Dignity GROUP SCHEMES

Employee Protection Plan acceptance form

SCHEME MANAGERS
Dignity Life Administrators
Twoline Trading 112 (Pty) Ltd
Reg No. 2000/001457/07
FSP License: Long Term Insurance
Category 1A (Funeral Cover) & 4
E-Mail: admin@dignity.co.za Tel 086 111 26 54

Occupational class		Type of Business	

You must complete this form before you sign it. Make sure all the information is accurate, or your claim may be declined. Tell us immediately if any information changes, or if you want to add or remove a life insured.

Employer details

Company name		Registration no	
Date of acceptance	d d m m y y y y	Gender	**male** ☐ **female** ☐
Surname		First names	
ID number		Marital status	**single** ☐ **married** ☐ **divorced** ☐ **widowed** ☐
Tel	( )	Mobile	( )
Fax	( )	E-mail	
Street address		Postal address	
	code		code
Communication via	**post** ☐ **e-mail** ☐	Nature of business	

Re-employment benefit

Please indicate the application option in respect of premium payment, in order to enable Assupol Life to issue membership certificates and section 48 summaries correctly.

A ☐ Employer pays total premium **B** ☐ Employer pays premiums and deducts from employees remuneration.

This benefit is only available should the employer be paying the total premium (If option A above has been chosen) Please tick the block below should you require this benefit.

Re-employment benefit ☐

Payment by bank debit order

Will pay from date	d d m m y y y y	Premium	R (monthly)
Day of the month on which payment must be made - for example the 25th of every month			
Account holder		Name of Bank	
Name of branch		Branch code	
Account no		Type of account	**current** ☐ **savings** ☐ **transmission** ☐

I authorise Assupol to draw the premiums from my bank account and pay it to Assupol. If the premium changes for any reason in terms of this policy or by agreement between Assupol and the policyholder, Assupol likewise may draw the premium from my bank account. If payment cannot be done on the preferred day of the month filled in above, it must be done on a day that is as close as to the day, determined by Dignity Life Administrators. If the policy ends the authority also ends. I may cancel, amend or replace this authorisation by written notice to Dignity Life Administrators. I accept that Dignity Life Administrators must receive the notice not later than 31 days before the month from which the cancellation, amendment or replacement is to apply. The reference on your bank account will start with ASSUPOL. Annual increases will take place as follows: cover by 6% and premiums by 10%. In addition to the yearly increase the Underwriter shall at all times be entitled to review the premiums payable and may increase the premiums by way of (31) thirty one days written notice to the principal member, prior to the increase being affected.

Applicant signature		**Date**	d d m m y y y y

Declaration by the employer

1. I, the employer, hereby undertake to apply for the Dignity Life Employee Protection Plan for all my employees, as set out in the form "Member details for the Dignity Life Employee Protection Plan" attached to this application form, in accordance with the conditions and exclusions of the plan as set out in the policy document.
2. I undertake to inform Dignity Life Administrators of any changes in respect of the details of the employer as set out above.
3. In accordance with the Long-term Insurance Act, a policyholder has 31 days from receipt of the Section 48 summary to cancel a policy. If this policy is cancelled within 31 days, any payment that has been received will be refunded.
4. I am aware of the waiting periods applicable to this policy and a have informed my Employees accordingly.
5. There is a limit of 1 policy per employer under the Dignity Life Employee Protection Plan, which will include all employees in the permanent employment of the employer.
6. The employer shall indicate monthly amendments to the membership on a schedule, and shall provide such schedule to Dignity Life Administrators along with the premium payment of the employer.
7. I, the undersigned, hereby declare and warrant all information supplied herein to be true and complete. I am aware and understand that any non-disclosure or misrepresentation of information which is material to the determination of the risk by Assupol, may lead to the policy being declared null and void, in which case all premiums paid in will be forfeited. I am certain that the product that I am applying for meets the specific needs of my employees and feel that I have all the necessary information order to make an informed decision in respect of the purchase thereof.
8. The benefits in of the policy will be paid to the employee or nominated beneficiaries in the event of death.
9. Benefits in terms of the re-employement benefit, where applicable, will always be paid to the employer.

Signature by employer		**Date**	d d m m y y y y

Details of insured lives to be covered under this group scheme

Please supply initials and surnames of all members listed below. If an identity number is not available for children, the date of birth will be accepted.

Company name		Page		of	

Particulars of employee and additional insured lives (Please select chosen plan)

Particulars of	Surname	First names	ID number
Main member			
Spouse			
Child 1			
Child 2			
Child 3			
Child 4			
Child 5			

	PROTECTION	PRIMARY	PROMINENT	PRESTIGE	SIGN
Single	R 66.00	R 72.00	R 82.00	R 93.00	
Family	R 77.00	R 92.00	R 112.00	R 127.00	

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