

Application for the Discovery Life Plan 3.0

Not applicable to Classic, Essential, Purple or Smart Life Plans



Contact us

Tel: 0860 00 54 33, PO Box 3888, Rivonia 2128, www.discovery.co.za

How to complete this application form



- To enable Discovery Life to process the application form quickly and accurately, please make sure that it is completed in full, and sign and date any changes made.
- The fields marked with an * are mandatory.

Please provide the required supporting documents:

- A copy of the identity document or passport must be included with this application.

Policy tax status

The policy will be non-tax-deductible. This means that premiums are not tax-deductible and benefits are tax-free.

Important information



When you complete the underwriting questions, please remember these important points

As the owner or insured life on this policy, you have these responsibilities:

- Answer all the questions truthfully, accurately and provide full disclosure, even if you previously disclosed information to Discovery or submitted a claim to Discovery Life. This also applies even if you are a member of a participating health plan from a medical scheme that is administered by Discovery Health.
- Disclose all information asked for, regardless of whether you believe that it is important or not.
- Fully and accurately disclose all information about smoking, alcohol use and drug use, regardless of how long ago it happened.
- Describe your occupation correctly, including the breakdown of your daily duties.
- Inform us about all hazardous pursuits you take part in.
- If there are changes in your health, occupation or pursuits after accepting this application but before the start date of the policy, you must let us know immediately. This is so that we can reassess and accept or decline the risk. Failure to do so could result in the policy being declared void (treated as if you never applied for a policy) or revised.

What information needs to be disclosed throughout the duration of the policy?

1. Any change in your nominated occupation and change in duties of your occupation.
2. Changes in your smoking status.
3. If you take up new hazardous pursuits.

Declaration by the insured life

I/We understand and accept that the validity of this application depends on relevant, true and complete disclosure of all information. If the information is incorrect, my benefits may be revised or cancelled and my claims may be declined

☐

What is non-disclosure and misrepresentation?

- Non-disclosure is leaving information out on purpose or forgetting to mention something relevant.
- Misrepresentation is giving a false or misleading answer to any question in this application form.

Both of the above may result in a claim being rejected or your insurance policy being made invalid.

If a financial adviser helps you to complete the questions, make sure the information is correct before accepting the document.

If you or any of the lives to be insured do not understand any questions, ask your financial adviser, a medical doctor or contact Discovery Life.

Full information about these and other important points are available in the terms and conditions section of the application.

1 Client details

It is important that you provide us with the correct contact details, which will be used to send all future correspondence and notifications. Discovery Life will not be legally responsible for any loss or harm you may suffer as a result of your personal and confidential information being sent to the wrong contact details.

1.1 Principal life

First names											Surname											
Title						Date of birth	D	D	M	M	Y	Y	Y	Y	Sex	M	<input type="checkbox"/>	F	<input type="checkbox"/>			
Previous/Maiden name																						
Country of birth*																						
ID Number																						
Nationality at birth*											OR	Foreign passport number										
												Nationality* (as per passport)										
												Expiration date*	D	D	M	M	Y	Y	Y	Y		
Marital status*	Single	<input type="checkbox"/>	Married	<input type="checkbox"/>	Common-law spouse	<input type="checkbox"/>	Divorced	<input type="checkbox"/>	Widowed	<input type="checkbox"/>												
Registered tax payer	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Income tax reference number																	

1.2 Socio-economic details

Nominated occupation*																			
Highest educational qualification	No matric	<input type="checkbox"/>	Matric	<input type="checkbox"/>	3-year diploma	<input type="checkbox"/>	3-year Degree	<input type="checkbox"/>	3+ year diploma	<input type="checkbox"/>	3+year Degree	<input type="checkbox"/>	Professional	<input type="checkbox"/>					
Total gross monthly income for nominated occupation	R																		
Have you smoked or used any tobacco products and/or have you used vaping products or e-cigarettes in the past 12 months?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>															
Do you participate in any hazardous pursuits, for example underwater diving, private aviation, skydiving, rock climbing or motocross?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>															
If Yes, please provide more information																			

1.3 Contact details

Email*																				
Cellphone*															Telephone (W)					
Telephone (H)																				
Physical address*																				
Complex/unit/house number						Complex/estate name														
Street number						Street name/name of farm														
Suburb/district											City/Town									
Region/Province											Country									
Code																				

1.4 Employment details

Employer*			
Industry of operation or employment*			
Does your industry include importing or exporting of goods and/or services?*	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Are you a domestic prominent influential person / foreign prominent public official?*	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

(For definitions of prominent persons please see Appendix A)

Source of funds and wealth (please select a code from the list provided below)

Source of funds*	Selection code	<input type="text"/>	<input type="text"/>	
Source of wealth*	Selection code	<input type="text"/>	<input type="text"/>	
01. Salary ¹	02. Pension	03. Self-employed	04. Own business	05. Sale of business
06. Retirement annuity	07. Donation/Gift	08. Rental	09. Commission	10. Insurance claim
11. Allowance	12. Sale of property	13. Sale of vehicle	14. Inheritance	15. Maintenance/Alimony
16. Tax rebate	17. Social grant	18. Bonus	19. Sale of assets	20. Loan
21. Sale of shares	22. Legal settlement	23. Savings		

¹not available for source of wealth

Are you insolvent?*	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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1.5 Occupation details

Please provide a brief description of your occupational duties

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Please give a breakdown of the percentage of time spent on different functions within your occupation in an 8-hour day*

Functions	Examples	Percentage of time (%)
Desk-bound and office-bound tasks	Data capturing, filing	<input type="text"/> <input type="text"/> <input type="text"/>
Supervising staff within the office	Admin manager, call centre manager	<input type="text"/> <input type="text"/> <input type="text"/>
Travelling (please do not include travelling from home to work)	Driver, visiting clients	<input type="text"/> <input type="text"/> <input type="text"/>
Supervising staff on site, in a factory, or during field work	Building contractor, factory foreman, storeroom supervisor	<input type="text"/> <input type="text"/> <input type="text"/>
Light manual work that requires extensive manual dexterity	Hairdresser, teacher, jeweller	<input type="text"/> <input type="text"/> <input type="text"/>
Moderate manual work	Supermarket shelf packer, plumber, electrician, mechanic	<input type="text"/> <input type="text"/> <input type="text"/>
Heavy manual work	Miner, farrier, diesel mechanic	<input type="text"/> <input type="text"/> <input type="text"/>

1.6 Spouse details

Completing the spouse's Highest educational qualification and gross monthly income details may improve the socio-economic rating on the policy. Please complete if applicable.

Title*	<input type="text"/>						
First names*	<input type="text"/>	Surname*	<input type="text"/>				
Previous/Maiden name	<input type="text"/>						
ID Number	<input type="text"/>	OR	Foreign passport number	<input type="text"/>			
			Nationality* (as per passport)	<input type="text"/>			
			Expiration date*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of birth	<input type="text"/>		Age next	<input type="text"/>	Sex*	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Marital status*	Single <input type="checkbox"/>	Married <input type="checkbox"/>	Common-law spouse <input type="checkbox"/>	Divorced <input type="checkbox"/>	Widowed <input type="checkbox"/>		
Country of birth*	<input type="text"/>		Nationality at birth*	<input type="text"/>			
Cellphone	<input type="text"/>	-	<input type="text"/>				

2 Discovery details

2.1 Health plan details

2.1 Health plan from a medical scheme that is administered by Discovery Health

Are you a member of a Health plan from a medical scheme that is administered by Discovery Health?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Membership number	<input type="text"/>	
Name of medical scheme?	<input type="text"/>	Name of medical plan? <input type="text"/>

2.2 Vitality

Vitality membership	No Vitality <input type="checkbox"/>	Vitality <input type="checkbox"/>	Vitality Active <input type="checkbox"/>
If not a member of Vitality, would you like to join?	Vitality <input type="checkbox"/>	Vitality Active <input type="checkbox"/>	No <input type="checkbox"/>

