SALHA 16: PANUSA

# Application for Membership
# Aansoek om Lidmaatskap

# APPLICATION FOR MEMBERSHIP

# AANSOEK OM LIDMAATSKAP

## A. OPTION CHOICE

## A. OPSIEKEUSE

MARK THE APPLICABLE BLOCK WITH A ✔

- GOLD COMPREHENSIVE ☐
- GOLD BUDGET ☐
- NOVEL SAVINGS ☐
- NOVEL NETWORK ☐

REQUIRED ENTRY DATE
VERLANGDE INWERKINGTREDING

D D M M C C Y Y

MERK DIE TOEPASLIKE BLOKKIE ✔

- GOUD OMVATTEND ☐
- GOUD BEGROTINGS ☐
- NOVEL SPAAR ☐
- NOVEL NETWERK ☐

## B. PARTICULARS OF APPLICANT

## B. BESONDERHEDE VAN APPLIKANT

TITLE: Prof/Dr/Mr/Mrs/Miss etc.
TITEL: Prof/Dr/Mnr/Mev/Mej ens.

SURNAME:
VAN:

FIRST NAME/S:
EERSTE NAAM/NAME:

POSTAL ADDRESS:
POSADRES:

POSTAL CODE:
POSKODE:

TEL. CODE & NO:
TEL. KODE & NR:

CELL. NO.:
SEL. NR.:

E-MAIL:
E-POS:

DATE OF BIRTH: (dd mm ccyy)
GEBOORTEDATUM: (dd mm eejj)

AGE NEXT BIRTHDAY:
OUDERDOM VOLGENDE VERJAARDAG:

MARITAL STATUS:
HUWELIKSTATUS:

MARRIED GETROUD | SINGLE ONGETROUD | DIVORCED GESKEI | WIDOW(ER) WEDUWEE/NAAR | WOON SAAM CO-HABITING

SEX:
GESLAG:

MALE MANLIK ☐ FEMALE VROULIK ☐

LANGUAGE:
TAAL:

ID. NUMBER:
ID. NOMMER:

UNION AFFILIATION:
VAKBONDAFFILIASIE:

☐ YES JA ☐ NO NEE

If YES UNION NAME:
INDIEN jA VAKBOND NAAM:

UNION NUMBER:
VAKBONDNOMMER:

## C. FOR OFFICE USE ONLY

## C. SLEGS VIR KANTOORGEBRUIK

UNDERWRITING DECISION:
ONDERSKRYWINGSBESLUIT:

GROUP CODE:
GROEPKODE:

MEMBER NO.:
LID NR.:

OPTION:
OPSIE:

CONTRIBUTION:
BYDRAE:

ENTRY DATE: (dd mm cc yy)
AANVANGSDATUM: (dd mm eejj)

BENEFIT DATE: (dd mm ccyy)
VOORDEELDATUM: (dd mm eejj)

INDIVIDUAL MEMBERSHIP:
INDIVIDUELE LIDMAATSKAP: ☐

GROUP MEMBERSHIP:
GROEPLIDMAATSKAP: ☐

UNION CODE:
VAKBONDKODE: ☐



* 1 3 9 6 9 *

## D. EMPLOYMENT DETAILS

## D. WERKSBESONDERHEDE

GROSS MONTHLY INCOME *(must be completed)*:
*(please attach salary slip or copy thereof)*:
MAANDELIKSE INKOMSTE *(moet voltooi word)*:
*(heg asb. salarisstrokie, of afdruk daarvan aan)*

R p.m.

OCCUPATION:
BEROEP:

EMPLOYER COMPANY:
WERKGEWERMAATSKAPPY:

EMPLOYER ADDRESS:
WERKGEWERADRES:

POSTAL CODE:
POSKODE:

TEL. CODE & NO. (W)
TEL. KODE & NR. (W)

FAX CODE & NO. (W):
FAKSKODE & NR. (W):

Are you applying as an INDIVIDUAL?
Doen u aansoek as 'n INDIVIDU?
YES / JA

Or as a member of the EMPLOYER COMPANY GROUP?
Of as 'n lid van die WERKGEWER-MAATSKAPPYGROEP?
YES / JA

