SRIC
Ensuring your tomorrow, today.

LIFE ASSURANCE APPLICATION FORM

Proposal number		Policy Number		Introducer's Code	

A. LIFE ASSURED

First Names					
Surname					
Maiden, former or other name					
Nationality					
Date of Birth	DD / MM / YYYY	Age Next Birthday			
Place of Birth					
Marital Status		Gender		Age Admitted	
ID Number		Telephone Number (work)			
Mobile Number		Telephone Number (home)			
Email Address					
Occupation					
Postal Address					
Residential Address					
Name and Address of Employer					
Contact Details		Tel		Fax	
Source of Income					

On average, during the past twelve months, did you earn: (tick one)

- ☐ 1. E0 - E3 000
- ☐ 2. E 3 001 - E7 000
- ☐ 3. E7 001 - E10 000
- ☐ 4. Over E10 000

Source of Wealth

(Indicate, below, the origin of the funds being invested if not from salary. e.g. savings, inheritance, investment, etc)

Bank Name

Account Number

B. NEXT OF KIN / CONTACT PERSON

Name	Tel (h)	Tel (w)	Cell	Relationship
1				
2				

C. APPLICANT IF OTHER THAN THE LIFE ASSURED (NOT FOR RETIREMENT ANNUITY)

Name and Surname			
Maiden, former or other name		Nationality	
ID Number		Date of Birth	DD / MM / YYYY
Place of Birth		Age Next Birthday	
Marital Status	Gender	Age Admitted	
ID Number	Telephone Number (work)		
Mobile Number	Telephone Number (home)		
Email Address			
Occupation			
Postal Address			
Residential Address			
Name and Address of Employer			
Contact Details	Tel	Fax	
Source of Income			

On average, during the past twelve months, did you earn: (tick one)

- ☐ 1. E0 - E3 000
- ☐ 2. E 3 001 - E7 000
- ☐ 3. E7 001 - E10 000
- ☐ 4. Over E10 000

Source of Wealth

(Indicate, below, the origin of the funds being invested if not from salary. e.g. savings, inheritance, investment, etc)

Bank Name

Account Number

D. DETAILS OF PLAN

Details of Plan and Supplementary Benefits	Table Code	Term In Years Ben	Term In Years Prem	Sum Assured E	Premium/ Contribution E
Plan Description					
Auxiliary Benefits: Optional					
1. Disability Cash Benefit On Carrier					
2. Accidental Death					
3. Investment					
4. Premiums Waiver on Life Assured's a. Disability					
b. Death					
5. Others (Specify)					
Premium Escalation Percentage			Policy fee, if applicable		
Sum Assured Percentage			Total premium/contribution		

Premium Frequency

- Monthly
- Yearly
- Other (specify)

Method Of Payment

- Bank Debit Order ☐
- Bank Stop Order ☐
- Staff Stop Order ☐
- Govt Stop Order ☐

Commencement Date: Related to acceptance and payment of first premium — DD / MM / YYYY

E. GENERAL, OCCUPATION AND ACTIVITIES (ONLY FOR CASES WITH LIFE COVER OR DISABILITY COVER)

		Y/N
1	Have you, in the past, made any application for life assurance to this Corporation?	
2	Has any application on your life ever been declined, withdrawn or accepted on special terms?	
3	What is the total amount of insurance cover on your life at present (excluding this application)?	
4	Are you engaged in any occupation other than that stated on page 1?	
5	Have you, in the past five years, been engaged in or intend engaging in hazardous occupations or pursuits, e.g. Mining, Use of Explosives, Parachuting, Hang-gliding, Private Flying, Underwater Diving, etc?	
6	Do you, in the course of your occupation perform any duties that are not clerical or administrative?	

If you have answered yes to any question above, please provide details below. Questionnaires are available for specific hazardous occupations and pursuits and should be completed now where applicable.

Question No.	Details (Please provide dates and, where applicable, proposal policy numbers)

F. HEALTH STATEMENT (ONLY FOR CASES WITH LIFE OR DISABILITY COVER)

Completed only where a medical examination is not being arranged.

