momentum

Application for Myriad			Policy	numbe	r				
Policy details									
Is this application for one of a group of policies?	Yes	No	Group number						
Is this policy linked to a Myriad group solution policy?	Yes	No	Please numb	per this a	applica	tion		of	=
How many clients (insured lives and applicants) are the	re under this p	oolicy?							
How many stand-alone benefits does this policy have (t	otal of all insu	red lives)?							
How many beneficiaries does this policy have?									
Multiply application included?	Yes	No	Is this	s a confo	orming	policy?	Yes		No
Starting date of policy									
Automatic starting date The starting date will	I be the first d	ay of the month	following the acc	eptance	of the	benefit	S.		
Fixed starting date* 0 1 - M M -	2 0 Y	Y	3 · · · · ·						
* The starting date will be the date that the applicant has		nless:							
Momentum accepts the benefits after the date that the			d provided that no	ne of th	e insui	ed lives	has ha	ıd a bir	thday betwe
the indicated date and the date of acceptance. The	_		-		_				
Momentum accepts the benefits after the date that the date and the date of acceptance. The starting date							thday b	etwee	n the indica
The commission split below applies to the entire policy of * Please complete details of servicing financial adviser. Name Financial adviser's complete to the entire policy of t		oker house code	e Com	mission	ref no		Con	nmissio	on split %
*									· ·
Are you registered to market life insurance under the A you fully conversant with and do you accept the 'S' refer		•		ica (ASI	SA) ar	nd are	Yes		No
Fastlane requires the financial adviser's conse	ent for the N	/lomentum m	edical staff to	visit th	e clie	nt			
I request Momentum to contact my client(s) directly if the do not want Momentum to contact your client, please m for specialised examinations.)							Yes		No
Please complete the consultation address of the client in	n the space th	at we provide b	elow the doctor's	informa	tion in	Section	1.		
FICA declaration									
I confirm that I have identified the client, including the po- applicable, and verified his/her/their details on this co- Intelligence Centre Act, No 38 of 2001 sets out. I furthe all the verification documents.	ontract under	the requirement	its that Section	21 of th	ne Éina	ancial	Yes		No
Signature of servicing financial adviser				Date				- 2	0 Y Y

Replacement of insurance

Does this application 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 last four months or within the next four months)?

Yes No	
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If Yes, the financial adviser must discuss and complete the Replacement Policy Advice Record (MYRIAD013).

Important note: The replacement of any insurance has various potentially detrimental consequences which your financial adviser should disclose to you. Momentum will not automatically cancel a Momentum policy(ies) on acceptance, unless the client submits a conditional termination form with this application form.

Declaration by the financial adviser

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

I further declare that, irrespective of the client's response to the question with regard to replacement, that I have explained the following to the client:

- 1. The meaning of replacement,
- 2. That a replacement is potentially prejudicial, and
- 3. That where a replacement is considered, the client is legally entitled to comprehensive information regarding the consequences of replacement

	·							promor			1		-3-							•		
Signature of financial adviser													Date	е	D D	-	M	M	- 2	2 0	Υ	Υ
Marketing adviser details																						
Name													М	arke	eting	advis	er's	cod	е			
Branch name									Те	lepl	hone	e - W0	ork									
Section 1: Insured life deta	ils																					
ROLE(S)				Tick 1	the a	oprop	riate r	ole(s)	that t	this	clier	nt wil	ll play	on	this	policy	:					
Client number 0 1				Polic	yholo	ler (c	ontrac	ting pa	arty)			%	Owne	ersh	ip				ŀ	Insure	ed life	×
Title				Init	ials				First	t na	ıme											
Surname																						
Previous surname(s)																						
Gender	Male			F	emal	е		Cor	respo	ond	ence	e lan	guage) E	Engli	sh			i	Afrika	ans	
Date of birth	D D	_	M	M -	Υ	Υ	YY			Nat	tiona	lity										
Permanent identity/passport number													Per	mar	nent	RSA	ID	Yes			No	
Postal address																						
																	Р	ostal	code	•		
Residential address																						
																	Р	ostal	code	•		
Telephone - work											1	Fax ·	- work	(
Telephone - home											F	ax -	home	•								
Cellphone number																						
E-mail address																						
Which method of communication do you	prefer?															Po	st			E-	-mail	
Note: Certain Momentum documents ar	e not ye	t ava	ilable	elect	tronic	ally a	nd the	e posti	ng of	tho	ose v	vill co	ontinu	e fo	r the	time	bei	ng.				
Are you currently insolvent?	Yes			No					If Y	es,	date	of i	nsolve	ency	/	D	-	M	M -	- Y	Υ	Y
Marital status	Singl	е			Ma	rried			Se	ера	rated	t		[Divor	ced			١	Widov	ved	
nterest of applicant in the insured	Busir	ness	overh	neads	cove	r		Buy-	and-s	sell			(Con	tinge	nt lial	oility	<i>,</i>				
ife (need for insurance or insurable nterest):	Debte	or's c	cover			Inco	me re	placer	nent			Ke	ypers	on			Lo	an ac	cou	nt pro	tectic	n
	Perso	onal/	Estate	e duty	/		Se	ecurity	for Ic	oan,	/bon	d										

Section 1: Insure	d life detai	ls (conti	inued)																		
Highest educational quali	ification	No matri	ic	Matr	ric		3-у	ear d	liplor	ma			3-y	ear d	egre	e / 4-	-yea	ır dipl	loma	a	
		4-year d	egree / profe	essiona	al																
Highest educational quali	ification of	No matri	ic	Matr	ric		3-у	ear d	liplor	ma			3-y	ear d	egre	e / 4·	-yea	ır dipl	loma	а а	
spouse		4-year d	egree / profe	essiona	al							_									
Name of educational inst	itution																				
Monthly income		Insured I	life R				Ħ						Spo	use	R				$\overline{}$		Ť
Self-employed													•			Ye	s		T	No	
Occupation															T				-		
Have you been continuou	uslv emploved ir	n a perman	ent and full-	ime od	ccupatio	on for	at lea	ast tw	o ve	ars?	•					Ye	es			No	
Percentage of working ho				%			Perce		-			hour	s sne	ent or	n adr			on	-		%
Percentage of working ho	•			%			Perce	_			-		•					-	_		%
Description of main duties		0. 10.011		70		·	0.00	mag	0 01		g .	ioui	o opc		mai	iaai	1000	_			70
Employer															<u>_</u>	<u> </u>			_		
Years with current employ	yer		Industry													Ļ					<u> </u>
Do you intend to change	your career or to	o become i	involved in a	ny oth	er occu	patio	n?									Ye	s			No	
If Yes, please provide det	tails																				
Will your occupation requ	ire you to travel	or reside of	outside the b	orders	of the	RSA?	?									Ye	s			No	
If Yes, to which country, for	or how long and	how often	?																		
Existing insurance	history																				
Please fill in the table bel insurers.	ow, giving the to	otal for whic	ch your life is	curre	ntly insi	ured,	as we	ell as	sim	ultan	eous	s ap _l	olicat	ions	with	Mom	nent	um o	r an	y oth	er life
Existing insurance	Death be	nefit	Dread d			Lun	np sur	n dis	abili	ty	ı	Mon	thly o	lisabi ne	lity			nnatu ccide			
Business	R		R			R					R					F					
Personal	R		R			R					R					F	₹				
Simultaneous applications	Death be	nefit	Dread d			Lun	np sui	n dis	abili	ty	I	Mon	thly o	lisabi me	lity			nnatu ccide			
Business	R		R			R					R					F	?				
Personal	R		R			R					R					F	₹				
Replacement insurance	Death be		Dread d critical				np sur	n dis	abili	ty			thly o	lisabi me	lity		а	nnatu ccide			
Business Personal	R		R R			R R					R R					F					
reisonai	K		N.			N					Α.						_				
Momentum Interac	tive																				
Do you want to become a	a member of Mo	mentum In	teractive?													Ye	s			No	
If Yes, please complete th	ne following:																				
Have you had any vehicle	e accident insura	ance claim	s during the	last the	ree yea	rs?										Ye	:S			No	
Distance travelled by roa	d during the last	t year (drive	er or passen	ger)																	km
Are you the regular driver	r of a vehicle ins	sured with I	Momentum S	Short-te	erm Ins	urand	e?									Ye	s		Ī	No	
Please indicate your curr	ent Multiply stat	us					Noi	n-mei	mbe	r		Br	onze			Sil	ver			Gold	
* For calculation purposes	only, we regard the M	fultiply status a	as Bronze.				Pla	tinum	n		Pr	ivate	e clul)		Ne	ew a	pplic	atio	n*	