EMPLOYEE/STAFF NO.:
WERKNEMER NR.:
PERSAL NO./NR.:

## E. PREVIOUS MEDICAL SCHEME MEMBERSHIP

## E. VORIGE MEDIESE SKEMA-LIDMAATSKAP

Were you a member of a registered medical scheme, or were you covered by your parents' medical scheme?
Was u 'n lid van 'n geregistreerde mediese skema, of was u gedek deur u ouers se mediese skema?
If 'yes', please attach a certificate of membership from your current medical scheme (a membership card is not sufficient).
Indien 'ja', heg asb. 'n sertifikaat van lidmaatskap van u huidige mediese fonds aan ('n lidmaatskapkaart is nie voldoende nie).

YES / JA ☐ NO / NEE ☐

1. NAME OF MEDICAL SCHEME:
NAAM VAN MEDIESE SKEMA: .....

MEMBER NO:
LIDMAATSKAP NR.:

2. PERIOD OF MEMBERSHIP:
TYDPERK VAN LIDMAATSKAP:

FROM: (dd mm ccyy)
VANAF:(dd mm eejj)

TO: (dd mm ccyy)
TOT: (dd mm eejj)

NAME OF PREVIOUS MEDICAL SCHEME:
NAAM VAN VORIGE MEDIESE SKEMA: .....

MEMBER NO:
LIDMAATSKAP NR.:

PERIOD OF MEMBERSHIP:
TYDPERK VAN LIDMAATSKAP:

FROM: (dd mm ccyy)
VANAF: (dd mm eejj)

TO: (dd mm ccyy)
TOT: (dd mm eejj)

Was membership subject to any restrictions e.g. late-joiner penalty or waiting period/exclusions?
Was lidmaatskap onderworpe aan enige beperkings, bv. boete vir laat aansluiting of wagperiodes/uitsluitings?
YES / JA ☐ NO / NEE ☐

If 'yes', state particulars of restrictions:
Indien 'ja', gee besonderhede van beperkings: .....

## F. PARTICULARS OF DEPENDENTS

## F. AFHANKLIKES SE BESONDERHEDE

(Husband/wife and children under 21 years, who are unmarried and not in full time employment. Include children up to 25 years if they are dependent full time students at an educational institution. Those with more than four children, please attach a list).
(Man/vrou en kinders onder 21 jaar, wat ongetroud is, en nie 'n voltydse beroep het nie. Sluit kinders in tot op 25 jaar as hulle afhanklike voltydse studente is by 'n opvoedkundige inrigting. Heg asb. 'n lys aan indien u meer as vier kinders het.

| FULL NAMES<br>VOLLE NAME | ID NUMBER<br>ID NOMMER | RELATIONSHIP TO APPLICANT<br>VERWANTSKAP MET APPLIKANT | SEX M/F<br>GESLAG M/V | DATE OF BIRTH<br>GEBOORTEDATUM | | |
|---|---|---|---|---|---|---|
| | | | | D | M | Y/J |
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## G. MEDICAL INFORMATION

## G. MEDIESE INLIGTING

*Please give the name and address of your general practitioner, dentist, as well as any specialist you may recently have consulted.*
*Gee asseblief die naam en adres van u algemene praktisyn, tandarts, sowel as enige spesialis wat u onlangs besoek het.*

| Dentist:<br>Tandarts: | Doctor:<br>Dokter: | Specialist<br>Spesialis: |
|---|---|---|
| Address:<br>Adres: | Address:<br>Adres: | Address:<br>Adres: |
| Tel. no.:<br>Tel. nr.: | Tel. no.:<br>Tel. nr.: | Tel. no.:<br>Tel. nr.: |

**To be completed by all principal members. Please complete all the required information by marking the relevant box.**
**Die volgende moet deur alle hooflede voltooi word. Voltooi asseblief die nodige inligting deur die relevante blokkie te merk.**

