momentum

Application for Myriad

Policy number

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 number this application of

How many clients (insured lives and applicants) are there under this policy?

How many stand-alone benefits does this policy have (total of all insured lives)?

How many beneficiaries does this policy have?

Multiply application included? Yes No Is this a conforming policy? Yes No

Starting date of policy

Automatic starting date — The starting date will be the first day of the month following the acceptance of the benefits.

Fixed starting date* 0 1 – M M – 2 0 Y Y

* The starting date will be the date that the applicant has indicated, unless:

1. Momentum accepts the benefits after the date that the applicant has indicated and provided that none of the insured lives has had a birthday between the indicated date and the date of acceptance. The starting date will then be the first day of the month following acceptance.
2. Momentum accepts the benefits after the date that the applicant has indicated and one of the insured lives has had a birthday between the indicated date and the date of acceptance. The starting date will then be the first day of the month of the insured life's birthday.

Financial adviser details

The commission split below applies to the entire policy contract.

* Please complete details of servicing financial adviser.

Name	Financial adviser's code	Broker house code	Commission ref no	Commission split %
*				

Are you registered to market life insurance under the Association for Savings & Investment South Africa (ASISA) and are you fully conversant with and do you accept the 'S' reference system and the consequences thereof? Yes No

Fastlane requires the financial adviser's consent for the Momentum medical staff to visit the client

I request Momentum to contact my client(s) directly if the company requires additional medical information or tests. If you do not want Momentum to contact your client, please mark No. (This service may not be available in certain areas and/or for specialised examinations.) Yes No

Please complete the consultation address of the client in the space that we provide below the doctor's information in Section 1.

FICA declaration

I confirm that I have identified the client, including the policyholder, insured life/lives, premium payer and cessionary, where applicable, and verified his/her/their details on this contract under the requirements that Section 21 of the Financial Intelligence Centre Act, No 38 of 2001 sets out. I further confirm that, in terms of section 22 of the same Act, I have stored all the verification documents. Yes No

Signature of servicing financial adviser

Date D D – M M – **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 ☐

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.

Signature of financial adviser ☐ **Date** D D – M M – **2 0** Y Y

Marketing adviser details

Name ☐ Marketing adviser's code ☐

Branch name ☐ Telephone - work ☐

Section 1: Insured life details

ROLE(S) Tick the appropriate role(s) that this client will play on this policy:

Client number **0 1** Policyholder (contracting party) ☐ % Ownership ☐ Insured life X

Title ☐ Initials ☐ First name ☐

Surname ☐

Previous surname(s) ☐

Gender Male ☐ Female ☐ Correspondence language English ☐ Afrikaans ☐

Date of birth D D – M M – Y Y Y Y Nationality ☐

Permanent identity/passport number ☐ Permanent RSA ID Yes ☐ No ☐

Postal address ☐

Postal code ☐

Residential address ☐

Postal code ☐

Telephone - work ☐ Fax - work ☐

Telephone - home ☐ Fax - home ☐

Cellphone number ☐

E-mail address ☐

Which method of communication do you prefer? Post ☐ E-mail ☐

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

Are you currently insolvent? Yes ☐ No ☐ If Yes, date of insolvency D D – M M – Y Y Y Y

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

Interest of applicant in the insured life (need for insurance or insurable interest): Business overheads cover ☐ Buy-and-sell ☐ Contingent liability ☐ Debtor's cover ☐ Income replacement ☐ Keyperson ☐ Loan account protection ☐ Personal/Estate duty ☐ Security for loan/bond ☐

Section 1: Insured life details (continued)

Highest educational qualification
No matric | Matric | 3-year diploma | 3-year degree / 4-year diploma | 4-year degree / professional

Highest educational qualification of spouse
No matric | Matric | 3-year diploma | 3-year degree / 4-year diploma | 4-year degree / professional

Name of educational institution

Monthly income
Insured life R | Spouse R

Self-employed
Yes | No

Occupation

Have you been continuously employed in a permanent and full-time occupation for at least two years?
Yes | No

Percentage of working hours spent on travel %
Percentage of working hours spent on administration %
Percentage of working hours spent on supervision %
Percentage of working hours spent on manual labour %

Description of main duties

Employer

Years with current employer
Industry

Do you intend to change your career or to become involved in any other occupation?
Yes | No

If Yes, please provide details

Will your occupation require you to travel or reside outside the borders of the RSA?
Yes | No

If Yes, to which country, for how long and how often?