Section 1: Insured life details (continued) **Momentum Interactive (continued)** Annual fitness discount Have you participated and successfully completed one of the following events during the last 12 months? Yes No If Yes, please specify: Running Half marathon Marathon and longer Road cycling 50 km and longer 90 km and longer Mountain biking 35 km and longer 65 km and longer Sprint distance Olympic distance and longer Triathlon Swimming > 1.5 km Name of qualifying sport event Section 2: Underwriting of the insured life **Avocation** Do you, have you or do you intend to participate in any pursuit or avocation that might be considered hazardous Yes No (e.g. aviation, diving, racing, parachuting, mountaineering, mining)? If Yes, please provide full details Insurance history Has an insurer ever declined, postponed or withdrawn any of your benefit(s) applied for, or accepted it at an increased premium, or reduced the benefit(s) applied for, or issued a benefit subject to an exclusion clause, or have you ever been No medically boarded, or have you ever submitted claims for disability or third-party benefits? If Yes, please provide full details **Medical history** If you answer Yes to any question, please provide full details in the space provided. 1. Heart or blood circulation Do you have, or have you previously had any heart or blood circulation complaints (e.g. high blood pressure, Yes No raised cholesterol, palpitations, heart attack, heart murmur, rheumatic fever, stroke, brain disorders or any cardiac procedures)? Condition/impairment Fully recovered? Doctor's name Currently on treatment? Last symptoms Yes No Yes No Yes No Yes No Respiratory and/or lung complaints Do you have, or have you previously had any respiratory and/or lung complaints (e.g. asthma, bronchitis, Yes No tuberculosis, persistent coughing or any breathing problems)? Doctor's name Condition/impairment Currently on treatment? Last symptoms Fully recovered? Yes No Yes No Yes No Yes No 3. Disorders of the digestive system, gall bladder, pancreas or liver Do you have, or have you previously had any disorders of the digestive system, gall bladder, pancreas or liver (e.g. Yes No hiatus hernia, gall stones, hepatitis A/B/C, jaundice, gastric ulcers or recurrent indigestion problems)? Doctor's name Last symptoms Fully recovered? Condition/impairment Currently on treatment? Yes No Yes No Yes No Yes No Disorders of the kidneys, bladder or reproductive organs Do you have, or have you previously had any disorders of the kidneys, bladder or reproductive organs (e.g. kidney Yes No stones, bladder infection, blood in urine, protein in urine or prostate problems)? Condition/impairment Doctor's name Fully recovered? Currently on treatment? Last symptoms Yes No Yes No Yes Yes

Section 2: Underwriting of the insured life (continued)

Medical history (continued)

	s, epilepsy, migraine or blackou	10).				No
Condition/impairment	Doctor's name	Currently on	treatment?	Last symptoms	Fully recov	ered?
		Yes	No	Y Y M M	Yes	No
		Yes	No	Y Y M M	Yes	No
Disorders of the eye, ear, nose or	throat					
Do you have, or have you previously lenses or keratotomy), ear, nose or t	y had any disorders of the eye			y glasses, contact	Yes	No
Condition/impairment	Doctor's name	Currently on	,	Last symptoms	Fully recov	ered?
		Yes	No	Y Y M M	Yes	No
		Yes	No	Y Y M M	Yes	No
Problems with your spine, joints,	bones, muscles, limbs or sk	in				
Do you have, or have you previously back problems, neck problems, fract				os or skin (e.g.	Yes	No
Condition/impairment	Doctor's name	Currently on	treatment?	Last symptoms	Fully recov	rered?
		Yes	No	Y Y M M	Yes	No
		Yes	No	Y Y M M	Yes	No
Diabetes, raised blood sugar, othe	er endocrine, alandular, bloc	d or hormonal di	cordore			
Diabetes, raised blood sugar, office Do you have, or have you previously or hormonal disorders (e.g. thyroid of the blood sugar s	y had any form of diabetes, rais	sed blood sugar, of	her endocrine	, glandular, blood	Yes	No
Condition/impairment	Doctor's name	Currently on		Last symptoms	Fully recov	ered?
		Yes	No	Y Y M M	Yes	No
		Yes	No	Y Y M M	Yes	No
A 6						
Any form of cancer, growth or tun	nour					
Do you have, or have you previously	y had any form of cancer, grow	rth or tumour (inclu	ding fibroaden	omas, moles	Yes	No
Do you have, or have you previously removed - both either malignant or b	y had any form of cancer, grow	rth or tumour (inclu Currently on		omas, moles Last symptoms	Yes Fully recov	
Do you have, or have you previously	y had any form of cancer, grow penign)?					
Do you have, or have you previously removed - both either malignant or b	y had any form of cancer, grow penign)?	Currently on	treatment?		Fully recov	rered?
Do you have, or have you previously removed - both either malignant or be Condition/impairment	y had any form of cancer, grow penign)? Doctor's name	Currently on Yes	treatment?		Fully recov	rered?
Do you have, or have you previously removed - both either malignant or be Condition/impairment Drugs, tranquillisers or any other Are you taking, or have you ever taken	y had any form of cancer, grow penign)? Doctor's name medicines en any drugs, tranquillisers or a	Currently on Yes Yes Any other medicine	treatment? No No S in any form form	Last symptoms Y Y M M Y Y M M or any other reason	Fully recov	rered?
Do you have, or have you previously removed - both either malignant or be Condition/impairment Drugs, tranquillisers or any other Are you taking, or have you ever take than colds and flu (e.g. antidepressal	y had any form of cancer, grow penign)? Doctor's name medicines en any drugs, tranquillisers or a	Currently on Yes Yes Any other medicine	No No s in any form for annabis or cool	Last symptoms Y Y M M Y Y M M or any other reason	Fully recov Yes Yes	vered? No No
Do you have, or have you previously removed - both either malignant or be Condition/impairment Drugs, tranquillisers or any other Are you taking, or have you ever take than colds and flu (e.g. antidepressal	y had any form of cancer, grow penign)? Doctor's name medicines en any drugs, tranquillisers or a ants, tranquillisers, any homeor	Currently on Yes Yes any other medicine pathic medicines, of	No No s in any form for annabis or cool	Last symptoms Y Y M M Y Y M M or any other reason caine)?	Fully recov Yes Yes Yes	vered? No No
Do you have, or have you previously removed - both either malignant or be Condition/impairment Drugs, tranquillisers or any other Are you taking, or have you ever take than colds and flu (e.g. antidepressal	y had any form of cancer, grow penign)? Doctor's name medicines en any drugs, tranquillisers or a ants, tranquillisers, any homeor	Currently on Yes Yes any other medicine pathic medicines, of Currently on	No No s in any form for annabis or coottreatment?	Last symptoms Y Y M M Y Y M M or any other reason caine)?	Yes Yes Yes Fully recov	vered? No No No vered?
Do you have, or have you previously removed - both either malignant or be Condition/impairment Drugs, tranquillisers or any other Are you taking, or have you ever take than colds and flu (e.g. antidepressa Condition/impairment Have you sought any medical ad	y had any form of cancer, grow benign)? Doctor's name medicines en any drugs, tranquillisers or a ants, tranquillisers, any homeop Doctor's name	Yes Yes Any other medicine pathic medicines, of Currently on Yes Yes Yes Yes	No No No s in any form for annabis or contreatment? No No No No	Last symptoms Y Y M M Y Y M M or any other reason caine)? Last symptoms Y Y M M Y Y M M oms, or have you	Yes Yes Yes Fully recov Yes Yes Yes	vered? No No No vered? No
Do you have, or have you previously removed - both either malignant or be Condition/impairment Drugs, tranquillisers or any other Are you taking, or have you ever take than colds and flu (e.g. antidepressa Condition/impairment Have you sought any medical ad been a patient in a hospital or nur	y had any form of cancer, grow benign)? Doctor's name medicines en any drugs, tranquillisers or a ants, tranquillisers, any homeop Doctor's name	Yes Yes Any other medicine pathic medicines, of Yes Yes Yes Ars for any conditions of Yes Ars for any conditions of Yes Yes Ars for any conditions of Yes Yes	No No No s in any form for annabis or coortreatment? No No No No cition or symptomation (including	Last symptoms Y Y M M Y Y M M or any other reason caine)? Last symptoms Y Y M M Y Y M M oms, or have you	Yes Yes Yes Fully recov	vered? No No No vered? No
Do you have, or have you previously removed - both either malignant or be Condition/impairment Drugs, tranquillisers or any other Are you taking, or have you ever take than colds and flu (e.g. antidepressa Condition/impairment Have you sought any medical ad been a patient in a hospital or nur to ECG, scans, x-ray examinations	y had any form of cancer, grow benign)? Doctor's name medicines en any drugs, tranquillisers or a ants, tranquillisers, any homeop Doctor's name	Yes Yes Any other medicine pathic medicines, of Yes Yes Yes Ars for any conditions of Yes Ars for any conditions of Yes Yes Ars for any conditions of Yes Yes	No No No No No No s in any form for annabis or coortreatment? No No No No cion or symptetation (includied above?	Last symptoms Y Y M M Y Y M M or any other reason caine)? Last symptoms Y Y M M Y Y M M oms, or have you	Yes Yes Yes Fully recov Yes Yes Yes	vered? No No vered? No No No No No No No No No N
Any form of cancer, growth or tun Do you have, or have you previously removed - both either malignant or b Condition/impairment Drugs, tranquillisers or any other Are you taking, or have you ever take than colds and flu (e.g. antidepressa Condition/impairment Have you sought any medical ad been a patient in a hospital or nur to ECG, scans, x-ray examinations Condition/impairment	y had any form of cancer, grow benign)? Doctor's name medicines en any drugs, tranquillisers or a ants, tranquillisers, any homeographs, and benefit transported by the last five yearsing home, or undergone and sor specialised laboratory to the last five years or specialised labor	Currently on Yes Yes Any other medicine pathic medicines, of Currently on Yes Yes Yes Ars for any conditions and medical examinests) not mention	No No No No No No s in any form for annabis or coortreatment? No No No No cion or symptetation (includied above?	Last symptoms Y Y M M Or any other reason caine)? Last symptoms Y Y M M Oms, or have you ing but not limited	Yes Yes Yes Yes Yes Yes Yes Yes	vered? No No vered? No No No No No No No No No N

Section 2: Underwriting of the insured life (continued)

Medical history (continued)

AII		for, or received any medical advi e of the HI-viruses, or any sexually				Yes	No
Co	ondition/impairment	Doctor's name	Currently on t	reatment?	Last symptoms	Fully reco	vered?
			Yes	No	Y Y M M	Yes	No
			Yes	No	Y Y M M	Yes	No
		illness, disorder, disability or acci ich may influence the risk applied			ccidents or other	Yes	No
Co	ondition/impairment	Doctor's name	Currently on t	reatment?	Last symptoms	Fully reco	vered?
			Yes	No	Y Y M M	Yes	No
			Yes	No	Y Y M M	Yes	No
	you have any intention o	of having medical investigations, p	procedures or chec	k-ups done	for any condition	Yes	No
Co	ondition/impairment	Doctor's name	Currently on t	reatment?	Last symptoms	Fully reco	vered?
			Yes	No	Y Y M M	Yes	No
			Yes	No	Y Y M M	Yes	No
Hahite	s, measurements and f	amily history					
1. Ha		uniny motory					
1.1		ed any other form of tobacco in the p	ast six months?			Yes	No
	If Yes, quantity per day?	,	ade out monard.			100	
1.2						Yes	No
1.2		er week (1 unit = 1 bottle of beer or	1 alass of wine or 1	tot of spirits/li	anor)3	100	140
1.3		I medical advice or participated in a	· ·	•	. ,	Yes	No
	If Yes, please provide full	details					
2. Me	easurements						
	2 Height	, m	Weight	kg			
	-	d by more than 5 kg during the last y	/ear?			Yes	No
		ow much it has changed by	(kg), and wl	nv?			
3. Fa	mily history	o ,					
На	is any family member suffer	red from any major illness or heredita				Yes	No
	gh blood pressure, diabetes /es, please provide full deta	, cancer, depression, porphyria, poly	cystic kidneys) unde	er the age of 6	60?		
Р	Relation	Condition					Age diagnosed
	COLUMN	Condition				/	igo diagnosed
I decla	re that all the information th	at I have supplied about my health,	hobbies and occupa	tion is correc	t and complete.		
Sign	nature of insured life				Date D D - N	/ M – 2	2 0 Y Y

Section 2: Underwriting of the insured life (continued)

Medical doctor of the insured life

If Yes, please specify the amount:

3. If self-employed, is the business based at your home?

Please indicate the name of the doctor to whom we may send the reasons for health loadings or results of an HIV test. Confidential correspondence: Confidential doctor (may not be a hospital) Initials Surname Telephone - work Postal address Postal code Current/most recent doctor (if other than the above) Surname Telephone - work When did he/she become your regular doctor? **Fastlane** Consultation address Postal code Section 3: Additional benefit information A. Income Protector and Temporary Income Protector Income used in determining the benefit amount is defined as one of the following: **Gross Taxable Income** Taxable income payable or benefits receivable on account of the insured life's employment, or any services rendered by the insured life. **Cost to Company Income** This equals Gross Taxable Income plus the value of the use of a motor vehicle, as well as the employer's contributions to a medical scheme and a pension fund and the cost of any other benefits paid for by the insured's employer and drawings in the form of dividends. Gross Professional Income (professionals only) For professionals that charge a fee for services, this equals the sum of the professional fee and the net income from trading activities, after deducting business overheads expenses. 1. Details of income R 1.1 What was your average monthly income from your occupation for the last 12 months? 1.2 What amount of this income is based on commission? R Income from other sources (other occupations, investments, rentals, etc.) will not be taken into Yes No account when determining a benefit amount. Do you receive such income? If Yes, please provide details: 1.4 What will your projected monthly income for the next 12 months be? R 2. Does your group benefit include an income disability benefit? Yes No

No

R

Yes

B. Business Overheads Protector 1. Number of employees 2. Number of employees with your professional or trade qualifications Details of your interest in the business: 3.1 Total monthly overhead expenses 3.2 Your percentage (%) share of overhead expenses Percentage (%) of business turnover from sale of goods 3.4 Number of associates 3.5 Your percentage (%) share of the business 4. If self-employed, is the business based at your home? Yes No C. Business Protector (Only for professionals) The benefit amount is based on the sum of the professional fees, plus net income from trading activities. What was your average monthly fee income and net income from trading activities in the last 12 months? R What is your expected average monthly fee income and net income from trading activities for the next 12 months? R D. Funeral Benefit Please complete if you are the underwritten insured life on a Funeral Benefit and have children insured lives or extended family insured lives covered under the benefit. Child insured life(lives) Name and surname Gender Relationship Identity number 1 2 3 4 5 Extended family insured life(lives) (The spouse is not considered an extended family member) Name and surname Identity number Gender Relationship 1 2 3 4 5 6 7 8 1. Has any of the children insured lives or extended family insured lives, to your knowledge, ever been hospitalised, Yes No received treatment for any chronic condition or seen a specialist in the last year? If Yes, please provide details (including name of insured life and medical condition or impairment):

Section 3: Additional benefit information (continued)

Section 3: Additional benefit information (continued)

E. Education Protector

Details of biological/legally adopted child(ren) linked to an Education Protector.

