



# IEASA Income Protection Plan



Is this a: New Application  Replacement (From existing FMI policy)  (Policy No. \_\_\_\_\_ )

IEASA Membership Number: \_\_\_\_\_

**\* All fields must be completed in order for this application to be processed.**

## 1. PROPOSER / OWNER DETAILS (Only complete if different to life insured)

Name of Business: \_\_\_\_\_

Business postal address: \_\_\_\_\_  
Code: \_\_\_\_\_

(Dialling code and local area number)

Contact details: Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Policy tax status: Individual  Taxable company / institution  Non-taxable company / institution

## 2. LIFE INSURED'S DETAILS

Title: \_\_\_\_\_ First Name(s): \_\_\_\_\_

Surname: \_\_\_\_\_ Former/ Maiden name: \_\_\_\_\_

ID number: \_\_\_\_\_ Date of Birth: DD MM YYYY

Home Language: \_\_\_\_\_ Gender: M  F

Marital Status: Single  Married  Divorced  Widowed

Are you a permanent resident in South Africa?: YES  NO

## 3. LIFE INSURED'S CONTACT DETAILS

(Dialling code and local area number)

Home Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

Business Tel: \_\_\_\_\_ Cell number: \_\_\_\_\_

E-Mail: \_\_\_\_\_

## 4. LIFE INSURED'S ADDRESS DETAILS

Postal: \_\_\_\_\_ Code: \_\_\_\_\_

Residential: \_\_\_\_\_ Code: \_\_\_\_\_

## 5. LIFE INSURED'S OCCUPATIONAL DETAILS

Name of Business: \_\_\_\_\_

Nature of Business: \_\_\_\_\_

Business postal address: \_\_\_\_\_ Code: \_\_\_\_\_

(Dialling code and local area number)

Business details: Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

What is your annual income? \_\_\_\_\_

## 6. OTHER LIFE / DISABILITY INSURANCE

Please fill in the tables below, giving the total for which your life is currently insured, the name of the insurer as well as simultaneous / pending applications with FMI or any other life insurers.

Existing insurance	Monthly disability income		Business Overhead Expenses	Lump-sum disability
	Temporary	Permanent		
Amount	R	R	R	R
Name of insurer/s				

Simultaneous Applications	Monthly disability income		Business Overhead Expenses	Lump-sum disability
	Temporary	Permanent		
Amount	R	R	R	R
Name of insurer/s				

## 7. DEBIT ORDER DETAILS

ACCOUNT HOLDER:  ACCOUNT TYPE: Cheque  Transmission  Savings

BANK:  BRANCH NAME:

BRANCH CODE:  ACCOUNT NUMBER:

IF ACCOUNT HOLDER IS NOT APPLICANT STATE RELATIONSHIP :

1. Requested Date of Commencement (D.O.C.) of Policy,         or on acceptance of policy

2. Copy of the Life Insured's Identity Document attached to this application? Yes  No

3. Debit date to operate on 1st  5th  15th  of each month

Signature of Account Holder: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Account Holder: \_\_\_\_\_

NB : Should the quoted premium be inconsistent with the benefits applied for, acceptance should be based on:

SPECIFIC SUM INSURED  SPECIFIC PREMIUM  Quote reference number:

If the premium inconsistency is more than 10%, notification will be given in the form of a new quote.

## 8. NOTIFICATION OF REPLACEMENT

### a) REPLACEMENT OF INSURANCE

Replacement of insurance is nearly always to the disadvantage of the Life Insured as it involves duplication of the initial costs charged to the policy.

Is this application to replace the whole or part of your existing insurance with any insurer? (whether the replacement is to occur immediately or to replace any insurance discontinued in the past 6, or next 6 months). YES  NO

### b) DECLARATION BY THE FINANCIAL ADVISER (Complete if section (a) above answered YES) - please note that you will need to complete a R.P.A.R.

I declare that I have explained the meaning and implications of section (a) above and that the Life Insured is fully aware of the possible detrimental consequences of replacing an insurance policy.

Signature of adviser: \_\_\_\_\_

Date:

## 9. DECLARATION AND AGREEMENT BY LIFE INSURED

I warrant that all the information given in this application, and in all documents that have been or will be signed by me in connection with the proposed insurance, whether in my handwriting or not, is true and complete. I further warrant that all the information given or to be given by me, telephonically or electronically in connection with the proposed insurance is true and complete.