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 | No

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 | Platinum | Private club | New application*

** For calculation purposes only, we regard the Multiply status as Bronze.*

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 ☐
Triathlon	Sprint distance ☐	Olympic distance and longer ☐
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 (e.g. aviation, diving, racing, parachuting, mountaineering, mining)? Yes ☐ No ☐

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 medically boarded, or have you ever submitted claims for disability or third-party benefits? Yes ☐ No ☐

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, raised cholesterol, palpitations, heart attack, heart murmur, rheumatic fever, stroke, brain disorders or any cardiac procedures)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

2. Respiratory and/or lung complaints

Do you have, or have you previously had any respiratory and/or lung complaints (e.g. asthma, bronchitis, tuberculosis, persistent coughing or any breathing problems)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	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. hiatus hernia, gall stones, hepatitis A/B/C, jaundice, gastric ulcers or recurrent indigestion problems)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

4. 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 stones, bladder infection, blood in urine, protein in urine or prostate problems)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

Section 2: Underwriting of the insured life (continued)

Medical history (continued)

5. Nervous or mental disorders

Do you have, or have you previously had any nervous or mental disorders (e.g. depression, anxiety, consultation(s) with psychiatrist/psychologist, stress, epilepsy, migraine or blackouts)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

6. Disorders of the eye, ear, nose or throat

Do you have, or have you previously had any disorders of the eye (excluding conditions corrected by glasses, contact lenses or keratotomy), ear, nose or throat (e.g. defective vision, hearing loss, hoarseness)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

7. Problems with your spine, joints, bones, muscles, limbs or skin

Do you have, or have you previously had any problems with your spine, joints, bones, muscles, limbs or skin (e.g. back problems, neck problems, fractures/broken bones, gout, any arthritis, psoriasis, dermatitis)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

8. Diabetes, raised blood sugar, other endocrine, glandular, blood or hormonal disorders

Do you have, or have you previously had any form of diabetes, raised blood sugar, other endocrine, glandular, blood or hormonal disorders (e.g. thyroid or other glands problems, anaemia or bleeding disorders)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

9. Any form of cancer, growth or tumour

Do you have, or have you previously had any form of cancer, growth or tumour (including fibroadenomas, moles removed - both either malignant or benign)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

10. Drugs, tranquillisers or any other medicines

Are you taking, or have you ever taken any drugs, tranquillisers or any other medicines in any form for any other reason than colds and flu (e.g. antidepressants, tranquillisers, any homeopathic medicines, cannabis or cocaine)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

11. Have you sought any medical advice during the last five years for any condition or symptoms, or have you been a patient in a hospital or nursing home, or undergone any medical examination (including but not limited to ECG, scans, x-ray examinations or specialised laboratory tests) not mentioned above? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

Section 2: Underwriting of the insured life (continued)

Medical history (continued)

12. Have you ever been tested for, or received any medical advice, counselling or treatment in connection with AIDS, or any infection by one of the HI-viruses, or any sexually transmitted diseases (e.g. gonorrhoea, syphilis or genital herpes)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

13. Are you aware of any other illness, disorder, disability or accident, including motor vehicle accidents or other factors (past or present) which may influence the risk applied for on this policy? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

14. Do you have any intention of having medical investigations, procedures or check-ups done for any condition in the near future? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

Habits, measurements and family history

1. Habits

1.1 Have you smoked or used any other form of tobacco in the past six months? Yes ☐ No ☐

If Yes, quantity per day? ☐☐☐

1.2 Do you consume any form of alcohol? Yes ☐ No ☐

If Yes, how many units per week (1 unit = 1 bottle of beer or 1 glass of wine or 1 tot of spirits/liquor)? ☐☐☐

1.3 Have you ever received medical advice or participated in a rehabilitation programme to reduce alcohol and/or tobacco consumption? Yes ☐ No ☐

If Yes, please provide full details _____

2. Measurements

2.2 Height ☐,☐☐ m Weight ☐☐☐ kg

2.2 Has your weight changed by more than 5 kg during the last year? Yes ☐ No ☐

If Yes, please indicate how much it has changed by ☐☐☐ (kg), and why? _____

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? Yes ☐ No ☐

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.

Signature of insured life _____ **Date** D D – M M – **2 0** Y Y

Section 2: Underwriting of the insured life (continued)

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)

Surname | Initials

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? D D – M M – Y Y Y Y

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

   1.1 What was your average monthly income from your occupation for the last 12 months? R

   1.2 What amount of this income is based on commission? R

   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? Yes No

   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

   If Yes, please specify the amount: R

3. If self-employed, is the business based at your home? Yes No

Section 3: Additional benefit information (continued)

B. Business Overheads Protector

1. Number of employees
2. Number of employees with your professional or trade qualifications
3. Details 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
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.