Name and surname	Gender		Da	ate d	of bi	rth				Iden	ntity ı	านm	ber		
							Y								
							Υ								
							Υ								
							Υ								
				M			Υ								

ROLE(S)			Tick the app	oropriate role	e(s) that t	nis clie	nt wil	l play o	n this po	olicy:		
Client number 0 2		F	Policyholder (cont	racting party	/)	% O	wner	ship			Ins	sured life
A. Fill in if this client is an applic	ant or ad	ditiona	l insured life									
Title			Initials	Fi	rst name							
Surname/name of legal entity												
Previous surname(s)												
Contact person in case of legal entity												
Gender	Male		Female	Corres	pondence	e langı	ıage	Englis	sh		Afr	ikaans
Date of birth	D D	- M N	1 - Y Y Y	Υ	Nationa	lity						
Permanent identity/passport number							Perm	anent F	RSA ID	Yes		No
Postal address												
									Р	ostal c	ode	
Residential address												
									Р	ostal c	ode	
Telephone - work						Fax - v	work					
Telephone - home					Cellpho	ne nur	nber					
E-mail address												
Which method of communication do you	ı prefer?								Post			E-mail
Note: Certain Momentum documents ar	e not yet av	ailable (electronically and	the posting	of those v	will cor	ntinue	for the	time be	ing.		
Are you currently insolvent?	Yes	N	lo	l	f Yes, date	e of ins	solver	ісу	D -	MN	4 –	YY
f a legal entity, has the legal entity been the legal entity for liquidation or adminis	liquidated, tration?	placed ι	under administrati	on or are the	ere any pr	ocess	es pei	nding a	gainst	Yes		No
Tax status	Compar	y/Close	corporation (M)		Sole prop	rietor/	Partn	er (S)		Natu	ral pe	rson (N
	Non-tax	able inst	itution (I)									
Tax status of trust beneficiaries if the ap	plicant is a	trust	Company (C)		Non-taxa	ble ins	titutio	n (Z)		Natu	ral pe	rson (P

Section 4: Additional insured life/applicant details (continued)

B. Fill in if this client is an insured life

Marital status	Sir	ngle				Ν	/larri	ed				Se	epai	rate	d			D	ivor	ced				W	idow	/ed	
Interest of applicant in the insured	Bu	ısine	ss o	verh	neads	cov	ver			Вι	іу-а	nd-s	sell				С	onti	ngei	nt lia	bility	y					
life (need for insurance or insurable interest):	De	ebtor	's co	ver			In	cor	ne re	eplac	em	ent			Ke	ype	erso	n			Lo	an a	3000	ount	prot	tectio	n
	Pe	rson	al/E	stat	e dut	/			Se	ecur	ty f	or Ic	an/	bon	d												
Highest educational qualification	No	mat	tric			N	/latri	С			3-	yea	r dip	olom	na			3	-yea	r deg	gree	: / 4	-yea	ar dij	plom	na	
	4- y	year	degr	ree /	prof	essi	onal																				
Highest educational qualification of	No	mat	tric			N	/latri	С			3-	yea	r dip	olom	na			3	-yea	r deg	gree	/ 4	-yea	ar dij	plom	ıa	
spouse	4- y	year	degr	ree /	prof	essi	onal																				
Name of educational institution																											
Monthly income	Ins	surec	d life		R													S	pou	se	R						
Self-employed																						Ye	:S			No	
Occupation																											
Have you been continuously employed in	а ре	erma	nent	t an	d full-	time	e occ	cup	ation	for	at le	east	two	yea	ars?							Ye	s			No	
Percentage of working hours spent on trav	vel					%	6			F	erc	enta	age	of v	vorki	ing	hou	rs s	pen	t on a	adm	iinis	trati	ion			%
Percentage of working hours spent on supe	ervis	sion				%	0			P	erc	enta	age	of w	orki/	ng l	nou	rs s	pent	on r	nan	ual	labo	our			%
Description of main duties																											
Employer																											
Years with current employer				Ind	ustry																						
Do you intend to change your career or to	bec	come	e inv	olve	d in a	any (othe	r oc	cupa	ation	?											Ye	s			No	
If Yes, please provide details																											
Will your occupation require you to travel	or re	eside	out	side	the I	ord	lers (of tl	ne R	SA?												Ye	s			No	
If Yes, to which country, for how long and	how	ofte	n?																								
				_																							

Existing insurance history

Please fill in the table below, giving the total for which your life is currently insured, as well as simultaneous applications with Momentum or any other life insurers.

Existing insurance	Death benefit	Dread disease/ critical illness	Lump sum disability	Monthly disability income	Unnatural death/ accident benefit
Business	R	R	R	R	R
Personal	R	R	R	R	R
Simultaneous applications	Death benefit	Dread disease/ critical illness	Lump sum disability	Monthly disability income	Unnatural death/ accident benefit
Business	R	R	R	R	R
Personal	R	R	R	R	R
Replacement insurance	Death benefit	Dread disease/ critical illness	Lump sum disability	Monthly disability income	Unnatural death/ accident benefit
Business	R	R	R	R	R
Personal	R	R	R	R	R

Momentum Interactive Do you want to become a member of Momentum Interactive? Yes No If Yes, please complete the following: Have you had any vehicle accident insurance claims during the last three years? Yes Nο Distance travelled by road during the last year (driver or passenger) km Are you the regular driver of a vehicle insured with Momentum Short Term Insurance? Yes No Please indicate your current Multiply status Non-member Bronze Silver Gold * For calculation purposes only, we regard the Multiply status as Bronze. Platinum Private club New application* Annual fitness discount Have you participated and successfully completed one of the following events during the last 12 months? Yes No If yes, please specify: Running Half marathon Marathon and longer Road cycling 50 km and longer 90 km and longer Mountain biking 35 km and longer 65 km and longer Sprint distance Triathlon Olympic distance and longer Swimming > 1.5 km Name of qualifying sport event Section 5: Underwriting of the additional insured life **Avocation** Do you, have you or do you intend to participate in any pursuit or avocation that might be considered hazardous Yes No (e.g. aviation, diving, racing, parachuting, mountaineering, mining)? If Yes, please provide full details Insurance history Has any insurer ever declined, postponed, withdrawn or accepted any of your benefits applied for at an increased premium, No or reduced any of the benefits applied for, or issued a benefit subject to an exclusion clause, or have you ever been Yes medically boarded or have you ever submitted claims for disability or third-party benefits? If Yes, please provide full details **Medical history** If you answer Yes to any question, please provide full detail in the space provided. 1. Heart or blood circulation Do you have, or have you previously had any heart or blood circulation complaints (e.g. high blood pressure, Yes No raised cholesterol, palpitations, heart attack, heart murmur, rheumatic fever, stroke, brain disorders or any cardiac procedures) Condition/impairment Currently on treatment? Fully recovered? Doctor's name Last symptoms Yes No Yes No Yes No Yes No Respiratory and/or lung complaints Do you have, or have you previously had any respiratory and/or lung complaints (e.g. asthma, bronchitis, tuberculosis, No persistent coughing or any breathing problems)? Condition/impairment Currently on treatment? Last symptoms Fully recovered? Doctor's name Yes Yes No No Yes Yes No No

Section 4: Additional insured life/applicant details (continued)

Section 5: Underwriting of the additional insured life (continued)

Medical history (continued)

