Telephone:

4. First Names:
   Surname: Date of Birth: Y Y Y Y M M D D
   Gender: ☐ Male ☒ Female Title: Relationship:
   Cell/Mobile: Benefit Share %:
   Guardian Full names:
   Guardian Birthdate: Y Y Y Y M M D D Guardian Telephone:

5. First Names:
   Surname: Date of Birth: Y Y Y Y M M D D
   Gender: ☐ Male ☒ Female Title: Relationship:
   Cell/Mobile: Benefit Share %:
   Guardian Full names:
   Guardian Birthdate: Y Y Y Y M M D D Guardian Telephone:

How would you like to receive your statement/Policy document? (Tick One)
Postal Address ☒ Email ☐ Physical Address

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5. Disclosure Checklist – Bank Agency

The policyholder has the right to the following information. Kindly confirm that this has been provided.

5.1. Agent Status (Please enter your "Y" for Yes or "N" for No)

1. Have you provided the following information to the policyholder? ☐
   a) Your full name and title? ☐
   b) Office details (physical and postal address)? ☐
   c) Telephone and email contact details? ☐

5.2. Advice

1. Have you taken the circumstances of the policyholder into account in-order to satisfy their financial needs ☐
   b) Have you done a sufficient needs analysis? ☐

2. Have you disclosed the following information to the policy holder? ☐
   a) Name and type of policy? ☐
   b) The premium? ☐
   c) Type, extent, and limitations of benefits? ☐
   d) That commission is payable on this policy and answered any commission-related questions? ☐
   e) The 28-day cooling-off period? ☐
   f) Claims notification procedure? ☐
   g) Cancellation procedure and surrender? ☐

5.3. Application Stage

   a) Is the policyholder satisfied with the advice and disclosure that you have given? ☐
   b) Has the policyholder completed and signed the application form? ☐

5.4. New business Rater

A.	Gross Regular/Basic Earnings	UGX	_____
B.	Total Existing Deductions:	UGX	_____
C.	Premium for New Policy:	UGX	_____
D.	Total Deductions (B + C):	UGX	_____
E.	New Net Earnings:	UGX	_____
F.	1/3 of A:	UGX	_____
G.	Test: Is E>F ☐	Y/N, if NO, the application does not qualify	

Replacement Question

IMPORTANT NOTE: -REPLACEMENT OF ANY ASSURANCE MAY BE TO THE DISADVANTAGE OF THE POLICYHOLDER BECAUSE IT INVOLVES DUPLICATION OF INITIAL COSTS CHARGED TO THE CONTRACT.

Is this application to replace the whole or any part of your existing insurance with any assurer (whether replacement is to occur immediately or to replace an insurance discontinued within the past four months or within the next four months)? Please indicate your submission as a Yes or No: ☐

If "Yes", the agent must discuss and obtain written consent from you.