1. What was your average monthly fee income and net income from trading activities in the last 12 months? R
2. 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	Gender	Relationship	Identity number
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, received treatment for any chronic condition or seen a specialist in the last year? Yes No

   If Yes, please provide details (including name of insured life and medical condition or impairment):

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	Date of birth	Identity number
		D D M M Y Y Y Y	
		D D M M Y Y Y Y	
		D D M M Y Y Y Y	
		D D M M Y Y Y Y	
		D D M M Y Y Y Y	

Section 4: Additional insured life/applicant details

ROLE(S) — Tick the appropriate role(s) that this client will play on this policy:

Client number	**0**	**2**	Policyholder (contracting party)		% Ownership		Insured life	

A. Fill in if this client is an applicant or additional insured life

Title | Initials | First name

Surname/name of legal entity

Previous surname(s)

Contact person in case of legal entity

Gender: Male | Female — Correspondence language: English | Afrikaans

Date of birth: D D – M M – Y Y Y Y — Nationality

Permanent identity/passport number — Permanent RSA ID: Yes | No

Postal address

Postal code

Residential address

Postal code

Telephone - work — Fax - work

Telephone - home — Cellphone number

E-mail address

Which method of communication do you prefer? Post | E-mail

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

Are you currently insolvent? Yes | No — If Yes, date of insolvency: D D – M M – Y Y Y Y

If a legal entity, has the legal entity been liquidated, placed under administration or are there any processes pending against the legal entity for liquidation or administration? Yes | No

Tax status: Company/Close corporation **(M)** | Sole proprietor/Partner **(S)** | Natural person **(N)** | Non-taxable institution **(I)**

Tax status of trust beneficiaries if the applicant is a trust: Company **(C)** | Non-taxable institution **(Z)** | Natural person **(P)**

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

B. Fill in if this client is an insured life

Marital status: Single | Married | Separated | Divorced | Widowed

Interest of applicant in the insured life (need for insurance or insurable interest): Business overheads cover | Buy-and-sell | Contingent liability | Debtor's cover | Income replacement | Keyperson | Loan account protection | Personal/Estate duty | Security for loan/bond

Highest educational qualification: No matric | Matric | 3-year diploma | 3-year degree / 4-year diploma | 4-year degree / professional

Highest educational qualification of spouse: No matric | Matric | 3-year diploma | 3-year degree / 4-year diploma | 4-year degree / professional

Name of educational institution

Monthly income: Insured life R | Spouse R

Self-employed: Yes | No

Occupation

Have you been continuously employed in a permanent and full-time occupation for at least two years? Yes | No

Percentage of working hours spent on travel %

Percentage of working hours spent on administration %

Percentage of working hours spent on supervision %

Percentage of working hours spent on manual labour %

Description of main duties

Employer

Years with current employer

Industry

Do you intend to change your career or to become involved in any other occupation? Yes | No

If Yes, please provide details

Will your occupation require you to travel or reside outside the borders of the RSA? Yes | No

If Yes, to which country, for how long and how often?

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

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

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 ☐ No ☐

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 ☐
Triathlon	Sprint distance ☐	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 (e.g. aviation, diving, racing, parachuting, mountaineering, mining)? Yes ☐ No ☐

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, or reduced any of the benefits applied for, or issued a benefit subject to an exclusion clause, or have you ever been medically boarded or have you ever submitted claims for disability or third-party benefits? Yes ☐ No ☐

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, raised cholesterol, palpitations, heart attack, heart murmur, rheumatic fever, stroke, brain disorders or any cardiac procedures) Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

2. Respiratory and/or lung complaints

Do you have, or have you previously had any respiratory and/or lung complaints (e.g. asthma, bronchitis, tuberculosis, persistent coughing or any breathing problems)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

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

Medical history (continued)

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. hiatus hernia, gall stones, hepatitis A/B/C, jaundice, gastric ulcers or recurrent indigestion problems)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?
		Yes ☐ No ☐	Y Y M M	Yes ☐ No ☐
		Yes ☐ No ☐	Y Y M M	Yes ☐ No ☐