	Disorders of the digestive system, g Do you have, or have you previously h	had any disorders of the dig	gestive system, ga		, ,	Yes	No
	hiatus hernia, gall stones, hepatitis A/B Condition/impairment	3/C, jaundice, gastric ulcers of Doctor's name	or recurrent indige Currently on)? Last symptoms	Fully recove	
	Condition	Bostor o namo	Yes	No	Y Y M M	Yes	No No
			Yes	No	Y Y M M	Yes	No
			103	140	1 1 101 101	103	140
١.	Disorders of the kidneys, bladder or Do you have, or have you previously had bladder infection, blood in urine, protein	d any disorders of the kidneys		ductive organs	(e.g. kidney stones,	Yes	No
	Condition/impairment	Doctor's name	Currently on	treatment?	Last symptoms	Fully recove	ered?
			Yes	No	Y Y M M	Yes	No
			Yes	No	Y Y M M	Yes	No
5.	Nervous or mental disorders						
•	Do you have, or have you previously ha	ad any nervous or mental dis	orders (e.g. depre	ssion, anxiety,	consultation(s) with	Yes	No
	psychiatrist/psychologist, stress, epilep	sy, migraine or blackouts)?				100	140
	Condition/impairment	Doctor's name	Currently on	treatment?	Last symptoms	Fully recove	ered?
			Yes	No	YYMM	Yes	No
			Yes	No	Y Y M M	Yes	No
	Disorders of the eye, ear, nose or the	roat					
٠.	Do you have, or have you previously have or keratotomy), ear, nose or through	ad any disorders of the eye	`		by glasses, contact	Yes	No
	Condition/impairment	Doctor's name	Currently on	treatment?	Last symptoms	Fully recove	red?
			Yes	No	YYMM	Yes	No
			Yes	No	YYMM	Yes	No
,	Ducklama with warm only a lainte ha						
•	Problems with your spine, joints, bo Do you have, or have you previously ha problems, neck problems, fractures/bro	ad any problems with your s	pine, joints, bones		s or skin (e.g. back	Yes	No
	Condition/impairment	Doctor's name	Currently on	,			
				treatment?	Last symptoms	Fully recove	ered?
				No No	Last symptoms	•	
			Yes		Last symptoms Y Y M M Y Y M M	Yes Yes	No No
			Yes Yes	No No	Last symptoms Y Y M M Y Y M M	Yes	No
١.	Diabetes, raised blood sugar, other of Do you have, or have you previously have a standard or other than the standard or other th	ad any form of diabetes, rais	Yes Yes Ad or hormonal died blood sugar, of	No No sorders	Y Y M M Y Y M M	Yes	No
-	Do you have, or have you previously ha hormonal disorders (e.g. thyroid or other	ad any form of diabetes, rais er glands problems, anaemi	Yes Yes Yes Indicate of hormonal displayed blood sugar, of a or bleeding displayed blood sugar.	No No sorders ther endocrine, rders)?	Y Y M M Y Y M M	Yes Yes	No No
1 .	Do you have, or have you previously ha	ad any form of diabetes, rais	Yes Yes Yes In the domain of	No N	Y Y M M Y Y M M	Yes Yes Yes Fully recove	No No No Pred?
·-	Do you have, or have you previously ha hormonal disorders (e.g. thyroid or other	ad any form of diabetes, rais er glands problems, anaemi	Yes Yes Yes In the domain of the domain o	No No Sorders ther endocrine, rders)? treatment?	Y Y M M Y Y M M	Yes Yes Yes Fully recove Yes	No No No No No No
1-	Do you have, or have you previously ha hormonal disorders (e.g. thyroid or other	ad any form of diabetes, rais er glands problems, anaemi	Yes Yes Yes In the domain of	No N	Y Y M M Y Y M M	Yes Yes Yes Fully recove	No No No Pred?
	Do you have, or have you previously ha hormonal disorders (e.g. thyroid or other	ad any form of diabetes, rais er glands problems, anaemi Doctor's name	Yes Yes Yes In the domain of the domain o	No No Sorders ther endocrine, rders)? treatment?	Y Y M M Y Y M M	Yes Yes Yes Fully recove Yes	No N
	Do you have, or have you previously ha hormonal disorders (e.g. thyroid or othe Condition/impairment	ad any form of diabetes, rais er glands problems, anaemi Doctor's name	Yes Yes Yes Indicated blood sugar, of a or bleeding diso Currently on Yes Yes	No No No No No No No No No	glandular, blood or Last symptoms Y Y M M W	Yes Yes Yes Fully recove Yes	No No No No No No
	Do you have, or have you previously had hormonal disorders (e.g. thyroid or other Condition/impairment Any form of cancer, growth or tumor Do you have, or have you previously had	ad any form of diabetes, rais er glands problems, anaemi Doctor's name	Yes Yes Yes Indicated blood sugar, of a or bleeding diso Currently on Yes Yes	No N	glandular, blood or Last symptoms Y Y M M W	Yes Yes Yes Fully recove Yes Yes	No No No No No No
3.	Do you have, or have you previously had hormonal disorders (e.g. thyroid or other Condition/impairment Any form of cancer, growth or tumor Do you have, or have you previously have both either malignant or benign)?	ad any form of diabetes, rais er glands problems, anaemi Doctor's name ur d any form of cancer, growth	Yes Yes Yes Indian or hormonal diagram of the second of the sugar, of the second of	No N	glandular, blood or Last symptoms Y Y M M as, moles removed	Yes Yes Yes Fully recove Yes Yes Yes	No No No No No No

Section 5: Underwriting of the additional insured life (continued)

Medical history (continued)

10. Dr	ugs, tranquillisers or any other med	dicines					
	e you taking, or have you ever taken a ason than colds and flu (e.g. antidepre					Yes	No
Со	ndition/impairment	Doctor's name	Currently on	treatment?	Last symptoms	Fully recove	ered?
			Yes	No	Y Y M M	Yes	No
			Yes	No	Y Y M M	Yes	No
be	ive you sought any medical advice en a patient in a hospital or nursing ited to ECG, scans, x-ray examinat	g home, or undergone ar	ny medical exami	nation (includi	ng but not	Yes	No
Со	andition/impairment	Doctor's name	Currently on	treatment?	Last symptoms	Fully recove	ered?
		_	Yes	No	Y Y M M	Yes	No
			Yes	No	Y Y M M	Yes	No
All	ive you ever been tested for, or rece DS, or any infection by one of the H philis or genital herpes)?					Yes	No
Со	andition/impairment	Doctor's name	Currently on	treatment?	Last symptoms	Fully recove	ered?
			Yes	No	Y Y M M	Yes	No
		_	Yes	No	Y Y M M	Yes	No
	e you aware of any other illness, di ctors (past or present) which may ir				ccidents or other	Yes	No
Co	ndition/impairment	Doctor's name	Currently on	treatment?	Last symptoms	Fully recove	ered?
			Yes	No	Y Y M M	Yes	No
			Yes	No	Y Y M M	Yes	No
	you have any intention of having r the near future?	medical investigations, p	procedures or che	eck-ups done f	or any condition	Yes	No
Со	ondition/impairment	Doctor's name	Currently on	treatment?	Last symptoms	Fully recove	ered?
			Yes	No	Y Y M M	Yes	No
			Yes	No	Y Y M M	Yes	No
Habits	s, measurements and family his	story					
1. Ha	bits						
1.1	Have you smoked or used any other	er form of tobacco in the p	ast six months?			Yes	No
	If Yes, quantity per day?						
1.2	2 Do you consume any form of alcoh	nol?				Yes	No
	If Yes, units per week (1 unit = 1 bo	ottle of beer or 1 glass of v	vine or 1 tot of spir	its/liquor)?			
1.3	Have you ever received medical actobacco consumption?	dvice or participated in a re	ehabilitation progra	amme to reduce	e alcohol and/or	Yes	No
	If Yes, please provide details						
2. M e	easurements						
2.2	2 Height	, m	Weight	kg			
2.2				kg		Yes	No

Section 5: Underwriting of the additional insured life (continued) Habits, measurements and family history 3. Family history Has any family member suffered from any major illness or hereditary disorders (e.g. heart disease, raised cholesterol, high blood pressure, diabetes, cancer, depression, porphyria, polycystic kidneys) under the age of 60? If Yes, please provide full details

Relation Condition Age diagnosed I declare that all the information that I have supplied about my health, hobbies and occupation is correct and complete. D D - M M - 2 0 Date Signature of insured life Medical doctor of the insured life Please indicate the name of the doctor to whom we may send the reasons for health loadings or results of an HIV test. Confidential correspondence: Confidential doctor (may not be a hospital) Initials Surname Telephone - work Postal address Postal code Current/Most recent doctor (if other than the above) Surname Initials Telephone - work When did he/she become your regular doctor? **Fastlane** Consultation address

Section 6: Additional benefit information

A. Income Protector and Temporary Income Protector

Income used in determining the benefit amount is defined as one of the following:

Gross Taxable Income

Taxable income payable or benefits receivable on account of the insured life's employment, or any services rendered by the insured life.

Cost to Company Income

This equals Gross Taxable Income plus the value of the use of a motor vehicle, as well as the employer's contributions to a medical scheme and a pension fund and the cost of any other benefits paid for by the insured's employer and drawings in the form of dividends.

Gross Professional Income (professionals only)

For professionals that charge a fee for services, this equals the sum of the professional fee and the net income from trading activities, after deducting business overheads expenses.

- 1. Details of income
 - 1.1 What was your average monthly income from your occupation for the last 12 months?
 - 1.2 What amount of this income is based on commission?
 - 1.3 Income from other sources (other occupations, investments, rentals, etc.) will not be taken into account when determining a benefit amount. Do you receive such income?

R		
R		
	Yes	No

Postal code

Yes

No

Section 6: Additional benefit information (continued)

A. Income Protector and Temporary Income Protector (continued)

	If Yes, please provide details:				
					_
1.4	What will your projected monthly income for the next 12 months be?	R			
Do	es your group benefit include an income disability benefit?		Yes	No	
If Y	es, please specify the amount:	R			
If s	elf-employed, is the business based at your home?		Yes	No	
Bu	siness Overheads Protector				
Nu	mber of employees				
Nu	mber of employees with your professional or trade qualifications				
De	ails of your interest in the business:				
3.1	Total monthly overhead expenses	R			
3.2	Your percentage (%) share of overhead expenses				
3.3	Percentage (%) of business turnover from sale of goods				
3.4	Number of associates				
3.5	Your percentage (%) share of the business				_
If s	elf-employed, is the business based at your home?		Yes	No	
Bus	siness Protector (Only for professionals)				_
	nefit amount is based on the sum of the professional fees, plus net income from trading activities.				
Wh	at was your average monthly fee income and net income from trading activities in the last 12 months?	R			
Wh	at is your expected average monthly fee income and net income from trading activities for the next 12 months?	R			=

Please fill in if you are the underwritten insured life on a Funeral Benefit and have children insured lives or extended family insured lives covered under the benefit.