**Have you, your spouse, or any of your dependants experienced any of the following in the past ten years?**
**Het u, u gade, of enige van u afhanklikes enige van die volgende in die afgelope tien jaar ervaar?**

| | | YES JA | NO NEE |
|---|---|---|---|
| 1. | High cholesterol, stroke, high blood pressure, heart murmur, angina, heart attack, or any other cardiac or blood disorder?<br>Hoë cholesterol, beroerte, hoë bloeddruk, hartkloppings, angina, hartaanval of enige ander kardiovaskulêre of bloedkwaal? | ☐ | ☐ |
| 2. | Nephritis, kidney stone, congenital kidney disorders or any other urinary or related kidney disorder?<br>Nefritis, nierstene, aangebore nierkwale of enige ander urinere of verwante nierkwaal? | ☐ | ☐ |
| 3. | Difficulty when breathing, persistent cough, tuberculosis, asthma, bronchitis, croup, or any other respiratory related disorder or ear problems?<br>Asemhalingsprobleme, aanhoudende hoes, tuberkulose, asma, brongitis, kroep, of enige ander asemhalingsverwante ongesteldheid of oorprobleme? | ☐ | ☐ |
| 4. | Conditions of the joints or spine, including rheumatism, arthritis, neck or back disorders or any physical disability?<br>Gewrigs- of ruggraatkondisies, insluitende rumatiek, artritis, nek- of rugprobleme of enige ander liggaamsgebrek? | ☐ | ☐ |
| 5. | Diabetes, sugar in the blood or urine, glandular disorder, or any other related endocrine disorder?<br>Diabetes, suiker in die bloed of urine, klierkwaal, of enige ander verwante enkokriene kwaal? | ☐ | ☐ |
| 6. | Any lumps, growths, benign or malignant, or types of cancers, including Hodgkin's disease and leukaemia, skin cancer etc.?<br>Enige klonte, vergroeisels, goed- of kwaadaardig, of tipes kanker, insluitende Hodgkin se siekte en leukemie, velkanker ens.? | ☐ | ☐ |
| 7. | Epilepsy, migraine or any other neurological disorder?<br>Epilepsie, migraine of enige ander neurologiese ongesteldheid? | ☐ | ☐ |
| 8. | Ulcers, hiatus hernia, gall bladder or liver disorders or any other digestive system disorder?<br>Maagsere, hiatus hernia, galblaas of lewerkwale of enige ander verteringstelsel-ongesteldheid? | ☐ | ☐ |
| 9. | Any medical, major dental, chiropractic, optical or gynaecological treatment, advice, tests or hospitalisation?<br>Enige mediese, ernstige tandheelkundige, chiropraktiese, optiese of ginekologiese behandeling, advies, toetse of hospitalisasie? | ☐ | ☐ |
| 10. | Advice, counselling, treatment or therapy for alcoholism, drug dependancy, mental or emotional disorders?<br>Advies, berading, behandeling, of terapie vir alkoholisme, dwelmverslawing, geestelike of emosionele versteurings? | ☐ | ☐ |
| 11. | Medical advice, counselling or treatment in connection with the Aids virus or any sexually transmitted disease, e.g. hepatitis B, gonnorrhea or syphilis?<br>Mediese advies, berading of behandeling in verband met die Vigsvirus of enige seksuele oordraagbare siekte, bv. hepatitis B, gonoree of sifilis? | ☐ | ☐ |
| 12. | Has any medical scheme or insurer refused cover or offered cover to you or your spouse on special terms? If 'yes', please state name of scheme or company, date and reason.<br>Het enige mediese skema of versekeraar u al ooit dekking geweier of aangebied op spesiale voorwaardes? Indien 'ja', noem asseblief naam van skema of maatskappy, datum en rede. | ☐ | ☐ |
| 13. | Have any of your close relatives ever suffered from porphyria, cancer, mental illness, diabetes, stroke, chest pain, raised cholesterol, heart disorder or any other hereditary disease?<br>Het enige van u naasbestaandes al ooit gely aan porfirie, kanker, geestelike disfunksie, diabetes, beroerte, borspyn, hoë cholesterol, hartkwaal of enige ander oorerflike siekte? | ☐ | ☐ |
| 14. | Are you or any of your dependants pregnant? — If so, what is the expected date of delivery?<br>Is u of enige van u afhanklikes swanger? - Indien wel, wat is die verwagte geboortedatum? | ☐ | ☐ |
| 15. | For other than routine treatment, do you, your spouse or any of your dependents expect to seek medical advice or treatment in the next six months?<br>Verwag, u, u gade of enige ander afhanklike om mediese advies of behandeling in die volgende ses maande te ondergaan? | ☐ | ☐ |
| 16. | Has your weight or the weight of your spouse changed by more than 5 kg in the last 12 months? — If so, why?<br>Het u of u gade se gewig met meer as 5kg verander in die laaste 12 maande? - Indien wel, hoekom? | ☐ | ☐ |