4. 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 stones, bladder infection, blood in urine, protein in urine or prostate problems)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?
		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 had any nervous or mental disorders (e.g. depression, anxiety, consultation(s) with psychiatrist/psychologist, stress, epilepsy, migraine or blackouts)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?
		Yes ☐ No ☐	Y Y M M	Yes ☐ No ☐
		Yes ☐ No ☐	Y Y M M	Yes ☐ No ☐

6. Disorders of the eye, ear, nose or throat

Do you have, or have you previously had any disorders of the eye (excluding conditions corrected by glasses, contact lenses or keratotomy), ear, nose or throat (e.g. defective vision, hearing loss, hoarseness)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?
		Yes ☐ No ☐	Y Y M M	Yes ☐ No ☐
		Yes ☐ No ☐	Y Y M M	Yes ☐ No ☐

7. Problems with your spine, joints, bones, muscles, limbs or skin

Do you have, or have you previously had any problems with your spine, joints, bones, muscles, limbs or skin (e.g. back problems, neck problems, fractures/broken bones, gout, any arthritis, psoriasis, dermatitis)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?
		Yes ☐ No ☐	Y Y M M	Yes ☐ No ☐
		Yes ☐ No ☐	Y Y M M	Yes ☐ No ☐

8. Diabetes, raised blood sugar, other endocrine, glandular, blood or hormonal disorders

Do you have, or have you previously had any form of diabetes, raised blood sugar, other endocrine, glandular, blood or hormonal disorders (e.g. thyroid or other glands problems, anaemia or bleeding disorders)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?
		Yes ☐ No ☐	Y Y M M	Yes ☐ No ☐
		Yes ☐ No ☐	Y Y M M	Yes ☐ No ☐

9. Any form of cancer, growth or tumour

Do you have, or have you previously had any form of cancer, growth or tumour (including fibroadenomas, moles removed - both either malignant or benign)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?
		Yes ☐ No ☐	Y Y M M	Yes ☐ No ☐
		Yes ☐ No ☐	Y Y M M	Yes ☐ No ☐

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

Medical history (continued)

10. Drugs, tranquillisers or any other medicines

Are you taking, or have you ever taken any drugs, tranquillisers or any other medicines in any form for any other reason than colds and flu (e.g. antidepressants, tranquillisers, any homeopathic medicines, cannabis or cocaine)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

11. Have you sought any medical advice during the last five years for any condition or symptoms, or have you been a patient in a hospital or nursing home, or undergone any medical examination (including but not limited to ECG, scans, x-ray examinations or specialised laboratory tests) not mentioned above? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

12. Have you ever been tested for, or received any medical advice, counselling or treatment in connection with AIDS, or any infection by one of the HI-viruses, or any sexually transmitted diseases (e.g. gonorrhoea, syphilis or genital herpes)? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

13. Are you aware of any other illness, disorder, disability or accident, including motor vehicle accidents or other factors (past or present) which may influence the risk applied for on this policy? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

14. Do you have any intention of having medical investigations, procedures or check-ups done for any condition in the near future? Yes ☐ No ☐

Condition/impairment	Doctor's name	Currently on treatment?		Last symptoms	Fully recovered?	
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐
		Yes ☐	No ☐	Y Y M M	Yes ☐	No ☐

Habits, measurements and family history

1. Habits

1.1 Have you smoked or used any other form of tobacco in the past six months? Yes ☐ No ☐

If Yes, quantity per day? ☐☐☐

1.2 Do you consume any form of alcohol? Yes ☐ No ☐

If Yes, units per week (1 unit = 1 bottle of beer or 1 glass of wine or 1 tot of spirits/liquor)? ☐☐☐

1.3 Have you ever received medical advice or participated in a rehabilitation programme to reduce alcohol and/or tobacco consumption? Yes ☐ No ☐

If Yes, please provide details _____

2. Measurements

2.2 Height ☐☐,☐☐ m Weight ☐☐☐ kg

2.2 Has your weight changed by more than 5 kg during the last year? Yes ☐ No ☐

If Yes, please indicate how much it has changed by ☐☐☐ (kg), and why? _____

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? Yes ☐ No ☐

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.

Signature of insured life **Date** D D – M M – **2 0** Y Y

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)

Surname Initials

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? D D – M M – Y Y Y Y

Fastlane

Consultation address

Postal code

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? R

1.2 What amount of this income is based on commission? R

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? 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

2. Does your group benefit include an income disability benefit? Yes No

If Yes, please specify the amount: R

3. If self-employed, is the business based at your home? Yes No

B. Business Overheads Protector

1. Number of employees
2. Number of employees with your professional or trade qualifications
3. Details 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
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.

1. What was your average monthly fee income and net income from trading activities in the last 12 months? R
2. What is your expected average monthly fee income and net income from trading activities for the next 12 months? R

D. Funeral Benefit

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	Identity number
1				
2				
3				
4				
5				

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

	Name and surname	Gender	Relationship	Identity number
1				
2				
3				
4				
5				
6				
7				
8				

Section 6: Additional benefit information (continued)

D. Funeral Benefit (continued)

1. Has any of the children insured lives or extended family insured lives, to your knowledge, ever been hospitalised, received treatment for any chronic condition or seen a specialist in the last year? Yes ☐ No ☐

   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
		D D M M Y Y Y Y	
		D D M M Y Y Y Y	
		D D M M Y Y Y Y	
		D D M M Y Y Y Y	
		D D M M Y Y Y Y	

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 ☐

Gender Male ☐ Female ☐ Correspondence language English ☐ Afrikaans ☐

Date of birth D D – M M – Y Y Y Y Nationality ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Permanent identity/passport number ☐☐☐☐☐☐☐☐☐☐☐☐☐ Permanent RSA ID Yes ☐ No ☐

Registration number* ☐☐☐☐☐☐☐☐☐☐☐☐☐

Postal address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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Residential address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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Telephone - work ☐☐☐ ☐☐☐☐☐☐☐ Fax - work ☐☐☐ ☐☐☐☐☐☐☐

Telephone - home ☐☐☐ ☐☐☐☐☐☐☐ Fax - home ☐☐☐ ☐☐☐☐☐☐☐

Cellphone number ☐☐☐ ☐☐☐☐☐☐☐

E-mail address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Which method of communication do you prefer? Post ☐ E-mail ☐

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

** Registration number is compulsory for companies and close corporations.*

Section 8: Premium details

Preferred day of the month that Momentum should collect the premium (1-31)

Myriad premium amount R - Payment frequency Monthly Yearly

Name of account holder

Name of financial institution

Account number

Account type Current Savings Transmission

Branch code Branch name

Should Momentum group all collections from this account number and deduct them from your account as one amount? Yes No

I, the undersigned, authorise Momentum to debit my account with the premiums due for the insurance. I undertake to inform Momentum of any change in my bank details and I authorise Momentum to verify such bank details with my bank. I accept that Momentum may debit my account on a date other than that specified.

Signature of account holder **Date** D D – M M – 2 0 Y Y

Section 9: Beneficiaries for proceeds (only applies to mortality benefits, Savings Benefit and Retirement Provider proceeds)

	Title	Initials	First name and surname/name of legal entity	Relationship to applicant	Gender M/F	Identity number/Registration number
1						
2						
3						
4						

If there are more than four beneficiaries for proceeds on this contract, please use the *Beneficiary for Myriad form* (MYRIAD010) and attach it to this application form.

Section 10: Beneficiary for ownership of the policy

If you have already filled in the personal details of the beneficiary for ownership, please indicate the client number: **Client number**

If you have not completed the personal details of the beneficiary for ownership on the client page, please complete this part:

	Title	Initials	First name and surname/name of legal entity	Relationship to applicant	Gender M/F	Identity number/Registration number
1						

Signature(s) of witnesses **Date** D D – M M – 2 0 Y Y

Signature of witness

Signature of witness

Section 11: Risk benefit details

Initials and surname of the insured life | Client number

Initials and surname of second insured life* | Client number

Initials and surname of child | Child number

Are you exercising an option to purchase this benefit? Yes | No

If Yes, please attach the relevant form

(*Exercising options with limited evidence of health* – MOMUW100)

Stand-alone benefits *(Choose only one of the following benefits):*

- Death Benefit
- Modified Death Benefit
- Unnatural Death Benefit
- Last Survivor Death Benefit*
- Education Protector – Death and Disability*
- Education Protector – Death and Impairment*
- Education Protector – Death*
- Comprehensive Disability Benefit
- Own Occupation Disability Benefit
- Comprehensive ADW Disability Benefit
- ADW Disability Benefit
- Functional Impairment Benefit
- Physical Impairment Benefit
- Income Protector
- Temporary Income Protector
- Business Overheads Protector
- Business Protector
- Functional Protector
- Comprehensive Living Benefit
- Comprehensive Critical Illness Benefit
- Comprehensive Critical Illness Plus Benefit
- Elevated Comprehensive Critical Illness Benefit
- Elevated Comprehensive Critical Illness Plus Benefit
- Accidental HIV Benefit
- Future Cover – Death
- Future Cover – Death and Disability

* Details for a second insured life are required for these benefits.

