|  |  |
| --- | --- |
|  | **Spouse Life Insurance:**  **Application for benefit** |

## Name of Policyholder: Code

Name of participating employer or branch

***Important Notes*** This form is to be completed when:

* the insurance of a spouse/life partner/customary marriage commences in terms of the policy,
* a life partner in a co-habiting relationship is nominated to qualify for insurance; and
* a change in the information regarding the spouse/life partner as indicated in *Section B*, becomes applicable. All references to insured will mean either employee or fund member.

In the event of the death of the spouse/life partner/customary marriage, a copy of this form must accompany the death claim documents submitted to Sanlam.

**A Particulars of insured** *(Compulsory to be completed by the employer)*

Full names and surname: Identity number:

Date of birth: *(dd/mm/ccyy)* Gender: Marital status: Married Co-habiting Customary marriag

Male

e

Employee number: Date of entering service:

Female

Date of permanent appointment: Commencement date of insurance:

## Certified on behalf of the employer that the above information is correct

Full names and surname:

Signature Capacity: Date: *(dd/mm/ccyy)*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **B** | **Particulars of spouse/life partner and marriage/customary marriage** | | | | | |
|  | Full names and surname | | | | | |
|  | Identity number: | | | |  |  |
|  | Date of birth: | *(dd/mm/ccyy)* | | Gender: | Male | Female |
|  | ***Please note:*** | * It is compulsory for qualifying spouses of existing employees and new employees to join the group scheme. * All spouses in living together arrangements (i.e. co- habiting spouses) must provide medical evidence of good health in respect of their full cover amount, before their insurance commences. * If a person is in a *co-habiting relationship*, the partner can only be nominated if neither one of the couple living together, is married to another person. | | | | |
|  | Marital status: | Married (civil) | Customary marriage (Tribal / Labola / Hindu) | | |  |
|  |  | Date of entering into marriage: | |  | *(dd/mm/ccyy)* |  |
|  |  | Co-habiting | Life partnership | |  |  |
|  |  | Date of registration of the union with the employer: | | |  | *(dd/mm/ccyy)* |
|  | **Definitions:** | |  |  |  |  |
|  | ***Qualifying Spouse*** means the person with whom the employee is joined in **Marriage**, provided that such person, at the time of qualifying for the insurance, has already reached the age of 15 years. If an employee is joined in **Marriage** with two or more persons, **Qualifying Spouse** means:   1. only that one of them whom the employee nominated in writing to the employer during the person's life; or 2. if the employer advises Sanlam that the employee has failed to nominate only one of them in terms of paragraph (a), only the one with whom he/she is joined in **Marriage** first.   Once a nomination has been made in terms of paragraph (a), it remains in force as long as the employee is joined in marriage with the relevant spouse. | | | | | |

|  |
| --- |
| A **Qualifying Spouse** who is joined in a union referred to in paragraph (b) of the definition of **Marriage** must in terms of the clause submit proof of good health to the satisfaction of Sanlam to qualify for the spouse's life insurance. |
| ***Marriage*** means:   1. a marriage or union in accordance with the Marriage Act, 1961, the Recognition of Customary Marriages Act, 1998, or the Civil Union Act, 2006, or the tenets of a religion; or 2. a union where two persons are living together as if married, with the commitment of continuing to do so permanently provided that    * they have been doing so for at least six months; and    * in the format prescribed by the **Employer** from time to time, they successfully applied in writing to the employer, before the death of any one of them, for their union to be registered by the employer; and    * one or both of them are not joined in a marriage or union as contemplated in paragraph (a) above with another person. |