17. Height & weight (principal member) / Lengte & gewig (hooflid) — HEIGHT / LENGTE ☐☐☐ WEIGHT / GEWIG ☐☐☐

Height & weight (spouse) / Lengte & gewig (gade) — HEIGHT / LENGTE ☐☐☐ WEIGHT / GEWIG ☐☐☐

**If you have answered 'yes' to any of the above questions please complete details below in full:** include cause, nature, symptoms, date and duration of illness. State any investigations and the final diagnosis. State duration of any hospitalisation. State current treatment (name, dosage, frequency). If none, when were you last treated?

**As u 'ja' geantwoord het op enige van die bostaande vrae, vul asseblief die volgende ten volle in:** sluit oorsaak, aard, simptome, datum en duur van siekte in. Meld ook enige ondersoeke en die finale diagnose. Meld die duur van enige hospitalisasie. Meld dan ook huidige behandeling (naam, dosis, hoe gereeld gebruik). Indien geen, wanneer het u laas behandeling ontvang?

| NO. NR. | BENEFICIARY AFHANKLIKE | DATE OF CONSULTATION/ILLNESS DATUM VAN KONSULTASIE/SIEKTE | DETAILS BESONDERHEDE |
|---|---|---|---|
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If more space needed, please attach list.
Indien meer spasie benodig word, heg asseblief 'n lys aan.

## H. CHRONIC MEDICATION — H. CHRONIESE MEDIKASIE

Do you or any of your dependents use chronic medication? YES JA ☐ NO NEE ☐ If 'yes', complete the attached Chronic Application Form.
Gebruik u, of enige van u afhanklikes chroniese medikasie? Indien 'ja', voltooi die aangehegte Chroniese Aansoekvorm.

| BENEFICIARY AFHANKLIKE | ILLNESS SIEKTE | PERIOD MEDICATION USED PERIODE VAN GEBRUIK VAN MEDIKASIE |
|---|---|---|
| | | FROM: (dd mm ccyy) VANAF: (dd mm eejj) ☐☐☐☐☐☐☐☐<br>TO: (dd mm ccyy) TOT: (dd mm eejj) ☐☐☐☐☐☐☐☐ |
| | | FROM: (dd mm ccyy) VANAF: (dd mm eejj) ☐☐☐☐☐☐☐☐<br>TO: (dd mm ccyy) TOT: (dd mm eejj) ☐☐☐☐☐☐☐☐ |
| | | FROM: (dd mm ccyy) VANAF: (dd mm eejj) ☐☐☐☐☐☐☐☐<br>TO: (dd mm ccyy) TOT: (dd mm eejj) ☐☐☐☐☐☐☐☐ |

## I. YOUR BANK ACCOUNT DETAILS / I. U BANKREKENING BESONDERHEDE

(Required for paying member's portion of claims directly into account where applicable)
(Word benodig om lid se gedeelte van eise direk in rekening in te betaal waar van toepassing)

NAME OF ACCOUNT HOLDER:
NAAM VAN REKENINGHOUER:

TYPE OF ACCOUNT:
TIPE REKENING:
CHEQUE: TJEK: ☐ SAVINGS: SPAAR: ☐ TRANSMISSION: TRANSMISSIE: ☐

ACCOUNT NO.:
REKENINGNR:

BANK/BUILDING SOCIETY:
BANK/BOUVERENIGING:

BRANCH:
TAK:

6 DIGIT BRANCH CODE:
6 SYFER TAKKODE:

## J. DEBIT ORDER / J. DEBIETORDER

NAME OF BANK/BUILDING SOCIETY:
NAAM VAN BANK/BOUVERENIGING:

BRANCH:
TAK:

TYPE OF ACCOUNT:
TIPE REKENING:
CHEQUE: TJEK: ☐ TRANSMISSION: TRANSMISSIE: ☐ SAVINGS: SPAAR: ☐

6 DIGIT BRANCH CODE:
6 SYFER TAKKODE:

NAME OF ACCOUNT HOLDER:
NAAM VAN REKENINGHOUER:

ACCOUNT NO.:
REKENING NR.:

ID. NUMBER:
ID. NOMMER:

DATE OF FIRST DEDUCTION:
(dd mm ccyy)
DATUM VAN EERSTE AFTREKKING:
(dd mm eejj)

I authorise Publiserve to draw from my bank/building society account (wherever it may be), the premiums (and any stamp duty or short payments) due in terms of the Medical Scheme, without prejudice to the rights of Publiserve. I further authorise Publiserve to increase the amounts due to it in terms of the policy from time to time and authorise my bank/building society to effect payment of such increased amount upon receipt of a written notice from Publiserve stating the increased amount and the date from which it is payable. This authorisation is to remain in force until I cancel it by giving written notice to Publiserve.
I agree that I am not entitled to recover any amount drawn from my account by means of this debit order and that should my bank/building society repay such amount to me, I will refund it immediately to Publiserve. I undertake to notify Publiserve immediately of any change in respect of my address or bank/building society. I/We acknowledge that the party hereby authorised to effect the drawing(s) against my/our account may not cede or assign any of its rights to any third party without my/our prior written consent and that I/we may not delegate any of my/our obligations in terms of this contract/authority to any third party without prior written consent of the authorised party.

Hiermee gee ek magtiging dat Publiserve my bank/bouverenigingrekening (waar dit ook al is), mag debiteer met die verskuldigde premies (en seëlgeld of enige ander verhalings) kragtens die reëls van die mediese skema, sonder benadeling van Publiserve se regte. Voorts gee ek magtiging dat Publiserve bedrae kragtens my kontrak mag wysig soos van tyd tot tyd vereis word, en magtig ek my bank/bouvereniging om die gewysigde bedrag te verhaal slegs indien 'n kennisgewing van Publiserve wat die gewysigde bedrag asook datum aandui, ontvang word. Hierdie magtiging bly van toepassing totdat ek skriftelike kennis van kansellasie aan Publiserve verskaf. Ek stem in dat ek nie by magte is om enige bedrag te laat terugskryf wat deur hierdie debietorder aangevra is nie, en ek onderneem om Publiserve sonder versuim skriftelik van enige verandering van enige van adres of bankbesonderhede in kennis te stel.
Ek/Ons erken dat die party wat hiermee gemagtig word om die trekking(s) teen my/ons rekening te behartig, geen van sy/hulle regte aan 'n derde party mag afstaan of sedeer sonder my/ons skriftelike toestemming wat vooraf verkry is nie, en dat ek/ons geen van my/ons verpligtinge ingevolge hierdie kontrak/magtiging aan 'n derde party mag delegeer sonder die skriftelike toestemming wat vooraf van die gemagtige party verkry is nie.

Name/Naam | Signature/Handtekening | Date (dd mm ccyy)/Datum (dd mm eejj)

## K. INTERMEDIARY INFORMATION / K. TUSSENGANGERINLIGTING

BROKER HOUSE/COMPANY / MAKELAARHUIS/MAATSKAPPY

REGION/STREEK | OFFICE/KANTOOR | TEL

INTERMEDIARY / TUSSENGANGER

NAAM/NAAM | CODE/KODE | TEL

Registered with Council for Medical Schemes/Geregistreer met Raad vir Mediese Skemas
☐ YES/JA ☐ NO/NEE
Registered with the LOA/Geregistreer met die LOA
☐ YES/JA ☐ NO/NEE

CODE/KODE

Signature/Handtekening | Date (dd mm ccyy)/Datum (dd mm eejj)

UNION OFFICIAL / VAKBONDVERTEENWOORDIGER

NAME/NAAM | TITLE/TITEL | DEPT

## L. RESIGNATION OF PREVIOUS MEDICAL SCHEME
## L. BEDANKING VAN VORIGE MEDIESE SKEMA

TO: THE MANAGER (MEDICAL SCHEME)
AAN: DIE BESTUURDER (MEDIESE SKEMA)

FROM: NAME OF APPLICANT:
VAN: NAAM VAN AANSOEKER:

ADDRESS:
ADRES:

**RESIGNATION FROM PREVIOUS MEDICAL SCHEME**
**BEDANKING VAN VORIGE MEDIESE SKEMA**

I, _____ undersigned member of _____ Medical Scheme, membership no. _____

hereby resign my membership of _____ Medical Scheme with effect from _____ and authorise MetHealth Publiserve Medical Scheme to act on my behalf in respect of any further matters relating to my resignation.

