Dignity
FUNERAL FRIEND

ACCEPTANCE FORM

Referred by (name)	Contact number

	Functional		FAMILY		SINGLE		**Extended**
	Fixed		FAMILY		SINGLE	**SELECT MAIN MEMBER PLAN** (Please Tick ✓)	
	Focused		FAMILY		SINGLE		
	Feature		FAMILY		SINGLE		

Please note that any employee or member of Dignity Life Administrators may only introduce Dignity Life Administrators products to individuals. Members are not permitted to give any advice or intermediary services.

Step 1: You the Main Member

You must complete this form before you sign it. Make sure all the information is accurate or your claim may be declined.

Title | Initials | Date of birth D D M M Y Y | Identity number

Full Name | Surname

Postal address | Code

E-mail address | Cellphone

Tel No. (H) ( ) | Tel No. (W) ( )

Step 2: Your spouse

You may include your spouse as immediate family. He or she is either (a) the person to whom you are legally married under the law of SA (including a civil, customary or same-sex marriage) or (b) the person you have been living with for at least six months in a relationship that is similar to marriage.

Gender M F | Initial | Date of birth D D M M Y Y | Identity number

Full Name | Surname

STEP 3: You may cover up to six (6) children under the age of 22

They are your own children, stepchildren, and children legally adopted by you and financially dependant on you.

Date of Birth	Full name and surname	Relationship	Gender
D D M M Y Y			M F
D D M M Y Y			M F
D D M M Y Y			M F
D D M M Y Y			M F
D D M M Y Y			M F
D D M M Y Y			M F

STEP 4: You may cover more spouses, children or relatives as extended family.

They are persons in whom you have an insurable interest and who are not included above as immediate family. You can add an unlimited number of extended family members.

Date of Birth	Full name and surname	Relationship	Cover	Premium
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				

STEP 5: Your beneficiary (main member)

Your beneficiary is the person you appoint to receive the policy pay-out after your (main member) death. He or she must be 18 years or older. You may change your beneficiary at any time in writing to Dignity Life Administrators. If the pay-out cannot be made to the beneficiary, it will be paid to your estate.

Gender M F | Initial | Date of birth D D M M Y Y | Identity number

Full Name | Surname

Relationship | Contact Number

STEP 6: Salary deduction and pay-over authorisation

I authorise my employer to deduct the premiums from my salary and pay it to Assupol. If the premium changes for any reason in terms of the policy or by agreement between Assupol and the policyholder, Assupol likewise may draw the premium from my salary. 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 my employer. 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 payslip will start with ASSUPOL.

I, the undersigned | Identity number

Occupation | Department

Persal number | Date of first deduction

I authorise the Department/Paymaster/Paying Officer to deduct the sum of R in the name of **Assupol Life Ltd.**

I have read, understand and agree with the above authorisation regarding payment by Persal or any other stop order.

MY SIGNATURE:

Step 7: Alterations to method of payment (only applicable for persal deductions)

I hereby authorize the method of payment to be altered in the event of me not qualifying for Persal deductions as follows: ☐ DEBIT ORDER
I hereby confirm that I have read the information above and understand the content thereof.

MY SIGNATURE: Date D D M M Y Y

STEP 8: Debit order authorisation

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.

Name of bank | Account number | Branch code

Name of premium payer | Type of account ☐ Cheque ☐ Savings ☐ Transmission

Branch name | Please debit the amount of | on the ☐☐ of each month

MY SIGNATURE: **I have read, understand and agree with the above authorisation regarding payment by debit order.** Date D D M M Y Y

STEP 9: IMPORTANT INFORMATION – PLEASE READ AND SIGN

It is very important that you are quite sure that the product meets your need and that you can afford the chosen product. If you intend to replace an existing policy with this one please ensure that you do a comparison between the policies. Please do not hesitate to contact us on 086 111 2654 should you require any assistance in this regard. Please ensure you have all the information you need before you make a decision. The personal information hereby provided by the client will be used and processed as is necessary to carry out actions and functions for the conclusion or performance of the agreement entered into between the parties. Premiums are due and payable monthly in advance on the 1st working day of each month. A grace period of (31) thirty one days is allowed after which cover will cease and no claims will be considered. Premiums are only payable by way of Debit Order or Salary Deductions. No cash premiums are allowed. 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.

MY SIGNATURE:

Date D D M M Y Y

STEP 10: Your declaration as client

I have read, understand and agree with the above STEP 9: "IMPORTANT INFORMATION"

I declare that all information in this form is complete and correct. I am satisfied that I understand everything I need to know about the policy to make an informed decision myself in respect of the purchase thereof. I hereby confirm that no advice was given to me. I will be able to pay the premiums and I understand that if information is not correct, benefits under this policy may be declined and premiums paid could be forfeited. Are you taking out this policy to replace any of your existing insurance policies? YES / NO

MY SIGNATURE:

Date D D M M Y Y