Stand-alone benefit options

Benefit amount R

Benefit term:

Whole life | To retirement age

To age 70 | Fixed term

To age 65

Percentage of regulated commission required %

Premium pattern:

Level | Compulsory | Stepped 10 years | 15 years

Premium guarantee options:

Standard | Extended | 10-year capped

Tapering age:

None | From age 55 | From age 60 | From age 65

Additional feature:

Premium payback option

Waiting period:

Income Protection Benefits

7 days | 1 month | 3 months | 6 months | 12 months | 24 months

Payment term: (Temporary Income Protector)

6 months | 12 months | 24 months

Increase options

Premium increases:

Compulsory increase %

Voluntary increase , %

CPI increase rate (PVP)

Voluntary benefit amount increases:

Fixed (DFIX) , %

CPI increase rate (DVPI)

Rand Depreciation Index (DRDE)

Beneficiaries

Beneficiaries	Benefit share
Beneficiary number	%
Beneficiary number	%
Beneficiary number	%
Beneficiary number	%

Details of ancillary benefits

Disability/Impairment *(Choose only one of the following benefits):*

- Comprehensive Disability Benefit
- Own Occupation Disability Benefit
- Comprehensive ADW Disability Benefit
- ADW Disability Benefit
- Functional Impairment Benefit

Tapering age: None | From age 55 | From age 60 | From age 65

- Physical Impairment Benefit

Benefit term: Whole life | To age 70 | To age 65

Benefit amount R

Critical Illness *(Choose only one of the following benefits):*

- Elevated Comprehensive Critical Illness Plus Benefit
- Elevated Comprehensive Critical Illness Benefit
- Comprehensive Critical Illness Plus Benefit
- Comprehensive Critical Illnes Benefit

Benefit term: Whole life | To age 65

Benefit amount R

Living Benefits *(Choose only one of the following benefits):*

- Comprehensive Living Benefit
- Homeloan Protector

Benefit term: Whole life | To age 65

Benefit amount R

Premium Waivers:

Client number	Level		Increasing
Death		or	
Comprehensive Disability		or	
Functional Impairment		or	

Client number			
Death		or	
Comprehensive Disability		or	
Functional Impairment		or	

Section 11: Risk benefit details

Initials and surname of the insured life | Client number

Initials and surname of second insured life* | Client number

Initials and surname of child | Child number

Are you exercising an option to purchase this benefit? Yes | No

If Yes, please attach the relevant form

(*Exercising options with limited evidence of health* – MOMUW100)

Stand-alone benefits *(Choose only one of the following benefits):*

- Death Benefit
- Modified Death Benefit
- Unnatural Death Benefit
- Last Survivor Death Benefit*
- Education Protector – Death and Disability*
- Education Protector – Death and Impairment*
- Education Protector – Death*
- Comprehensive Disability Benefit
- Own Occupation Disability Benefit
- Comprehensive ADW Disability Benefit
- ADW Disability Benefit
- Functional Impairment Benefit
- Physical Impairment Benefit
- Income Protector
- Temporary Income Protector
- Business Overheads Protector
- Business Protector
- Functional Protector
- Comprehensive Living Benefit
- Comprehensive Critical Illness Benefit
- Comprehensive Critical Illness Plus Benefit
- Elevated Comprehensive Critical Illness Benefit
- Elevated Comprehensive Critical Illness Plus Benefit
- Accidental HIV Benefit
- Future Cover – Death
- Future Cover – Death and Disability

* Details for a second insured life are required for these benefits.

Stand-alone benefit options

Benefit amount R

Benefit term:

Whole life | To retirement age

To age 70 | Fixed term

To age 65

Percentage of regulated commission required %

Premium pattern:

Level

Compulsory

Stepped 10 years | 15 years

Premium guarantee options:

Standard

Extended

10-year capped

Tapering age:

None | From age 55

From age 60 | From age 65

Additional feature:

Premium payback option

Waiting period:

Income Protection Benefits

7 days | 6 months

1 month | 12 months

3 months | 24 months

Payment term: (Temporary Income Protector)

6 months | 12 months

24 months

Increase options

Premium increases:

Compulsory increase %

Voluntary increase , %

CPI increase rate (PVP)

Voluntary benefit amount increases:

Fixed (DFIX) , %

CPI increase rate (DVPI)

Rand Depreciation Index (DRDE)

Beneficiaries

Beneficiaries	Benefit share
Beneficiary number	%
Beneficiary number	%
Beneficiary number	%
Beneficiary number	%

Details of ancillary benefits

Disability/Impairment *(Choose only one of the following benefits):*

- Comprehensive Disability Benefit
- Own Occupation Disability Benefit
- Comprehensive ADW Disability Benefit
- ADW Disability Benefit
- Functional Impairment Benefit

Tapering age: None | From age 55 | From age 60 | From age 65

- Physical Impairment Benefit

Benefit term: Whole life | To age 70 | To age 65

Benefit amount R

Critical Illness *(Choose only one of the following benefits):*

- Elevated Comprehensive Critical Illness Plus Benefit
- Elevated Comprehensive Critical Illness Benefit
- Comprehensive Critical Illness Plus Benefit
- Comprehensive Critical Illnes Benefit

Benefit term: Whole life | To age 65

Benefit amount R

Living Benefits *(Choose only one of the following benefits):*

- Comprehensive Living Benefit
- Homeloan Protector

Benefit term: Whole life | To age 65

Benefit amount R

Premium Waivers:

Client number | Level | Increasing

- Death | or
- Comprehensive Disability | or
- Functional Impairment | or

Client number

- Death | or
- Comprehensive Disability | or
- Functional Impairment | or

Section 12: Savings Benefit and Retirement Provider details

Please choose one of the following stand-alone benefits: Savings Benefit ☐ Recurring-premium Retirement Provider ☐ Single-premium Retirement Provider ☐

Initials and surname of Savings Benefit insured life ______ Client number ____

Initials and surname of second Savings Benefit insured life ______ Client number ____

Premium:		**Term:**		**Choose one investment fund:**			
Recurring	R ______ - __	Fixed	☐	RMB Money Market	☐	Momentum Builder	☐
Single	R ______ - __	To retirement age	☐	RMB Absolute Focus	☐	Momentum Consolidator	☐
Single payment date	D D – M M – 2 0 Y Y		☐	RMB Balanced	☐	Momentum Defender	☐
Type of single payment	Voluntary ☐	Transfer from a non-retirement annuity fund	☐	RMB International Balanced FoF*	☐	RMB High Tide	☐
		Transfer from a retirement annuity fund	☐	LifeCycle Philosophy	☐	RMB Property	☐
If yes, transferring fund name:				Momentum Accumulator	☐	Other	______

* Not available on the Retirement Provider.

Premium increases		**Premium Waivers**			**Premium Waivers**		
Voluntary increase ☐	__ , __ %	Client number			Client number		
CPI increase rate (PVPI) ☐			Level	Increasing		Level	Increasing
Beneficiaries		Death	☐ or	☐	Death	☐ or	☐
Beneficiary number	Benefit share ___ %	Comprehensive Disability	☐ or	☐	Comprehensive Disability	☐ or	☐
Beneficiary number	Benefit share ___ %	Functional Impairment	☐ or	☐	Functional Impairment	☐ or	☐

Please choose one of the following stand-alone benefits: Savings Benefit ☐ Recurring-premium Retirement Provider ☐ Single-premium Retirement Provider ☐

Initials and surname of Savings Benefit insured life ______ Client number ____

Initials and surname of second Savings Benefit insured life ______ Client number ____

Premium:		**Term:**		**Choose one investment fund:**			
Recurring	R ______ - __	Fixed	☐	RMB Money Market	☐	Momentum Builder	☐
Single	R ______ - __	To retirement age	☐	RMB Absolute Focus	☐	Momentum Consolidator	☐
Single payment date	D D – M M – 2 0 Y Y		☐	RMB Balanced	☐	Momentum Defender	☐
Type of single payment	Voluntary ☐	Transfer from a non-retirement annuity fund	☐	RMB International Balanced FoF*	☐	RMB High Tide	☐
		Transfer from a retirement annuity fund	☐	LifeCycle Philosophy	☐	RMB Property	☐
If yes, transferring fund name:				Momentum Accumulator	☐	Other	______

* Not available on the Retirement Provider.