Ek, _____, die ondergetekende lid van _____ Mediese Skema, lidnommer _____

bedank hiermee as lid van _____ Mediese Skema met ingang van _____ en magtig hiermee MetHealth Publiserve Mediese Skema om namens my op te tree in enige verdere aangeleenthede wat verband hou met my bedanking.

Name/Naam | Signature/Handtekening | Date (dd mm yycc)/Datum (dd mm eejj)

ATTACH THE ORIGINAL LETTER OF RESIGNATION / HEG DIE OORSPRONKLIKE KANSELLASIEBRIEF HIERBY AAN.

## M. UNDERTAKING BY THE APPLICANT
## M. ONDERNEMING DEUR AANSOEKER

L.1. I, the undersigned, apply for membership of the Publiserve Medical Scheme. I agree that the terms and conditions as defined in the rules of the Publiserve Scheme shall be binding on me. I declare and understand that all answers and information that I disclose during this application, and all documents which in Publiserve's opinion, are relevant to the risk and which will be signed by me, shall be the basis of my membership and that they shall be warranted as true and complete. I declare and understand that my application shall be null and void if any information should be inaccurate or incomplete, in which case I will repay all monies paid to me by the Scheme, and I will forfeit any rights to any membership fees already paid to the Scheme.
I irrevocably give my consent to any medical doctor, person or organisation, who may possess, or come into possession of any information regarding my health or the health of my dependants, to disclose this information to MetHealth, also after my death or the death of my dependants.
I am aware that on joining Publiserve during the course of the calendar year, I shall only receive total benefits in proportion to that part of the year for which I am a member of Publiserve, i.e. *pro rata* benefits.

L.2. I give my consent to my employer to deduct from my salary and pay all amounts that may be due by me to Publiserve. (L.2 is not applicable to members paying by debit order).

L.3. I agree to familiarise myself with the benefits and obligations of the scheme.

L.4. I agree to use the benefits and facilities prudently and to report any cases of abuse and misconduct that may come to my attention.

L.1. Ek, die ondergetekende, doen hiermee aansoek om lidmaatskap van die Publiserve Mediese Skema. Ek verklaar dat die bepalings en voorwaardes, soos uiteengesit in die reëls van die Publiserve Mediese Skema, bindend vir my sal wees. Ek verklaar dat alle antwoorde en inligting wat deur my in hierdie aansoek verskaf is en alle dokumente wat na Publiserve se mening relevant tot die risiko is en deur my geteken word of sal word, juis en korrek is en ek onderneem om, indien dit later blyk dat enige van die antwoorde onvolledig of foutief verskaf is, alle voordele betaal aan my deur die Skema sal verbeur en alle gelde wat deur die Skema aan my betaal is ten volle sal terugbetaal en ek afstand sal doen van enige ledegeld wat ek aan die Skema betaal het.
Hiermee gee ek my onherroeplike toestemming aan enige mediese dokter, persoon of organisasie wat in besit is van of enige inligting kan bekom rakende my gesondheid of die gesondheid van my afhanklikes, om dit aan Publiserve te verskaf, ook voor of na my of my afhanklikes se afsterwe.
Ek is bewus daarvan dat indien ek gedurende 'n kalenderjaar dekking van Publiserve verkry, ek slegs *pro rata*-voordele vir die oorblywende gedeelte van die jaar sal ontvang.

L.2 Hiermee gee ek toestemming aan my werkgewer om enige bedrae betaalbaar aan Publiserve van my salaris af te trek. (L.2. is nie van toepassing op lede wat per debietorder betaal nie).

L.3 Ek onderneem om mysrlf te vergewis van die voordele en verpligtinge van lidmaatskap van die fonds.