I, the Life Insured:

- Declare that I am willing to undergo testing for HIV (Human Immunodeficiency Virus) and I understand the implications of a positive test and have been given the opportunity to read the counselling information. I further indemnify Lombard Life and FMI and their directors, consultants and employees against any claim of whatsoever nature, which may be made against them as a result of such test.
- Authorise any doctor, hospital, medical institution, or any other person(s) who may be in possession of any information, including the result of any test concerning physical or mental health or occupation to disclose such information to Lombard Life and/or FMI and agree that this authority shall remain in force after my death.
- Irrevocably authorise Lombard Life or the ASISA to obtain from any person whatever information is needed by them according to their practice from time to time, to assess the risk to which this application relates, or to assess claims in respect of contracts to which this application relates.
- Further authorise and request the person concerned to provide any information so required by Lombard Life and/or FMI.
- Understand that my right to privacy is curtailed to the extent permitted by me in this authorisation.
- Irrevocably authorise Lombard Life and/or FMI to share with other insurers that information and any information contained in this application or in any related policy or other document, either directly or through a data base operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as may from time to time be decided by Lombard Life and/or FMI or by the operators of such database.
- In the case of Lombard Life imposing a loading(s) and/or additional exclusion(s), I agree that my cover will only commence after I have accepted those conditions, in the manner as required by Lombard Life and after Lombard Life has received the first premium.
- I agree that this declaration together with all other relevant documents that have been or will be signed by me in terms hereof, shall be the basis of the contract between Lombard Life and myself, and that if any material information is withheld the benefits and all monies paid to Lombard Life shall be forfeited. I further understand that Lombard Life regards the answers given in this application, any documents signed by me or given telephonically or electronically, as material in assessing my application.
- I further agree that cover will only commence on the last of (i) the date of commencement as stipulated on the application form, (ii) the date of commencement as stipulated on the acceptance and (iii) the date on which the first premium is paid.
- I also agree to advise FMI in writing of any change of occupation and or country of residence.
- Non-smokers only: I, the proposed life insured, hereby confirm that I have not smoked during the past twelve months and have no intention of smoking in the future, but should I start, I will advise Lombard Life and/or FMI and the policy will be adjusted accordingly.
- Right to review: I understand that I have the opportunity to reflect on my decision to effect this policy and, if I am not satisfied with the conditions, to withdraw my application. This can be done provided that I notify FMI's Call Centre in writing within 30 days of the date of my policy schedule letter, which will be forwarded once my application has been accepted by Lombard Life. I further understand that should any premiums have been paid, the refund is subject to the cost of any risk cover I may have enjoyed and/or market value adjustment. I undertake to consult my financial adviser if it is my intention to cancel this policy. I the undersigned, confirm that I fully understand the implications of the 'right to review' clause.
- I consent to FMI performing tele-underwriting on my application in the event of the cover amounts applied for being in excess of the stated free cover limits.
- I understand that replacement of any insurance is nearly always to the disadvantage of the applicant because it involves duplication of initial costs charged to the policy.

I further agree that, should this application be accepted by Lombard Life, such acceptance will be conditional upon there having been no material alteration to the facts on which the decision was based and no illness or injury to myself between the date of signing this application and the date of payment in full of the first premium. Any such alteration to the facts must be communicated to FMI in writing, and failure to do so may result in repudiation of any future claim. I authorise FMI to draw on my bank account, as indicated in this application and forward the premiums to Lombard Life. I agree that variations can be made if I am given 30 days notice of a general increase or decrease of the monthly cost of this policy. I agree that a photostat copy of this authorisation shall be considered effective and as valid as the original. I am aware that I must forward all claims documentation to FMI within 30 days of initial notification of claim.

Signature (Of life to be insured): \_\_\_\_\_

Date: 

D	D
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M	M
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Y	Y	Y	Y
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Place: \_\_\_\_\_

## 10. COMMUNICATION PREFERENCES

Please specify your preferences below:

- 1 FMI subscribes to an environment safe policy. All communication will be sent to you electronically. Should you however wish to have your correspondence sent by post kindly indicate by ticking this box
2. Would you like to receive information on special offers, competitions, products and services? Yes  No



FMI House, Gleneagles Park, 10 Flanders Drive, Mount Edgecombe, 4300 PO Box 223, Mount Edgecombe, 4300  
 Telephone: (031) 538 3500 Fax: (031) 502 5250. Client Care: 086 010 1119. www.fmi.co.za  
 Financial Management International Ltd is an Authorised Financial Services Provider FSP 2717.

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Underwritten by:

