Business Person Elect
Application Form

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

Is this a:

☐ New Application
☐ Replacement (From existing FMI policy) (Policy No.________________________________)
☐ Replacement (From other insurer)

Would you prefer FMI to conduct tele-underwriting on this application?

☐ Yes - Please complete section A and C only
☐ No - Please complete Section A, B and C

Section A - Compulsory

1. POLICYHOLDER 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:

Email:

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 / Passport Number: Date of Birth: D D M M Y Y Y Y

Home Language: Gender: M ☐ F ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Are you currently residing in South Africa? ☐ YES ☐ NO

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

If NO, please attach a copy of your temporary residency and work permit documents.

3. LIFE INSURED'S CONTACT DETAILS

Home Tel: Fax:

Business Tel: Cell Number:

E-Mail:

Postal address:

Code:

Physical address:

Code:

FMI subscribes to an environmentally friendly policy. All communication will be sent to you electronically unless otherwise specified.

Do you wish to have your correspondence sent to you by post? Yes No

Would you like to receive information on special offers, competitions, products and services? Yes No

4. LIFE INSURED'S OCCUPATIONAL DETAILS

Name of Business:

Nature of Business:

Business postal address:

Code:

Business details: Phone: Fax:

Please select an option from the choices below and state your annual income in the space provided.

Are you a:

A. Salaried Employee -

Annual Cost to Company (Basic) R

Are you a commission earner? YES NO

Annual Commission R

Are you employed on a contract basis? YES NO If YES, please attach a copy of your contract.

Total for A R

B. Self Employed Non Professional -

Annual Gross Business Income R

Annual Personal Income (over the last 12 months, including net share of profit) R

C. Self Employed Professional -

Annual Gross Professional Fees R

Annual Personal Income (over the last 12 months, including net share of profit) R

If this is a policy for Key Man Cover, please indicate your percentage share in the business %

If you are a professional, of which recognised Professional organisation are you a member of?

What is your present nominated occupation?

What industry do you work in?

When did you begin your current occupation?

Previous occupation(s) in the last 5 years (with dates):

	3.
1.	4.
2.	5.

Please mark the appropriate box. Where required, full details must be given for all questions answered YES.

1. Are there any other occupations you are or may become involved in? If YES give details. ______________________

______________________ YES ☐ NO ☐

2. Is there any direct or indirect hazard associated with your occupation? If YES give details. ______________________

______________________ YES ☐ NO ☐

3. During the past 5 years have you been absent from work for a continuous period of more than one month as a result of an accident or illness? YES ☐ NO ☐

If YES please fill in table below.

Nature of incapacity	Periods	Dates

4. Is the business based at your home? YES ☐ NO ☐

5. Have you ever been declared insolvent? YES ☐ NO ☐

6. If YES, are you rehabilitated? YES ☐ NO ☐

7. Have you ever engaged in, or are you likely to engage in any hazardous occupation, pursuit or sport? e.g. mining, aviation, motorised speed contest, diving, mountaineering, etc? If YES give details. ______________________

______________________ YES ☐ NO ☐

8. Do you derive income from another source including sport related activities? If YES give details. ______________________

______________________ YES ☐ NO ☐

9. Do you ever work outside the borders of R.S.A.? YES ☐ NO ☐

10. As part of your daily work activity, do you handle cash? YES ☐ NO ☐

The following table applies to salaried individuals only.

Job Description:

Administration: ☐ % Details of duties: ______________________

Supervisory: ☐ % Details of duties: ______________________

Manual: ☐ % Details of duties: ______________________

Travel: ☐ % Details of duties: ______________________

Total 100 %

The following table and questions apply to self employed individuals only.

Business Owner Classification:

Business Management: ______ % Details of duties: ______________________

Operations: ______ % Details of duties: ______________________

Total 100 %

Duties:

Non-physical: ______ % Details of duties: ______________________

Light Manual: ______ % Details of duties: ______________________

Heavy Manual: ______ % Details of duties: ______________________

Travel: ______ % Details of duties: ______________________

Total 100 %

Please mark the appropriate box.