Child insured life(lives)

	Name and surname	Gender	Relationship			Ide	entity i	numb	er		
1											
2											
3											
4											
5											

Extended family insured life(lives) (The spouse is not considered an extended family member)

	Name and surname	Gender	Relationship			Ide	entit	ty nu	ımbe	er		
1												
2												
3												
4												
5												
6												
7												
8												

Section 6: Additional benefit information (continued) D. Funeral Benefit (continued) Has any of the children insured lives or extended family insured lives, to your knowledge, ever been hospitalised, Yes No received treatment for any chronic condition or seen a specialist in the last year? If Yes, please provide details including name of insured life and condition or impairment: **E. Education Protector** Details of biological/legally adopted child(ren) linked to an Education Protector. Name and surname Gender Date of birth Identity number Section 7: Details of premium payer If you have already filled in the personal details of the premium payer, please indicate the client number: Client number If you have not completed the personal details of the premium payer on the client page, please complete this part: Title Initials First name Surname/name of legal entity Contact person in case of legal entity Type of entity Company/close corporation Natural person/non-taxable institution/sole proprietor Partnership English Female Afrikaans Gender Male Correspondence language Date of birth Nationality Permanent identity/passport number Permanent RSA ID No Registration number* Postal address Postal code Residential address Postal code Telephone - work Fax - work Telephone - home Fax - home Cellphone number

Note: Certain Momentum documents are not yet available electronically and the posting of those will continue for the time being.

Post

E-mail

Which method of communication do you prefer?

E-mail address

^{*} Registration number is compulsory for companies and close corporations.

Se	ction	8: Prem	ium details																						
Pre	ferred d	ay of the mo	onth that Moment	um should co	ollect the	e pre	mium (1	1-31)																	
Myr	iad prer	mium amour	nt	R			[Paym	ent	freq	quen	су	М	onth	ıly			Ye	arly		
Nar	ne of ac	count holde	er																						
Nar	ne of fin	ancial institu	ution																						
Acc	ount nu	mber																							
Acc	ount typ	e		Current		Sav	/ings		Trar	nsmiss	sion														
Bra	nch cod	e							Bran	ch nar	me														
Sho	uld Mor	mentum gro	up all collections	from this acc	ount nur	mber	and de	educt	them fr	om yo	our acc	count	as o	one	amo	ount	t?		Ye	es			No)	
in m thar	ny bank n that sp	details and pecified.	horise Momentun I authorise Mom										Mon	nent	tum	ma	y de	ebit ı	my a	acco	unt	on a			
5	Signatu	re of accou	nt holder										Di	ate		D	_	IVI	M	-	2	0			
	Title		First name a					1	Relation to appli	icant	M		or M							gistra					this
If y	ou have	already fil	eficiary for	nal details o	f the be	nefic	ciary fo	r owr												ient part		mbe	r		
		-							Relatio			nder					_								
	Title	Initials	First name a	nd surname/r	name of	lega	l entity		to appl			/F		Į,	den	tity	num	ber/	/Reg	gistra	atior	n nu	mbe	er	
1																									
Sig	nature(s) of witnes	sses											Da	ate	D	D	-	M	M	-	2	0	Υ	Υ
		Signature of witness								ignatu f witne															

Section 11: Risk benefit details

Initials and surname of the insured life			Client number	Are you exercising a	Are you exercising an option to purchase this benefit? Yes	o Z
Initials and surname of second insured life*			Client number	If Yes, please attach the relevant form	the relevant form	
Initials and surname of child			Child number	(Exercising options w	(Exercising options with limited evidence of health – MOMUW100)	
Stand-alone benefits (Choose only one of the following benefits):	efits):					
Death Benefit	Compreh	Comprehensive Disability Benefit	Temporary Income Protector		Elevated Comprehensive Critical Illness Benefit	
Modified Death Benefit	Own Occ	Own Occupation Disability Benefit	Business Overheads Protector		Elevated Comprehensive Critical Illness Plus Benefit	nefit
Unnatural Death Benefit	Compreh	Comprehensive ADW Disability Benefit	Business Protector	Ac	Accidental HIV Benefit	
Last Survivor Death Benefit*	ADW Dis	ADW Disability Benefit	Functional Protector	Fu	Future Cover – Death	
Education Protector – Death and Disability*	Function	Functional Impairment Benefit	Comprehensive Living Benefit	Fu	Future Cover – Death and Disability	
Education Protector – Death and Impairment*	Physical	Physical Impairment Benefit	Comprehensive Critical Illness Benefit			
Education Protector – Death*	Income Protector	rotector	Comprehensive Critical Illness Plus Benefit	O *	* Details for a second insured life are required for these benefits	oenefits.
Stand-alone benefit options						
Benefit amount R	L	Premium pattern:	Tapering age:		Waiting period:	
Benefit term:	7	Level	None	From age 55	Income Protection Benefits	
Whole life To retirement age	O	Compulsory	From age 60	From age 65	7 days 6 m	6 months
To age 70 Fixed term	S	Stepped 10 years 15 years	S		1 month 12 r	12 months
To age 65	<u> </u>	Premium guarantee options:	Additional feature:		3 months 24 r	24 months
	S	Standard	Premium payback option		Payment term: (Temporary Income Protector)	ector)
	Ш	Extended			6 months 12 r	12 months
Percentage of regulated commission required %	_	10-year capped			24 months	
Increase options					Beneficiaries	Benefit share
Premium increases:	>	Voluntary benefit amount increases:			Beneficiary number	%
Compulsory increase	ш	Fixed (DFIX)	% '		Beneficiary number	%
Voluntary increase	O	CPI increase rate (DVPI)			Beneficiary number	%
CPI increase rate (PVP)	Ľ	Rand Depreciation Index (DRDE)			Beneficiary number	%
Details of ancillary benefits						
Disability/Impairment (Choose only one of the following benefits):	<u></u>	Critical Illness (Choose only one of the following benefits):	enefits): Living Benefits (Choose only one of the following benefits):	e of the following benefits):	Premium Waivers:	
Comprehensive Disability Benefit		Elevated Comprehensive Critical Illness Plus Benefit	Benefit Comprehensive Living Benefit		Client number Level	Increasing
Own Occupation Disability Benefit		Elevated Comprehensive Critical Illness Benefit	efit Homeloan Protector		Death	or
Comprehensive ADW Disability Benefit		Comprehensive Critical Illness Plus Benefit			Comprehensive Disability	or
ADW Disability Benefit		Comprehensive Critical Illnes Benefit			Functional Impairment	or
Functional Impairment Benefit					Client number	
Tapering age: None From	From age 55	Benefit term: Whole life	To age 65 Benefit term: Whole life	To age 65	Death	or
From age 60 From	From age 65	Benefit amount R	Benefit amount R		Comprehensive Disability	or
əfit					Functional Impairment	or
Whole life To age 70	To age 65					
Benefit amount						

Section 11: Risk benefit details

Initials and surname of the insured life		Client number	Are you exercising an	Are you exercising an option to purchase this benefit? Yes	o N
Initials and surname of second insured life*		Client number	If Yes, please attach the relevant form	le relevant form	
Initials and surname of child		Child number	(Exercising options wit	(Exercising options with limited evidence of health – MOMUW100)	
Stand-alone benefits (choose only one of the following benefits):	its):				
Death Benefit	Comprehensive Disability Benefit	Temporary Income Protector	Elev	Elevated Comprehensive Critical Illness Benefit	
Modified Death Benefit	Own Occupation Disability Benefit	Business Overheads Protector	Elev	Elevated Comprehensive Critical Illness Plus Benefit	nefit
Unnatural Death Benefit	Comprehensive ADW Disability Benefit	Business Protector	Acci	Accidental HIV Benefit	
Last Survivor Death Benefit*	ADW Disability Benefit	Functional Protector	Futc	Future Cover – Death	
Education Protector – Death and Disability*	Functional Impairment Benefit	Comprehensive Living Benefit	Futc	Future Cover – Death and Disability	
Education Protector – Death and Impairment*	Physical Impairment Benefit	Comprehensive Critical Illness Benefit			
Education Protector – Death*	Income Protector	Comprehensive Critical Illness Plus Benefit	* Def	* Details for a second insured life are required for these benefits	benefits.
Stand-alone benefit options					
Benefit amount R	Premium pattern:	Tapering age:		Waiting period:	
Benefit term:	Level		From age 55	Income Protection Benefits	
Whole life To retirement age	Compulsory	From age 60	From age 65	7 days 6 m	6 months
To age 70 Fixed term	Stepped 10 years				12 months
To age 65	Premium guarantee options:	Additional feature:		3 months 24 r	24 months
	Standard	Premium payback option		Payment term: (Temporary Income Protector)	ector)
	Extended			6 months 12 r	12 months
Percentage of regulated commission required %	10-year capped			24 months	
Increase options				Beneficiaries	Benefit share
Premium increases:	Voluntary benefit amount increases:	in		Beneficiary number	%
Compulsory increase	Fixed (DFIX)	% '		Beneficiary number	%
Voluntary increase , %	CPI increase rate (DVPI)			Beneficiary number	%
CPI increase rate (PVP)	Rand Depreciation Index (DRDE)			Beneficiary number	%
Details of ancillary benefits					
Disability/Impairment (Choose only one of the following benefits):	Critical Illness (Choose only one of the following benefits):	e following benefits): Living Benefits (Choose only one of the following benefits):	of the following benefits):	Premium Waivers:	
Comprehensive Disability Benefit	Elevated Comprehensive Critical Illness Plus Benefit	Iness Plus Benefit Comprehensive Living Benefit		Client number	Increasing
Own Occupation Disability Benefit	Elevated Comprehensive Critical Illness Benefit	Iness Benefit Homeloan Protector		Death	or
Comprehensive ADW Disability Benefit	Comprehensive Critical Illness Plus Benefit	s Benefit		Comprehensive Disability	or
ADW Disability Benefit	Comprehensive Critical Illnes Benefi	efit		Functional Impairment	or
Functional Impairment Benefit				Client number	
Tapering age: None From a	From age 55 Benefit term: Whole life	To age 65 Benefit term: Whole life	To age 65	Death	or
From age 60 From a	From age 65 Benefit amount R	Benefit amount R		Comprehensive Disability	or
əfit				Functional Impairment	or
Whole life To age 70	To age 65				
Benefit amount R					

Section 12: Savings Benefit and Retirement Provider details

Prease choose one of the following stand-arone benefits. Initials and surname of Savinos Benefit insured life	Savings Benefit	Recurring-premium Retirement Provider	Single-premium Retirement Provider Client number
Initials and surname of second Savings Benefit insured life			Client number
α α	Term: Fixed To retirement age	Choose one investment fund: RMB Money Market RMB Absolute Focus	Momentum Builder Momentum Consolidator Momentum Defender
Volunta	Transfer from a non-retirement annuity fund Transfer from a retirement annuity fund	RMB Balanced RMB International Balanced FoF* LifeCycle Philosophy	RMB High Tide RMB Property Other
If yes, transferring fund name:		Momentum Accumulator	* Not available on the Retirement Provider.
Premium increases ,	Client number Client number Level Increasing Comprehensive Disability or Functional Impairment or	Client number Level Increasing Death or Comprehensive Disability or Functional Impairment or	
Please choose one of the following stand-alone benefits initials and surname of Savings Benefit insured life initials and surname of second Savings Benefit insured life	Savings Benefit	Recurring-premium Retirement Provider	Single-premium Retirement Provider Client number
	Term: Fixed To retirement age	Choose one investment fund: RMB Money Market RMB Absolute Focus RMB Balanced	Momentum Builder Momentum Consolidator Momentum Defender RMB High Tide
Volunt	Transfer from a non-retirement annuity fund Transfer from a retirement annuity fund	RMB International Balanced FoF* LifeCycle Philosophy Momentum Accumulator	RMB Property Other * Not available on the Retirement Provider.
Premium increases Voluntary increase CPI increase rate (PVPI) Beneficiaries Benefit share Benefit share Benefit share Benefit share Where the stare the star t	Client number Level Increasing Death or Comprehensive Disability or Functional Impairment or	Client number Level Increasing Death Comprehensive Disability Functional Impairment or	

Section 13: Savings Benefit and Retirement Provider commission Advice fee - recurring premium

Commission as percentage of recurring premium	Advanced %
	As & when %
	Total (0 - 5%) %
Advice fee - single premium	Initial commission (0 - 3%) %
Replacement where the penalty is more than 15%	Yes No
Section 14: Funeral Benefit detail	s
Client number	
Initials and surname of underwritten insured life	
Benefit amount	R
Benefit amount increases	Fixed 5% per year (DFIX) CPI increase rate (DVPI)
Commission	
Percentage of regulated commission required	%
Beneficiaries	
Beneficiary number	Benefit share %
Beneficiary number	Benefit share %
Client number	
Initials and surname of second underwritten insur	ed life
Benefit amount	R
Beneficiaries	
Beneficiary number	Benefit share %

Section 15: Declaration by applicant(s), insured life/lives and fund member

I accept and understand that I am limiting my right to privacy. To enable the assessment of the risks and the calculation of the premium and to assist in considering any claim for benefits as a result of this, or any other application for insurance that I have made, or that was made for me as the insured life, I authorise the Momentum Group Limited (Momentum), including their current and future subsidiaries and/or representatives:

Benefit share

- to obtain from any person, other insurer, medical aid, medical practitioner/institution, any information that Momentum requires for purposes of underwriting this application and/or claims arising from this policy. I authorise such person(s) to give the said information to Momentum, and
- to share with other insurers any information in this application or in any related policy or other document, either directly or through a database operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as Momentum or the operators of such database may decide from time to time, and
- to disclose my medical information to any parties that Momentum uses in providing services in connection with the policy. I acknowledge that I cannot cancel this authorisation and that it will endure after my death.

I declare and confirm the following:

Beneficiary number

- 1. This application and any supplementary documents that were submitted in connection with it, form the basis of the contract I intend entering into.
- 2. All information that I have supplied is correct and complete.
- 3. That, should any material information be withheld or incorrectly furnished during the application process, Momentum may cancel the insurance contract or rectify the terms on which the contract was issued, and premiums paid may be used to offset expenses incurred by Momentum.
- 4. That it is prohibited in terms of the Long Term Insurance Act to sign a blank or incomplete application form. I acknowledge and understand that Momentum and/or any of its subsidiaries, agents and/or authorised representatives will not be responsible for any damage or loss that I sustain as a result of signing this application before completing it in full.
- 5. I will inform Momentum in writing if a change takes place in the health, avocation or occupation of the insured life(lives) between the date of this application and either the starting date of the policy, or the acceptance date, whichever occurs last. Where free cover is applicable, the duty to disclose changes in health terminates on the acceptance date. Failure to disclose these changes may result in the cancellation of the benefits and premiums paid may be used to offset expenses incurred by Momentum.
- 6. I understand that Momentum requires the insured life/lives to undergo an HIV test.
- 7. I consent that Momentum may communicate any information disclosed in this application to any person who may acquire rights to the policy in future

Section 15: Declaration by applicant(s), insured life(lives) and fund member (continued)

- 8. I understand that a cession of this policy will amend the legal obligation of the insurer to the policy beneficiary. Momentum will pay the proceeds of the policy to the cessionary and not to the beneficiary.
- 9. I understand that changes to the beneficiaries may be made under this policy by notifying Momentum in writing. Momentum must receive such notice prior to the death of the insured life.
- 10. If I find that this policy or any of the benefits that it contains are not what I require, I may cancel it. I will do so by informing Momentum in writing within 30 days of the date that I receive the acceptance letter or 60 days from the starting date of this policy, whichever occurs first. Momentum will refund any premiums that I have paid, as long as it has not yet paid any benefit and I have not claimed a benefit and an insured event has not yet occurred. Momentum will, however, deduct the cost of any risk cover that I enjoyed and where applicable, the costs of investment losses and/or currency fluctuations.
- 11. I have read the valid quotation that Momentum has issued that sets out the policy benefits for which I have applied on the properly completed policy application form. I confirm that my authorised financial adviser has explained the contents of the quotation to me and I agree that the details set out in it are binding.
- 12. I accept all risks associated in communicating with Momentum via the electronic medium as selected in this application. I indemnify Momentum against any consequent loss that any third party or I may suffer as a result of the misuse, misapplication or misinterpretation of this communication.
- 13. Where Momentum is liable to pay interest on any amount(s) owed in terms of this contract, Momentum will determine the rate of interest to be applied in accordance with Momentum's business practice at that time.
- 14. I accept that it is my sole responsibility to ensure that all premiums are paid and if premiums are in arrears or should I fail to pay premiums, it will prevent me from submitting any claim for benefits that the policy provides and may also result in the cancellation of the policy.
- 15. I agree that I shall inform Momentum in writing in the event that the insured life (lives) emigrates or is relocated to another country or if any new vocation followed outside South Africa increases the insured life (lives) risk (including, but not limited to hobbies, humanitarian assistance and extramural activities, and the like).
- 16. I accept that once the policy has lapsed or terminated that I will not be eligible for any benefits under the policy, irrespective of when any alleged event happened.