|  |  |
| --- | --- |
| **C** | **Disclaimers** |
|  | **Party Due Diligence requirements** |
|  | In line with the FIC Amendment Act, 2017 and other Party Due Diligence requirements, Sanlam has the obligation to identify and verify all persons or entities we interact with. Thus, please provide the information as requested in the forms. Sanlam reserves the right to cancel the insurance immediately if any of the obligations in terms of the FIC Amendment  Act, 2017 and other Party Due Diligence requirements are not met. |
|  | **Protection of Personal information** |
|  | ***Why Personal Information is required:*** Sanlam Life Insurance Limited ("Sanlam Life"), a subsidiary of Sanlam Limited, will process and protect your personal information as required by relevant laws and the Constitution of the Republic of South Africa ("RSA"). The personal information requested in this form, which may include special personal information is being collected and will be processed for the following purposes:   * underwriting and providing accurate and effective insurance cover and related value-added services; * member communication; * market research and statistical analysis; * verification of the personal information provided; * to comply with all legal and regulatory requirements, including applicable codes of conduct; * to protect Sanlam Life's interests; and * any purposes related to the above.   Failure to provide the mandatory information will prejudice your insurance cover.  ***Changing and correcting Personal Information:*** You have the right to:   * Request a copy of your personal information as processed by Sanlam Life; * Ask for an update and/or correction of your personal information; * Lodge a complaint with the Information Regulator.   Sanlam Life may charge an administrative fee subject to prior notice of any such cost before executing the request for a copy of your personal information.  ***Other parties that may receive the Personal Information:***   * We may share your personal information within Sanlam Limited and/or with other service providers where required for any of the purposes listed above, or with third parties where Sanlam Life is lawfully required to do so. * We may send your personal information to service providers outside the RSA for storage or further processing on Sanlam Life's behalf. We will however not send your information to a country that does not have information protection legislation similar to that of the RSA, unless we have a binding agreement with the service provider which ensures that it effectively adheres to the principles for processing of personal information in accordance with the Protection of Personal Information Act, 2013.   For more information, please refer to the [Sanlam Group Privacy Notice.](https://www.sanlam.com/legal/Pages/sanlams-privacy-policy.aspx) |

|  |  |  |
| --- | --- | --- |
| **Declaration by the insured** |  |  |
| I declare that when claiming a benefit for my spouse/life partner, I will be responsible to render proof of my relationship. | | |
| Signature of employee | Date | *(dd/mm/ccyy)* |
| Signature of witness | Date | *(dd/mm/ccyy)* |

### Reference number: G01

**Personal Health Statement**

### EB1463E

**Must be completed by the insured.**

***Important: No compensation is payable if an examiner completes this questionnaire.***

Scheme code Scheme name Membership number

# Particulars of insured

Surname First name and further initials Identity number / Passport number *(Compulsory)*

*Note: Passport number only if not in possession of a valid RSA identity document.*

Date of birth *(dd/mm/ccyy)*

Address

Postal code

Email address Cell phone number

# Information regarding your main occupation

1. What is your job title (occupation)?
2. Describe your exact duties (please be specific and provide full details)
3. What percentage of your normal working hours is spent on the following?

|  |  |
| --- | --- |
| Professional services, like doctors and attorneys | % |
| Administrative and clerical duties | % |
| Selling | % |
| Supervision of processes/machinery | % |
| Supervision/inspection of personnel | % |
| Always in the same building (i.e. factories) | % |
| In different buildings/work sites, (i.e. construction sites) | % |
| Travelling | % |
| Manual labour | % |
| Other *(please specify)* | % |

# Personal statement by the insured

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Has a proposal for insurance for life, health, dread disease, disability insurance or functional impairment insurance ever been declined, deferred or accepted with certain provisions, e.g. a premium loading, exclusion, etc.? If "Yes", give full details. | Yes |  | No |  |

1. **Medical history**

|  |  |  |  |
| --- | --- | --- | --- |
| Do you have, or have you ever had, any of the following? |  | |  |
| 2.1 Disorder of the heart, e.g. rheumatic fever, heart murmur, raised cholesterol, shortness of breath, | Yes | No |  |
| palpitations, chest pain or a heart attack? |  |  |  |
| 2.2 High blood pressure, disease of the blood vessels or circulatory disorder, e.g. cramps in the calves | Yes | No |  |
| with exercise or walking, etc.? |  |  |  |
| 2.3 Lung disorders, e.g. tuberculosis, asthma, bronchitis, persistent cough or other breathing problems? | Yes | No |  |
| 2.4 Disorder of the digestive system, stomach, gall bladder, gallstones, pancreas or liver, e.g. stomach ulcer recurrent indigestion or heart burn, hiatus hernia, herniae (umbilical or inguinal), rectal bleeding, piles or jaundice or have you ever had a gastroscopy or other special examinations? | Yes | No |  |
|  |  |  |  |

2.5 Disease or disorder of kidneys, bladder or sex organs, e.g. abnormal urine test, kidney stones, prostatitis, bladder infections, poor bladder control or sexually transmitted disease e.g. hepatitis B, gonorrhoea or syphilis, etc.?

Yes No

* 1. Disorders of the nervous system e.g. epilepsy, fits, blackouts, strokes, tremor or migraines?

Yes No

* 1. Mental disorders e.g. depression, anxiety, panic attacks or post-traumatic stress disorder?

Yes No

* 1. Eye, ear, nose or throat disorder, e.g. poor vision, visual disturbance, hearing loss, ear discharge, ringing in the ears, hoarseness, or sinusitis?

Yes No

* 1. Disorder or disease of the skin, muscles, bones, joints, limbs, spine, e.g. any skin rash, rheumatism or arthritis, gout or any back trouble?

Yes No

* 1. Sugar diabetes, insulin resistance, thyroid or other hormonal or blood disorders, e.g. anaemia, iron deficiency or bleeding tendency?

Yes No

* 1. Cancer, a growth or tumour of any kind, including moles, removed?

Yes No

* 1. If not already mentioned, have you had any other illness, including chronic fatigue (yuppie flu), fibromyalgia, tropical disease (bilharzia or malaria), or have you had any operations, disability or accidents including motor vehicle accidents) or been hospitalised?

Yes No

* 1. Have you ever been declared medically disabled, or have you ever submitted a claim for disability or third-party benefits?

Yes No

* 1. Any chronic condition of the joints, limbs or spine, that may need medical intervention, e.g. bunions, unstable knee ligaments, recurrent shoulder dislocations, rotator cuff problems or frozen shoulder etc.?

Yes No

* 1. In the last 3 months:
     1. Have you had direct contact with someone who tested positive for COVID-19, or was suspected to have been infected by COVID-19?

Yes No

* + 1. Have you been advised to self-isolate due to COVID-19 (excluding mandatory government orders to remain at home)?

Yes No

* + 1. Did you have a persistent cough, fever, raised temperature, fatigue, body aches or shortness of breath, or are you currently experiencing these symptoms?

Yes No

* 1. If you answered "Yes" to any of the questions in 2.15, have you made a full recovery and

returned to normal activities? Yes No N/a

If "Yes", when? *(dd/mm/ccyy)*

* 1. Have you been tested for the COVID-19 virus? Yes No

If "Yes", what was the result? Positive Negative Await result

* 1. If "Positive", please answer the following:

1. When were you diagnosed? *(dd/mm/ccyy)*
2. Were you admitted to hospital? Yes No

If "Yes", General Ward or High Care/ICU

1. Have you had a repeat test? Yes No

If "Yes", what was the date? *(dd/mm/ccyy)*

Result of the repeat test? Positive Negative Not applicable

***2.19 For female applicants only:***

Any condition or abnormality of the female reproductive system or breasts? This may include abnormal Yes No pap smears, abnormal or excessive menstruations, enlarged uterus or fibroids/myoma of the uterus,

ovarian cysts, any nodule/tumour/cyst of the breasts or fibro-adenosis, or other similar condition.

* 1. Are you pregnant? Yes No

If so, how many weeks?

* 1. If you answered "Yes" to any of the above questions, please give details in the tables below

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Date diagnosed** | **When was the last symptoms** | **Fully recovered? (Y/N)** | | **Still on treatment (Y/N)** | |
|  | y≤6 months | y≤6 months | **Yes** | **No** | **Yes** | **No** |
|  | >6 months - 2 years | >6 months - 2 years |
|  | >2 years - 5 years | >2 years - 5 years |
|  | >5 years | >5 years |
| **Nature of disease or abnormality:** | | | | | | |
| **Treating Doctor or Medical Institution:** | | | | | | |
| **Treatment received:** | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Date diagnosed** | **When was the last symptoms** | **Fully recovered? (Y/N)** | | **Still on treatment (Y/N)** | |
|  | y≤6 months | y≤6 months | **Yes** | **No** | **Yes** | **No** |
|  | >6 months - 2 years | >6 months - 2 years |
|  | >2 years - 5 years | >2 years - 5 years |
|  | >5 years | >5 years |
| **Nature of disease or abnormality:** | | | | | | |
| **Treating Doctor or Medical Institution:** | | | | | | |
| **Treatment received:** | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Date diagnosed** | **When was the last symptoms** | **Fully recovered? (Y/N)** | | **Still on treatment (Y/N)** | |
|  | y≤6 months | y≤6 months | **Yes** | **No** | **Yes** | **No** |
|  | >6 months - 2 years | >6 months - 2 years |
|  | >2 years - 5 years | >2 years - 5 years |
|  | >5 years | >5 years |
| **Nature of disease or abnormality:** | | | | | | |
| **Treating Doctor or Medical Institution:** | | | | | | |
| **Treatment received:** | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Date diagnosed** | **When was the last symptoms** | **Fully recovered? (Y/N)** | | **Still on treatment (Y/N)** | |
|  | y≤6 months | y≤6 months | **Yes** | **No** | **Yes** | **No** |
|  | >6 months - 2 years | >6 months - 2 years |
|  | >2 years - 5 years | >2 years - 5 years |
|  | >5 years | >5 years |
| **Nature of disease or abnormality:** | | | | | | |
| **Treating Doctor or Medical Institution:** | | | | | | |
| **Treatment received:** | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Date diagnosed** | **When was the last symptoms** | **Fully recovered? (Y/N)** | | **Still on treatment (Y/N)** | |
|  | y≤6 months | y≤6 months | **Yes** | **No** | **Yes** | **No** |
|  | >6 months - 2 years | >6 months - 2 years |
|  | >2 years - 5 years | >2 years - 5 years |
|  | >5 years | >5 years |
| **Nature of disease or abnormality:** | | | | | | |
| **Treating Doctor or Medical Institution:** | | | | | | |
| **Treatment received:** | | | | | | |

|  |  |  |
| --- | --- | --- |
| 3. If not already given, have you ever: |  |  |
| 3.1 been tested for Aids or Aids-related illness (excluding for insurance purposes), for Hepatitis B or any other sexually transmitted diseases or have you received any medical advice, counselling or treatment in respect thereof? | Yes | No |
| 3.2 during the past 5 years undergone any X-rays, ECG’s, blood tests or examinations including genetic testing or tumour markers, with abnormal results or resulting in treatment? | Yes | No |
| 3.3 undergone any operations (excluding procedures for sinus, caesarean section, varicose veins, haemorrhoids, appendix, tonsils, gall-bladder)? | Yes | No |
| * 1. taken any medications, including anti-depressants, tranquillisers, or drugs including cannabis dagga), cocaine, anabolic steroids, etc. for medical or other reasons during the past 5 years?   *Please note*: State present or past medication, dosage and reason for use. | Yes | No |
| * 1. consulted any doctors or other practitioners for example chiropractors, homeopaths, reflexologists, or   traditional healers, etc. including routine annual check-ups and insurance medicals during the past 12 months? | Yes | No |
| * 1. been hospitalised for 24 hours or more for any medical condition, psychiatric problem or injury (excluding confinement)? | Yes | No |
| * 1. If "Yes" to any of the above please give details in the tables below |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Date diagnosed** | **When was the last symptoms** | **Fully recovered? (Y/N)** | | **Still on treatment (Y/N)** | |
|  | y≤6 months | y≤6 months | **Yes** | **No** | **Yes** | **No** |
|  | >6 months - 2 years | >6 months - 2 years |
|  | >2 years - 5 years | >2 years - 5 years |
|  | >5 years | >5 years |
| **Nature of disease or abnormality:** | | | | | | |
| **Treating Doctor or Medical Institution:** | | | | | | |
| **Treatment received:** | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Date diagnosed** | **When was the last symptoms** | **Fully recovered? (Y/N)** | | **Still on treatment (Y/N)** | |
|  | y≤6 months | y≤6 months | **Yes** | **No** | **Yes** | **No** |
|  | >6 months - 2 years | >6 months - 2 years |
|  | >2 years - 5 years | >2 years - 5 years |
|  | >5 years | >5 years |
| **Nature of disease or abnormality:** | | | | | | |
| **Treating Doctor or Medical Institution:** | | | | | | |
| **Treatment received:** | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Date diagnosed** | **When was the last symptoms** | **Fully recovered? (Y/N)** | | **Still on treatment (Y/N)** | |
|  | y≤6 months | y≤6 months | **Yes** | **No** | **Yes** | **No** |
|  | >6 months - 2 years | >6 months - 2 years |
|  | >2 years - 5 years | >2 years - 5 years |
|  | >5 years | >5 years |
| **Nature of disease or abnormality:** | | | | | | |
| **Treating Doctor or Medical Institution:** | | | | | | |
| **Treatment received:** | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Date diagnosed** | **When was the last symptoms** | **Fully recovered? (Y/N)** | | **Still on treatment (Y/N)** | |
|  | y≤6 months | y≤6 months | **Yes** | **No** | **Yes** | **No** |
|  | >6 months - 2 years | >6 months - 2 years |
|  | >2 years - 5 years | >2 years - 5 years |
|  | >5 years | >5 years |
| **Nature of disease or abnormality:** | | | | | | |
| **Treating Doctor or Medical Institution:** | | | | | | |
| **Treatment received:** | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Number** | **Date diagnosed** | **When was the last symptoms** | **Fully recovered? (Y/N)** | | **Still on treatment (Y/N)** | |
|  | y≤6 months | y≤6 months | **Yes** | **No** | **Yes** | **No** |
|  | >6 months - 2 years | >6 months - 2 years |
|  | >2 years - 5 years | >2 years - 5 years |
|  | >5 years | >5 years |
| **Nature of disease or abnormality:** | | | | | | |
| **Treating Doctor or Medical Institution:** | | | | | | |
| **Treatment received:** | | | | | | |

## Details of family doctor consulted in the last 5 years

Initials and surname

Postal address

Postal code Telephone number ( ) Fax number ( )

Since when has this been your doctor? / / (*dd/mm/ccyy)*

Initials, surname and postal address of previous family doctor.

## Habits

*Important: Sanlam reserves the right to perform a urine or blood test for drugs.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 5.1 Have you smoked in the last 12 months? | Yes |  | No |  |

If "Yes" indicate the daily nicotine intake.