Premium increases		**Premium Waivers**			**Premium Waivers**		
Voluntary increase ☐	__ , __ %	Client number			Client number		
CPI increase rate (PVPI) ☐			Level	Increasing		Level	Increasing
Beneficiaries		Death	☐ or	☐	Death	☐ or	☐
Beneficiary number	Benefit share ___ %	Comprehensive Disability	☐ or	☐	Comprehensive Disability	☐ or	☐
Beneficiary number	Benefit share ___ %	Functional Impairment	☐ or	☐	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 details

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 insured life

Benefit amount R

Beneficiaries

Beneficiary number Benefit share %

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:

- 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:

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.

Section 17: Multiply

Contract number **M** **M**

Minimum monthly qualifying Momentum premium is R300.00 (excluding the Multiply option premium)

Member information

Please indicate the client number for the information of the applicant **Client number**

Initials and surname of investment owner

	Initials	First name and surname	Relationship to applicant	Gender M/F	Date of birth/Identity number
Spouse					
Dependant 1					
Dependant 2					
Dependant 3					
Dependant 4					

Spouses and dependants must be Momentum policyholders or insured lives to qualify for membership of Multiply.

The same family members must be registered on both Multiply and your qualifying medical scheme.

Indicate the contribution payer for Multiply by client number **Client number**

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

Starting date 0 1 – M M – 2 0 | Frequency Monthly X

Name of previous lifestyle programme

Previous lifestyle programme status*

* Please provide proof of status with the most recent statement (not older than one month)

Section 18: Terms and conditions for Multiply

1. 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.
2. 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.
3. 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 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.
4. 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.
Tick the box and save thru spend will call you with more information. Yes

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 **Date** D D – M M – **2 0** Y Y

Signature(s)

Client number

Signature of parent/guardian or trustee (if applicable)

Client number

Client number

Client number

Client number

Client number

Client number

Client number

Momentum 268 West Avenue Centurion 0157 PO Box 7400 Centurion 0046 South Africa
ShareCall 0860 66 23 45 Fax +27 12 675 3911 myriad-client@momentum.co.za www.momentum.co.za

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 advise the insurer in writing about cancellation of a policy.)

Name of policyholder

ID/Registration no. of policyholder

Name of intermediary

Name of FSP (Broker house or insurer)

New policy

Type of policy *(please tick)*				**Policy number**	**Insurer**
Investment		Risk			
Investment		Risk			
Investment		Risk			

Policy being replaced

Type of policy *(please tick)*				**Policy number**	**Insurer**
Investment		Risk			
Investment		Risk			
Investment		Risk			

Question to the intermediary

Does this proposal constitute replacement of an investment policy with a recurring premium that will lead or has led to the levying/deduction of a termination charge of more than 15% of the replaced policy's fund value? Refer to the definitions in Part 3 of the Regulations to the Long-Term Insurance Act, 1998 (commission regulations).

Yes ☐ No ☐

1. Reasons why replacement may not be advisable

If you do replace any policy, we want to ensure that you make an informed choice. Please read the following information carefully and discuss it with your intermediary.

- You will **pay some charges and fees twice** (e.g. commission, underwriting expenses and other initial charges levied by the insurer) – initially on the existing policy and once again on the new policy.
- You may **pay higher premiums** for risk (or a bigger part of the premium) on the new policy because you are older now or your health condition may have changed.
- Your new policy may not have the same **life cover or premium** guarantees as the existing policy. Check the period for which the life cover or other cover amounts are guaranteed before the insurer is entitled to change your premiums or reduce or remove cover.
- Your new policy may not have the same ***investment performance guarantees*** as the existing policy (if applicable).
- Your new policy may have **more exclusions, restrictions or waiting periods** particularly if your health has deteriorated.
- The amount of money that you can withdraw under the new policy may be less (if applicable). A new policy will usually have legal restrictions on access within the first five years.
- You may **lose the tax advantage** of your existing policy (if applicable).
- The surrender value or paid-up value of your existing policy may be as low as 65% of the policy value before the change and could be even less than the premiums paid in, since the insurer must first deduct **unrecovered initial expenses.** Check what charges you will be paying on the termination of the old policy and see whether the advantage of the new policy will make up for any such charges.
- The investment risk under the new policy may be higher. Remember that the past performance of a fund or asset manager of a fund is not necessarily an indication of future performance.

2. Reasons for the change of policy/policies

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.

Name

Signature

Date D D – M M – **2 0** Y Y

Policyholder

I confirm that the adviser has fully explained the consequences of the replacement of the policy/ies mentioned in this Replacement Policy Advice Record and I understand the consequences of such replacement/s.

Name

Contact telephone number and/or e-mail address

Signature

Date D D – M M – **2 0** Y Y