Free cover

17. I acknowledge that a claim, based on free cover that Momentum offers, is also subject to the declaration and any terms and conditions contained in this application form.

Immediate cover

18. I acknowledge that a claim, based on my *Application for immediate cover* (MOMUW 064), is also subject to the declaration and any terms and conditions contained in this application form.

Momentum Interactive

- 19. I acknowledge, where I chose to become a member of Momentum Interactive, that I have read the terms and conditions that apply to membership.
- 20. Momentum Interactive offers two choices if you qualify for a premium discount. Please select the option that you require:

,	
Contract premium remains unchanged (life cover will increase)	
Reduce contract premium (life cover remains unchanged)	
If no option is selected, then the contract premium will reduce and the life cover will remain unchanged.	

Replacement of policies

21. Amounts payable under this policy are subject to the cancellation of all policies to be replaced as indicated in the *Replacement policy advice record*. If you fail to cancel the policy/policies you have indicated are being replaced, Momentum will adjust, or entirely cancel, the policy benefits this policy offers. You may further forfeit any premiums you paid on this policy to cover costs and commission payments.

Signature(s) of applicant(s)		Date D D - M M - 2 0 Y Y
Client number	Client number	

Section 16: Terms and conditions for Retirement Provider and Savings Benefit General

I declare and confirm the following:

- 1. The original policy contract will incorporate by reference, the contractual terms and conditions of the application to add a Retirement Provider benefit to an existing Myriad policy and it will form part of the original terms and conditions. Should a dispute arise as to the interpretation of the policy contract, the original terms and conditions will apply.
- 2. I understand the inherent risks of signing a blank or incomplete application form. I acknowledge and understand that Momentum and/or any of its subsidiaries, agents and/or authorised representatives will not be responsible for any damage or loss that I sustain if I sign this application before completing it in full.
- 3. All information that I have supplied is correct and complete.

Section 16: Terms and conditions for Retirement Provider and Savings Benefit (continued) General (continued)

- 4. I have read the valid quotation that Momentum has issued that sets out the policy benefits for which I have applied on the properly completed policy application form. I confirm that my authorised financial advisor has explained the contents of the quotation to me and I agree that the details set out in it are binding.
- 5. I understand that a cession of this policy in terms of the Pension Funds Act will amend the legal obligation of the insurer to the policy beneficiary. Momentum will pay the proceeds of the policy in accordance with the cession whilst operative.
- 6. I understand that I may cancel or change the beneficiaries under the policy by notifying Momentum in writing. Momentum must receive such notification prior to my death.
- 7. I accept all risks associated in communicating with Momentum via electronic medium as selected in this application form. I indemnify Momentum against any consequent loss that any third party or I may suffer as a result of the misuse, misapplication or misinterpretation of this communication. In the event of a conflict between the contents of the electronic communication and any subsequent written instruction of the policyholder, the electronic communication will be binding on the policyholder.
- 8. I accept that it is my sole responsibility to ensure that all premiums are paid.

LifeCycle Philosophy

- 9. I acknowledge that Momentum has based this philosophy on four portfolios with different risk profiles. Momentum will automatically switch my investment from portfolio to portfolio, depending on the remaining term to the contract maturity date, unless Momentum receives a witten instruction from me, where I clearly indicate my specific investment choice.
- 10. Momentum reserves the right to alter the term to the maturity date that activates the switch from one portfolio to another. The effective date of a switch may also depend on my age.
- 11. As I near my specified contract maturity date, I authorise Momentum to implement a conservative investment approach.

Fees

- 12. Momentum will pay the financial adviser's fees that this application form sets out. Momentum will deduct these fees from my investment. I acknowledge that these fees are based on the agreement between the financial adviser and me.
- 13. The new business documents will clearly specify all fees that Momentum charge under these contracts. Momentum will send these to me after it has accepted the application. It is the responsibility of the financial adviser to make sure that I am fully informed of all fees and costs under this agreement.
- 14. Momentum reserves the right to review its fees that apply to the contract after giving appropriate and reasonable notice of these changes.

Retirement Provider

- 15. I apply for membership of the Momentum Retirement Annuity Fund (the fund), whichever applies to me, and agree that the provisions contained in the rules of that fund will be binding. The Momentum Group, a registered long-term insurer, underwrites and administers the fund.
- 16. This application, the fund rules, the policy issued to the fund in relation to this investment and other new business documents govern the legal relationship between me as member of the fund, the fund and Momentum.

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If not any of the existing clients, please complete a separate Multiply application form (MULTIPLY001)

Section 17: Multiply (continued) **Contract details** Contributions will be calculated based on the membership composition: Single member Family of two Family of three or more 2 Starting date Frequency Monthly Name of previous lifestyle programme * Please provide proof of status with the most recent statement (not older than one month) Previous lifestyle programme status* Section 18: Terms and conditions for Multiply I, the principal member, hereby apply for my dependants (where applicable) and me to become members of Multiply, which is administered by Momentum Interactive (Pty) Ltd. If Momentum Interactive (Pty) Ltd accepts this application then this application will serve as evidence that I agree to be bound by the rules of Multiply and undertake to adhere to such rules at all times. I may obtain a copy of the rules from the Momentum website (www.momentum.co.za) or the Multiply client contact centre at 0861 88 66 00. I consent to paying the monthly contributions in return for the benefits supplied by Multiply to my dependants (where applicable) and myself. I understand that it is my sole responsibility to ensure that my monthly contributions are received by Momentum Interactive (Pty) Ltd. I acknowledge that Momentum Interactive (Pty) Ltd reserves and shall have the right to cancel the membership applied for herein if I or any of my 3. dependants (that are members of the programme by virtue of this application) breach any of the terms and conditions of this agreement inclusive of rules and regulations pertaining to the Multiply programme in force from time to time. Momentum Interactive (Pty) Ltd reserves the right to amend the rules referred to in 1 above and the Multiply benefits unilaterally from time to time, but shall inform members of any such amendments. I understand that I may cancel my participation on Multiply at any time, including when I do not accept the amended rules and benefits. Section 19: save thru spend Momentum has a unique reward programme, save thru spend, which allows you to save while you spend. Yes Tick the box and save thru spend will call you with more information. Section 20: Signatures I acknowledge that I have read the declaration above, that I fully understand its nature and effect and that it will be binding. Signed at Signature(s) Signature of parent/guardian or trustee (if applicable) Client number Client number Client number

Client number

Client number

Client number

Client number

Client number

Client number



Replacement policy advice record
(Please complete in consultation with your adviser – please note that this does not serve as a cancellation of the replaced policy; you must

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Did you establish whether the existing/terminated policy could be amended to provide similar benefits to the replacement policy? If such amendment is/was possible, why do you regard it as appropriate to replace the terminated policy by the replacement policy?

3. Declaration (compulsory)

Intermediary

I confirm that I have taken all reasonable steps to confirm that the information in this Replacement Policy Advice Record (RPAR) is true and correct. I confirm that in pursuance of my advice to the policyholder to replace the policy/ies mentioned in the RPAR, I have fully discharged my duties as set out in section 8 (d) of the General Code of Conduct for Authorised Financial Services Providers and their Representatives (the Code) and have retained a record of such advice as required by section 3 of the said Code.

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Policyholder																								
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