		Y/N
1	Have you, during the past five years, sought medical advice, had surgical treatment or undergone any medical investigation such as x-rays, ECGs, blood tests, etc?	
2	If not already recorded in answer to the previous question, have you ever experienced any of the health problems listed below?	
2.1	Rheumatic fever, heart murmurs, chest pains, angina, coronary thrombosis	
2.2	High blood pressure, impaired blood circulation, stroke	
2.3	Conditions of the lungs e.g. asthma, shortness of breath, pneumonia, tuberculosis, etc	
2.4	Conditions of the kidneys e.g, nephritis, congenital abnormalities, etc	
2.5	Anxiety or depressive states or epilepsy	
2.6	Sexually transmitted conditions	
2.7	Diabetes, sugar in urine or glandular disorders	
2.8	Conditions of the joints or spine e.g. rheumatism, arthritis, back problems, etc	
2.9	Cancer, tumours or blood disorders	
3	Are you currently taking any drugs or prescribed medicine?	
4	Do you have any form of disability e.g loss of use of any limb, impaired sight or hearing, etc?	
5	Are you aware of any other circumstances which may influence the risk of assurance on your life?	
6	Habits:	
6.1	Have you smoked tobacco in any form during the past 24 months?	
6.2	Do you currently smoke more than 20 cigarettes per day?	
6.3	Do you on average consume more than four alcoholic drinks per day? (1 drink= 1 tot of spirits or 1 pint of beer or 1 glass of wine)	
6.4	Did you ever drink more in the past?	
7	Is there a history in your family of diabetes, raised cholesterol, heart disease, stroke, high blood pressure, nervous or mental disorder, cancer, retinitis, haemophilia or any other hereditary disease? If yes, please state relationship, nature of disease and present age or age at death of relative	
8	Height (Specify em or ft)	
9	Mass (weight) (Specify)kg or lbs)	
10	Have you ever had:	
10.1	Unexplained, persistent fever or skin disorder?	
10.2	Unexplained, persistent night sweats?	
10.3	Unexplained weight loss?	
10.4	Unexplained persistent cough?	

		Y/N
10.5	Unexplained infections or swollen glands?	
10.6	Chronic or recurrent diarrhoea?	
10.7	Hepatitis B or sexually transmitted diseases, including genital sores or discharges?	
11	Have you ever had a blood test for HIV and AIDS condition?	
11.1	Have you ever been refused as a blood donor?	
11.2	Have you ever received a blood transfusion within the last 5 years?	

If you have answered yes to any question above, please provide details below

Question No	Details such as nature of complaint, dates, doctors consulted, last symptoms, smoking habits, alcohol consumption, family history, etc.

Note: Please complete questionnaires available for specific conditions, eg, asthma, chest pain, indigestion, diabetes, etc

FEMALES ONLY

12	Have you ever had any disorder of the female organs (breasts, ovaries, uterus) or any abnormality of pregnancy or confinements e.g. caesarian section or miscarriage? If yes, please provide full details including dates	
12.1	When was your last child born?	
12.2	Are you now pregnant?	
	If yes, please state expected date of confinement	

and arrange for completion of PRIVATE MEDICAL ATTENDANT'S REPORT

G. DETAILS OF USUAL MEDICAL ATTENDANT

Name	Postal Address	Contact NO.	Period as your doctor

ATTACH HOSPITAL/OUTPATIENT CARD

H. REPLACEMENT

Is this application to replace an existing assurance or application with this or any other assurer? Yes ☐ No ☐

If the answer is yes, please provide the name and address of the assurer.

IMPORTANT: Replacement of any assurance is nearly always to the disadvantage of the applicant because it involves duplication of initial costs charged to the policy

I. DECLARATION (PLEASE READ CAREFULLY)

It is agreed and declared that:

1. All information supplied or to be supplied in connection with this application, whether in my/our handwriting or not, is true and complete and will form the basis of the contract with the Corporation. All statements and declarations made in respect of an existing contract containing an option resulting in this application will form part of the basis of the new contract.
2. If any material information has been withheld,.or any material information supplied proves to be incorrect, the contract will be invalid and all premiums/contributions paid will be forfeited.
3. The Corporation will be notified immediately of any change in the health and occupation of the life assured which occurs before cover commences so that the terms of acceptance may be reconsidered.
4. The Corporation's standard conditions will apply to the contract and to any beneficiary nomination.
5. Any doctor, other person or institution is authorised before and after the death of the life assured to disclose any information concerning his or her health to the Corporation.
6. **Authorisation by account holder if payable by debit order**: The Corporation may draw against the account all amounts due to it in terms of this application. The authority is to remain in force until terminated by myself or the Corporation and I agree to advise the Corporation of any change in the account details.

Signature(s) (To be countersigned by legal guardian if life assured is under age 21)	Date
Life Assured	DD / MM / YYYY
Applicant, if other than life assured	DD / MM / YYYY
Account holder, if other than life assured or account holder	DD / MM / YYYY

If the applicant or the account holder is a business undertaking, an authorised official must sign across the business stamp

J. INTRODUCER'S REPORT

Is this applicant to replace any existing contract or current application with this or any other assurer? Yes ☐ No ☐

Was this application form completed by the applicant in his/her handwriting? Yes ☐ No ☐

Name(s) of Introducer(s) Please complete in BLOCK letters	Share
	%
	%
Special Remarks	
Signatures Date	DD / MM / YYYY

