TR2603

Preparing for tomorrow, today

HEAD OFFICE
First Floor
Grosvenor Corner
195 Jan Smuts Avenue
Rosebank
Tel: 011 778 8000
Fax: 086 677 3224
P.O. Box 616
Johannesburg, 2000

BLOEMFONTEIN
6 Elizabeth Street
Fin Bond Building
Bloemfontein, 9323
P.O. Box 100962
Brandhof
Bloemfontein, 9324
Tel: 051 430 1201/2/3
Fax: 051 430 1206

CAPE TOWN
P.O. Box 4921
Cape Town 8000
Tel: 021 419 0090
Fax: 021 421 0104

DURBAN
P.O. Box 5008
Durban 4000
Tel: 031 305 1800
Fax: 031 304 3738

PORT ELIZABETH
P.O. Box 35036
Newton Park 6055
Tel: 041 363 1477
Fax: 041 363 0208

POLOKWANE
P.O. Box 1021
Polokwane 0700
Tel: 015 291 3358
Fax: 015 291 3336

☐ NEW APPLICATION	☐ AMMENDMENT
BRANCH NAME:	
POLICY COMMENCEMENT DATE:	Y Y Y Y M M D D

COMPULSORY FUNERAL ASSURANCE APPLICATION FOR MEMBERSHIP

1. PERSONAL DETAILS OF MAIN MEMBER

PRINCIPAL MEMBER SURNAME		FIRST NAMES			
ID / PASSPORT NUMBER	Y Y M M D D	DATE OF BIRTH	Y Y Y Y M M D D	GENDER	M F
TEL		CELL			
E-MAIL ADDRESS					
RESIDENTIAL ADDRESS					
				CODE	
POSTAL ADDRESS					
				CODE	
JOINED COMPANY	Y Y Y Y M M D D	STAFF NUMBER			

2. PERSONAL DETAILS OF SPOUSE

SPOUSE'S SURNAME		FIRST NAMES			
ID / PASSPORT NUMBER	Y Y M M D D	DATE OF BIRTH	Y Y Y Y M M D D	GENDER	M F

3. PRINCIPAL MEMBER'S CHILDREN

	NAME & SURNAME	DATE OF BIRTH / ID NUMBER	GENDER
1		Y Y M M D D	M F
2		Y Y M M D D	M F
3		Y Y M M D D	M F
4		Y Y M M D D	M F
5		Y Y M M D D	M F
6		Y Y M M D D	M F
7		Y Y M M D D	M F
8		Y Y M M D D	M F

PLEASE NOTE:
- Option to join must be within 6 (six) months of joining the Company
- Where a premium is underpaid, the benefit payable in respect of a claim will be reduced in proportion to the under payment.

FULL FAMILY PREMIUM	R
TOTAL PREMIUM	R

4. BENEFICIARY NOMINATION

I hereby nominate the following person, who is my dependant or nominee for any benefit due to be paid from the scheme in the event of my death.

NAME		SURNAME	
ID NUMBER	Y Y M M D D	RELATIONSHIP	

5. DECLARATION BY THE POLICYHOLDER OR APPLICANT

I declare to the best of my knowledge and belief that the particulars given above are true and correct. I understand and agree that any willful misrepresentation in this application will invalidate any benefit under this Policy and that I undertake to abide by the terms and conditions of the Policy. Safrican Insurance Company Limited shall not be liable for any amount until it has accepted this application and first premium.

**NB: If the participant is over the age limit when joining, the claim will be repudiated and premiums refunded.

SIGNATURE OF PRINCIPAL MEMBER	
DATE	Y Y Y Y M M D D

FOR OFFICE USE ONLY

POLICY NUMBER:	
MEMBER GROUP NUMBER:	
DATE:	Y Y Y Y M M D D