L.3 Ek onderneem om die voordele en fasiliteite van die fonds oordeelkundig en spaarsaam te benut en om wanpraktyke en ongeruimdhede te rapporteer.

Name/Naam | Signature/Handtekening | Date (dd mm ccyy)/Datum (dd mm eejj)



10254 (V01'00) (P01'00) MP

APPLICATION FOR:

# FUTUREMED

METROPOLITAN LIFE

Proud Sponsor of the South African Olympic Team

Note: 1. This application form may only be used for FutureMed (FM) policies. (Table 7R with no other benefits, except optional RIM.)
2. The shaded areas are for region and head office use only.
3. Please tick where appropriate and complete in black pen.

Policy number 4 2

## 1. MEMBER (hereinafter referred to as First Life)

Surname: | Maiden Name:
First Names: | Title: Mr Mrs Miss Other (state)
Marital Status:
Sex: Male Female Lang: Eng Afr | Date of Birth: (ddmmyyyy)
Address: (Home): | ID Number:
Address: (Postal)
Postal Code: Area Code: | Postal Code:
Tel. (H): | Cell no.
Tel. (W): | Tax status: Taxable ✓ Premium Payer:

## 2. PREMIUM PAYER (Complete this section if the premium payer is not the First Life)

Surname: | Maiden Name:
First Names: | Title: Mr Mrs Miss Other (state)
Marital Status:
Sex: Male Female Lang: Eng | Date of Birth: (ddmmyyyy)
Address: (Postal): | ID Number:
Postal Code: | Relationship to First Life:
Tel. (H): | Tel. (W):

## 3. BENEFICIARY DETAILS (The beneficiary should preferably be a dependant)

The payment of the death benefit is regulated by the Pension Funds Act, which may be amended from time to time.

Surname: | Address: (Postal) :
First Names: | Postal Code:
Maiden Name: | Lang: Eng Afr
ID Number: | Title: Mr Mrs Miss Other (state)
Sex: Male Female | Marital Status:
Relationship to First Life: | Date of Birth: (ddmmyyyy)

## 4. OCCUPATION, INCOME, EDUCATION AND REPLACEMENT

Occupation | Code | Employer | Code

Income per month Education: Not Matriculated (3) Matriculated (4)

3 year university degree or 4 year technicon degree/diploma or 4 year teacher's diploma (6)

4 year university degree or 3 year university degree & honours or Two 3 year degrees (7)

Is this application to replace the whole or part of any other application to this or any other life office or to replace all or any part of your existing insurance with any life office whether replacement is to occur immediately or to replace an insurance discontinued within the past six months or to be discontinued within the next six months? **IMPORTANT:** Replacement of any insurance is nearly always to the disadvantage of the policy owner because it involves duplication of initial cost in respect of the policy. Y N

If "yes" the introducer must discuss and complete the Policy Replacement Advice Record (10513) and attach it to this proposal form.

## 5. INTRODUCER(S)

| Name: | Commission Numbers Introducer | Sales Manager | Split |
|---|---|---|---|
| 1. | | | % |
| 2. | | | % |
| 3. | | | % |

Debit number Broker Proposal number:



*13969*

**Tick and complete** **NB:** If the policy is a FLIP/conversion then commission will be the same as that chosen on the initial policy.

5.1 **Type of commission**

- ☐ (a) Commission payable in advance.
- ☐ (b) Commission payable "as and when" over the premium paying term.
- ☐ (c) Advance commission based on premium paying term of _____ years,[1] and thereafter "as and when" commission for the balance of the premium paying term.
- ☐ (d) A set fee (payable in advance) of _____.
- ☐ (e) Advance commission on ____% of the premium and "as and when" commission on the balance of the premium throughout the premium paying term.

5.2 If choice in respect of 5.1 is (a), (b), (c) or (e) what percentage of the commission do you want to sacrifice? _____%

5.3 If type of commission choice is (a), (c), (d), or (e), how must the advanced commission be paid?

☐ (I) On issue of the policy. ☐ (P) On receipt of the first premium. ☐ (M) Over 12 months as each premium is paid.

| | | Y | N |
|---|---|---|---|
| 5.4 | Are you fully conversant with the "S-referencing system" embodied in the Life Office's Association's Code of Conduct and do you consent and accept its operation as well as the consequences thereof? | ☐ | ☐ |
| 5.5 | I/We declare that the meaning of the replacement question and the note thereto has been explained to the First Life and that I am/we are fully aware of the possible detrimental consequences of the replacement of an insurance policy. | ☐ | ☐ |

Signature 1. 2. 3. Date

[1] Maximum term is the smallest of (Basic Premium Term - 1 year) or 15 years.

## 6. DEBIT ORDER

Name of Account Holder

Name of bank/building society

Account number

Branch

Current ☐ Transmission ☐ Mortgage bond ☐

Branch code

Savings ☐ Credit card ☐

Town/city

Employer code

Date of first debit (ddmmyyyy)

I authorise METROPOLITAN LIFE LIMITED (herein referred to as METROPOLITAN) to draw from my bank/building society account (wherever it may be) the premiums (and any short payments) due in terms of the policy, without prejudice to the rights of METROPOLITAN. I further authorise METROPOLITAN to increase the amounts due to it in terms of the policy from time to time and authorise my bank/building society to effect payment of such increased amount upon receipt of notice from METROPOLITAN stating the increased amount and the date from which it is payable. This authorisation is to remain in force until cancelled by me by giving written notice to METROPOLITAN.

I agree that I am not entitled to recover any amount which has duly been drawn from my account by means of this debit order and I furthermore agree that, in the event of my bank/building society repaying such amount to me, in error, I will refund it to METROPOLITAN. I undertake to notify METROPOLITAN of any changes in respect of my address or my bank/building society.

Signature of Account holder

Signature of authorised representative (If applicable.) Authorised capacity must be indicated

Date (ddmmyyyy)

## 7. PLAN OF INSURANCE

PERSONAL DETAILS

| Age NB | Occupation class | Smoker Y | Smoker N | SE Class | AIDS Test | AIDS Class |
|---|---|---|---|---|---|---|
| | | | | | N | C |

Level of cover: Pure — Whole Life: N

Package Code: F M

PAYMENT INFORMATION

Method of Payment: Cash ☐ S/O ☐ D/O ☐ Staff ☐

Freq. of Payment: Weekly ☐ Mthly ☐ Qtly ☐ H/Y ☐ Yearly ☐

S/O, BDO code

Pension/Force/Sal no.

Pay Point/Dept Code:

POLICY PARTICULARS

AIM Benefit: Premium increase only if 10% selected 0% ☐ 10% ☐

| TABLE CODE | LIFE | TERM | COVER | PREMIUM | PREMIUM |
|---|---|---|---|---|---|
| 7R | 1 | | 0 | | |
| | | | | | |

PLANNED COMMENCEMENT DATE 0 1

TOTAL

May be adjusted by Metropolitan to coincide with first possible deduction date taking cash premiums into consideration.

RECEIPT NUMBER(S):

CASH DEPOSIT:

RECEIPT DATE(S):

## 8. DECLARATION

8.1 I/We hereby apply to Metropolitan Life Limited (herein referred to as Metropolitan) for the policy as detailed above on Metropolitan's usual terms and conditions and I/we declare and warrant that the information in the application and all documents submitted in connection with the application, whether in my/our handwriting or not, is true, correct and complete and will form the basis of the proposed contract.

8.2 I/We agree that the increase in premium selected in section 6 will apply, provided that such an increase will take place automatically on each and every anniversary of the commencement date of the policy, unless I/we request in writing before such an anniversary date not to increase the premium.

8.3 I apply for membership of the Metropolitan Retirement Annuity Fund and agree to be bound by the rules of the fund and the conditions of the contract between the trustees of the fund (as amended from time to time) and Metropolitan, and I understand that the benefits of the fund will be secured through an insurance policy with Metropolitan.

8.4 I/We understand that I am/we are entitled to cancel this application within 21 days of the date of the Letter of Acceptance issued by Metropolitan. I/We agree that I/we will receive a refund of all premiums paid less the cost of any investment enjoyed by me/us.

Signature of First Life

Signature of Premium Payer

Signature of Guardian (required if First Life is under the age of 18)

Date: (ddmmyyyy)