K. DOCUMENTS TO BE ATTACHED

Where the Life Assurance policy has a funeral extension, attach the following

- Certified copies of Birth Certificates of all dependants including children and spouses
- Certified copies of ID's of all parents and parents in law
- Certified copies of ID's and certified copies of marriage certificates of spouses
- Certified copy of 10 of beneficiary where one has been nominated

L. FOR OFFICE USE

The Officer in charge shall ensure that the client has accurately filled in the under-listed information:

☐ Personal Details ☐ Payment Details

☐ Employment Details ☐ Any other Vital Information

Signature of Officer

REVOCABLE BENEFICIARY NOMINATION

PERSONAL DETAILS

Policy Owner			
Policy Number		ID Number	
Postal Address			
Physical Address			
Telephone (work)		Telephone (home)	
Mobile Number			

I (full names) _____ hereby wish to nominate the under mentioned person(s) to receive the benefit payable by the policy in the event of my death in the proportions indicated. This form supersedes any previous nomination that I may have made.

APPOINTMENT OF BENEFICIARY

1. The person designated below has been duly appointed as the Beneficiary under this Policy with the effect that the Swaziland Royal Insurance Corporation will pay such benefits as are specified in the Policy as being payable in the event of the death of the Life Assured to such Beneficiary instead of to the person to whom they are expressed in the Policy to be payable, subject to the conditions of the Policy and this endorsement, and subject to the deduction of any amounts owing to the Swaziland Royal Insurance Corporation in respect of loans made upon the security of the Policy and of any amounts so owing for which the policy or any interest there in has been ceded as security to the Swaziland Royal Insurance Corporation and of arrear premiums and Interest thereon, and subject also to any encumbrance on the Policy or rights therein of which the Swaziland Royal Insurance Corporation has received notice before payment.

2. The Beneficiary shall have no right in or to the Policy prior to the death of the Life Assured, and, until that time, the Proposer shall be free to cede, assign or surrender the Policy or any bonus thereunder, to effect loans on the security of the Policy, or otherwise to dealt herewith and to receive any amounts payable in terms thereof, without the consent of the Beneficiary: and any advance or payment bona fide made by the Swaziland Royal Insurance Corporation upon or in receipt of the Policy before the date upon which written notice of the death of the Life Assured shall have been received by the Swaziland Royal Insurance Corporation at its Head Office shall be valid and effectual against the Beneficiary.

3. The Proposer may by notice in writing to the Swaziland Royal Insurance Corporation at its Head Office revoke the above mentioned appointment without the consent of the Beneficiary, but no revocation shall be of any force or effect unless notice is received by the Swaziland Royal Insurance Corporation at its Head Office prior to the death of the Life Assured.

4. This appointment shall automatically become null and void in the event of the Proposer ceding or assigning the Policy or any interest therein (whether as security or otherwise) or surrendering the Policy or in the event of the Beneficiary predeceasing the Life Assured or the sum assured under the Policy becoming payable in terms thereof before the death of the Life Assured. This clause shall, however not apply to accession of the Policy or any interest therein in favour of the Swaziland Royal Insurance Corporation as security for a loan or any amount owing to the Swaziland Royal Insurance Corporation.

5. Any reinstatement of the Policy after it has lapsed shall have the effect of reinstating this endorsement.

I hereby revoke any previous revocable beneficiary nomination made by me in respect of this Policy

Signed at		Date	DD / MM / YYYY
Witness Signature		Signature of Proposer	
Address			

BENEFICIARY 1				
Name				% Benefit
Relationship				
ID Number		Date of Birth	DD / MM / YYYY	
Physical Address				
Postal Address				
Telephone (home)		Telephone (work)		
Mobile Number		Email Address		

BENEFICIARY 2				
Name				% Benefit
Relationship				
ID Number		Date of Birth	DD / MM / YYYY	
Physical Address				
Postal Address				
Telephone (home)		Telephone (work)		
Mobile Number		Email Address		

BENEFICIARY 3				
Name				% Benefit
Relationship				
ID Number		Date of Birth	DD / MM / YYYY	
Physical Address				
Postal Address				
Telephone (home)		Telephone (work)		
Mobile Number		Email Address		

BENEFICIARY 4				
Name				% Benefit
Relationship				
ID Number		Date of Birth	DD / MM / YYYY	
Physical Address				
Postal Address				
Telephone (home)		Telephone (work)		
Mobile Number		Email Address		

BENEFICIARY 5				
Name				% Benefit
Relationship				
ID Number		Date of Birth	DD / MM / YYYY	
Physical Address				
Postal Address				
Telephone (home)		Telephone (work)		
Mobile Number		Email Address		

Total Benefit must equal 100%

Note: We urge you to update your beneficiary nomination form on a regular basis, particularly as and when your circumstances change