Cigarettes pd Cigars pd Pipe

* 1. State type and amount of alcoholic liquor you consume per week.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 5.3 Have you ever consumed more alcohol on a regular basis, or have you ever been charged with drunken driving? If "Yes", give full details including any treatment. | Yes |  | No |  |
|  | | | | |
|  | | | | |
|  | | | | |
|  | | | | |

1. **Build and physical condition**

Height meter Weight kg

## Family history

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have any of the following relatives suffered from or died as a result of sugar diabetes, heart disease, cancer, high blood pressure, raised cholesterol or any other hereditary disease? | Yes |  | No |  |

If "Yes", please complete the table.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Father**  (Dx age) | **Mother**  (Dx age) | **Brother 1**  (Dx age) | **Sister 1**  (Dx age) | **Brother 2**  (Dx age) | **Sister 2**  (Dx age) |
| Heart and blood vessel disease  (**incl**. angina, heart attack, stroke/trombosis, raised cholesterol) |  |  |  |  |  |  |
| Hypertension |  |  |  |  |  |  |
| Diabetes (high blood sugar) |  |  |  |  |  |  |
| **Cancer(s):** | | | | | | |
| Breast |  |  |  |  |  |  |
| Ovaria |  |  |  |  |  |  |
| Prostate |  |  |  |  |  |  |
| Colon or Colo-rectal |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |
| **Inherited diseases:** | | | | | | |
| Polycystic kidney disease |  |  |  |  |  |  |
| Familial polyposis |  |  |  |  |  |  |
| Huntington's disease |  |  |  |  |  |  |
| Alzheimers |  |  |  |  |  |  |
| Multiple sclerosis |  |  |  |  |  |  |
| Parkinsons |  |  |  |  |  |  |
| Muscular dystrophy |  |  |  |  |  |  |
| Motor neuron disease |  |  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Do you intend seeking medical advice in the next 8 weeks? If "Yes", give full details. | Yes |  | No |  |
|  | | | | |
|  | | | | |
|  | | | | |
|  | | | | |
|  | | | | |
|  | | | | |

# Declaration by insured / member

I declare that this *Personal Health Statement*, whether in my handwriting or not, is complete and true in all aspects. I understand that should this not be complete and true, the following possible consequences could follow:

* I might not be paid any benefit at claim stage.
* I might be limited to the free cover limit at claim stage.
* My cover could be declined by Sanlam Life Insurance Ltd (Sanlam).

I understand that this statement and all the information contained in it will be stored electronically by Sanlam, no physical record will be kept. I understand that Sanlam requires access to my personal information (including special personal information, such as medical records) in order to assess any application for insurance made by me for the purposes of underwriting risks and assessing claims. Further that Sanlam will disclose any opinion regarding my medical assessment and medical history as well as exclusions etc.

I consent to Sanlam:

* Sharing my personal information with other insurers; and
* Collecting my personal information from other insurers,

For the purposes of underwriting risks and assessing claims at any time (including after my death), irrespective of whether it is shared/collected directly or through a data base.

All insurers are members of ASISA (The Association for Savings and Investment South Africa) share policy information on a central register to keep track of and ensure proper handling of the replacement of financial products, whether it concerns this existing application or the future. This information is protected and can only be accessed by authorised persons. To enable such authorised persons to access my policy information, I hereby give consent that my information may be used on the ASISA register.

This information will be treated in accordance with the applicable law, for example safeguard of and threating as confidential.

The provision of this information is a compulsory requirement from my insurer to provide me with this insurance product. If I choose not to provide this information to Sanlam will not be able to assess my application for insurance.

I may request details of the information held by Sanlam and request its correction where appropriate.

I will not hold Sanlam and/or its directors, agents, intermediaries and/or employees liable for any consequences that may arise as a result of such sharing/disclosure and/or collection of my personal information.

In so far as it is necessary for the purposes of underwriting risks and assessing claims, I consent to Sanlam requesting and obtaining my personal information (including special personal information, such as medical records) from any healthcare practitioner and/or healthcare institution, at any time (including after my death). I further expressly authorise such healthcare practitioner and/or healthcare institution, as the case may be, to provide Sanlam with the information it has requested, irrespective of when such request is made (including after my death).

Signature of insured / member

Date / / *(dd/mm/ccyy)* Place