1. Are you the sole owner of your business? YES ☐ NO ☐
2. If you are unable to work, how soon will your pre-disability business revenue reduce?
   From Day 1 ☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ More than 3 Months ☐
3. Do you actively manage your business on a regular basis for more than 10 hours per week? YES ☐ NO ☐
4. Are you certified and accredited with the appropriate governing body? YES ☐ NO ☐
5. How many people are employed in your business? 1 to 3 ☐ 4 to 10 ☐ 11 to 20 ☐ 21 to 50 ☐ 51 to 100 ☐ More than 100 ☐
6. How many of your employees have the same/similar skills as you have? 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ More than 4 ☐

5. 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 - **Temporary** Income Protection	Monthly disability income - **Permanent** Income Protection	Monthly disability income - **Business** Overhead Protection	Lump-sum disability
Amount	R	R	R	R
Name of insurer/s				

Simultaneous insurance	Monthly disability income - **Temporary** Income Protection	Monthly disability income - **Permanent** Income Protection	Monthly disability income - **Business** Overhead Protection	Lump-sum disability
Amount	R	R	R	R
Name of insurer/s				

6. DEBIT ORDER DETAILS

Account Holder: Account Type: Cheque / Current ☐ Savings ☐

Bank: Branch Name:

Branch Code: Account Number:

If the account holder is not the Life Insured, please state relationship:

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

2. Is a 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

I / we authorise FINANCIAL MANAGEMENT INTERNATIONAL LTD to draw on my/our Bank/Building Society account (as indicated above) and forward the premiums to the respective Insurer, the monthly premium required in terms of the benefit I/we have chosen.

Signature of Account Holder: ________________________ Date: ____________________

Name of Account Holder: ________________________

7. 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: D D M M Y Y Y Y

8. FINANCIAL ADVISER DETAILS AND COMMISSION BREAKDOWN (To be completed by Financial Adviser)

Name of Financial Adviser : Brokerage :

FMI Financial Adviser Code : M B Licence No :

PRI Number (If applicable):

Financial Adviser: Tel No: Cell No:

FMI Financial Adviser Consultant Name:

Commission Structure: Upfront Monthly ☐ Upfront Annualised ☐

Percentage of commission (0-100%)	%

(This refers to the percentage commission taken on a policy)

Please note 1: that the standard premium quoted will always be the automatic default premium applicable - Preferred or Super Preferred premiums will be subject to additional underwriting requirements.

Please note 2: that commencement of this policy is subject to FMI's standard medical requirements being fulfilled, and/or any additional medicals or questions needed, and/or any financial premium loadings deemed necessary by the underwriter at his/her discretion.

Do you consent to FMI conducting tele-underwriting on your client? **YES** ☐ **NO** ☐

FICA Standard Financial Adviser Declaration in terms of Exemption 4 as contained in the Regulations to the Financial Intelligence Centre Act, No. 38 of 2001 declaration I, ________________________

(Full Names, Surname and ID-number of Financial Adviser) of ________________________ (Name of Brokerage if it is a Legal Entity), confirm that I have identified the client(s)/employer(s) that have applied for this policy and have verified their identity according to the requirements as set out in the Financial Intelligence Centre Act, 38 of 2001, and any legislation, regulations or guidelines related thereto. I further confirm that I will keep record of the verification documents as required in terms of the said Act and will make available copies of these documents and details of the verification procedures followed on request to any party entitled thereto in terms of the Act.

Signature: ________________________ Date: D D M M Y Y Y Y Place: ________________________

Section B - Complete for Full Application (no tele-underwriting)

9. MEDICAL DETAILS - Full details must be given for all questions answered YES. Please mark the appropriate box.

Where medical tests are required: ☐ You would prefer to have a nurse sent to you ☐ You would prefer to go to the Lab / Doctor yourself

Have you ever experienced, been treated for, are currently suffering from or had any indication of the following conditions? If YES, please provide full details in the space provided, or under item 31.

1 Your heart or circulation (eg. blood pressure, chest pains, heart murmur, palpitations, rheumatic fever, stroke, cholesterol) YES ☐ NO ☐

2. Your lungs (eg. persistent cough, shortness of breath, tuberculosis, asthma, bronchitis) YES ☐ NO ☐

3. Your digestive system or liver (eg. recurrent indigestion, ulcers, bleeding from the bowel, hepatitis, gallstones) YES ☐ NO ☐

4. Your kidneys or bladder (eg. stones, infections, bilharzias, prostate problems) YES ☐ NO ☐

5. Your reproductive organs (eg. menstrual disorders, endometriosis, fibroids, menorrhagia, ovarian cyst) YES ☐ NO ☐

6. Your nervous system including psychiatric disorders (eg. concussion, paralysis, fits, blackouts, depression, anxiety, persistent headaches, epilepsy) YES ☐ NO ☐

7. Your eyes (excluding errors or refraction), ears, nose or throat (eg. deafness, ear discharge) YES ☐ NO ☐

8. Your skeleton, bones, joints or muscles (eg. rheumatism, arthritis, back or neck trouble, gout) YES ☐ NO ☐

9. Your glands or blood (eg. diabetes, thyroid, spleen, bleeding disorder, Leukaemia) YES ☐ NO ☐

10. Your skin, including cancers, growths and tumours of any kind YES ☐ NO ☐

11. Any other condition not mentioned above YES ☐ NO ☐

12. Are you currently pregnant? YES ☐ NO ☐

13. Have you sought medical advice during the past five years in connection with any symptom or condition, or been a patient in a hospital or nursing home or undergone any medical examination (including ECG, X-Ray examination or specialised laboratory tests) not mentioned above? YES ☐ NO ☐

14. Do you intend to seek medical treatment or advice in the next 12 weeks? YES ☐ NO ☐

15. Are you taking, or have you taken drugs, tranquilisers or any other medicines in any form for a continuous period of more than two weeks? Please provide details of medication in the table below. YES ☐ NO ☐

16. Have you ever been tested for or received advice, counselling or treatment in connection with AIDS, or any infection by one of the AIDS viruses or any sexually transmitted disease (eg.hepatitis B, gonorrhoea, syphilis or any venereal disease), other than for application for insurance purposes? YES ☐ NO ☐

17. Have you ever claimed any benefit against a sickness, accident, dread disease or disability policy? YES ☐ NO ☐

18. Are you aware of any health or other factors (past or present), which may influence the risk attached to this policy? YES ☐ NO ☐

19. Are all your immediate family members (parent or sibling) alive and healthy? YES ☐ NO ☐

If NO, please provide ALL your family medical history in the table below. This includes, but is not limited to, any parent or sibling of yours who have ever suffered from diabetes, cancer, stroke, heart complaint, high blood pressure, raised cholesterol, porphyria, mental disorders, haemophilia or any other hereditary disease not mentioned.

	Age if alive	If alive, briefly describe health condition	If deceased, cause of death	Age at death
Father				
Mother				
Brothers				
Sisters				

20. Height: ________ Metres Weight: ________ KG

21. Has your weight changed by more than 5 kg in the last 12 months? YES ☐ NO ☐

If YES, please state amount, whether weight was gained or lost and reason for this change: ____________________

____

22. Do you exercise regularly? YES ☐ NO ☐

23. Are you a member of a medical aid? If YES, state name and policy number: ____________________ YES ☐ NO ☐

24. Do you consume any alcohol? If YES, state quantity and type per week: ____________________ YES ☐ NO ☐

25. Have you habitually taken more alcohol in the past? YES ☐ NO ☐

26. Have you ever received medical advice to reduce or discontinue your liquor consumption? YES ☐ NO ☐

27. Do you currently smoke, or have you smoked in the last 12 months? YES ☐ NO ☐

28. If so how many cigarettes do you smoke per day? ______________________________

29. Have you ever received medical advice to reduce or discontinue smoking? YES ☐ NO ☐

30. Do you currently, or have you ever, consumed drugs, or other habit forming substances for recreational purposes? YES ☐ NO ☐

31. If any question is answered YES to the previous medical questions, please supply full details below. If the space provided is not sufficient, please attach additional information.

Question	Details of Disorder	Date Diagnosed	Duration and type of treatment, date of last symptoms, consulting doctor's name, address and telephone number	Degree of Recovery

32. Are you left handed or right handed? Left ☐ Right ☐

33. Please detail names and telephone numbers of your consulting doctor. Please indicate how many years you have been consulting the relevant doctor.

Name of Doctor:

Contact No:

Postal Address:

Code:

From : ______________ To : ______________

10. OTHER LIFE/DISABILITY INSURANCE - Full details must be given for all questions answered YES, please mark the appropriate box.

1. Have you been declined, deferred or accepted on special terms for life, accident or health insurance? YES ☐ NO ☐

   If YES, state the name of the company ______________________________

2. Have you undergone Life Insurance Medical Underwriting in the past 6 months? YES ☐ NO ☐

   If YES, please give details (Policy No. / Insurer details) ______________________________

3. Have you undergone an HIV test in the last 3 months? If YES, please give details. ______________ YES ☐ NO ☐

Section C - Compulsory

11. DECLARATION AND AGREEMENT BY POLICYHOLDER AND 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 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 Policyholder: ______________________________ Date: DD MM YYYY

Place: ______________________________

Signature of Life Insured (If different to Policyholder): ______________________________ Date: DD MM YYYY

Place: ______________________________