Existing Discovery Bank account?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bank product	Full Banking Suite <input type="checkbox"/>	
	Credit card account <input type="checkbox"/>	
	Transaction account - Bundled fees <input type="checkbox"/>	
	Transaction account - Pay as you transact <input type="checkbox"/>	
Card colour	Blue <input type="checkbox"/>	Gold/Gold Pre-funded <input type="checkbox"/>
	Black <input type="checkbox"/>	Purple/Purple Wealth <input type="checkbox"/>
		Platinum <input type="checkbox"/>
I would like to join Discovery Bank	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Assisted by my financial adviser <input type="checkbox"/>	Yes <input type="checkbox"/>
	To be contacted by Discovery Bank <input type="checkbox"/>	No <input type="checkbox"/>
Discovery Bank product being applied for (complete if you have requested to be assisted by your financial adviser)	Full Banking Suite <input type="checkbox"/>	
	Credit card account <input type="checkbox"/>	
	Transaction account - Bundled fees <input type="checkbox"/>	
	Transaction account - Pay as you transact <input type="checkbox"/>	
I authorise Discovery Bank Limited (the "Bank") to access all information, including confidential information, disclosed to Discovery Life, pursuant to my application for credit as a prospective consumer, in terms of section 68(1)(b)(ii)(aa) of the National Credit Act 34 of 2005.		<input type="checkbox"/>

2.4 Discovery Insure

Are you a member of Vitality Drive?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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3.1 Banking details for the recurring premium

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|-----------------------|--|---------|--|--------------------------|--------------|--|--------------------------|---------|--|--------------------------|--|----------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Account holder name | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bank name | | | | | | | | | | | | Branch name | | | | | | | | | | | | | | | | |
| Branch code | | | | | | | | | | | | Account number | | | | | | | | | | | | | | | | |
| Account type: | | Current | | <input type="checkbox"/> | Transmission | | <input type="checkbox"/> | Savings | | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |
| Quoted premium amount | | R | | | | | | | | | | . | | | | | | | | | | | | | | | | |

Do you wish to use the banking details provided above, for the PayBack Benefit? Yes ☐ No ☐
If "No", please complete the *PayBack Benefit* section below.

3.2 PayBack Benefit (This is the bank account that will receive the PayBack Benefit and must be in the name of the owner of the policy)

Account holder name											
Bank name											
Branch name							Branch code				
Account number											
Account type:	Current	<input type="checkbox"/>	Transmission	<input type="checkbox"/>	Savings	<input type="checkbox"/>					

Payment beneficiary details

- To: Discovery Life Limited, registration number 1966/003901/06 (Discovery Life)
- Abbreviated name as registered with the bank: DISCLIFE
- Beneficiary address: Discovery Life, PO Box 3888, Rivonia, 2128

3.3 I/we, the undersigned:

- 3.3.1. Warrant that the account information I/we have provided above is an account in my/our name and that the information furnished by me/us in this Authority and Mandate is true and correct;
- 3.3.2. Authorise Discovery Life to issue and deliver payment instructions to my/our bank, recorded above, for the collection by Discovery Life from the bank account (or any other bank or branch to which I/we may transfer my/our account) any amounts due under or in terms of this Policy on condition that the sum of such payment instructions will never exceed my/our obligations as framed in the Policy and which shall commence on the nominated Policy commencement date and shall continue until this Authority and Mandate is terminated by me/us by giving Discovery Life no less than 20 ordinary working days' written notice thereof or immediately in the event that I/we instruct my/our bank to withdraw this Authority and Mandate.
- 3.3.3. Confirm that the payment instructions mentioned above must be issued and delivered on the day that I/we have nominated ("payment day") and thereafter on the same day in each and every successive month. If the payment day falls on a Sunday or recognised South African public holiday, the payment day will automatically be the next working day;
- 3.3.4. Payments in December may be debited against my/our account on the nominated payment date and understand that it is my/our responsibility to ensure that I/we have funds available;
- 3.3.5. Authorise Discovery Life to track my/our bank account and re-present the payment instruction referred to above in the event that there are insufficient funds in my/our bank account to meet my/our obligations under or in terms of this Policy;
- 3.3.6. Authorise Discovery Life to obtain and provide any information about me/us from any one or more of the following:
- Any credit bureau;
 - Any life assurance or credit providers' industry association;
 - Any other association of any industry in which we operate, this includes information related to creditworthiness, credit history, financial history, personal information, judgement history and default history.
- 3.3.7. Acknowledge that my/our bank will treat each payment instruction to pay premiums or amounts due under this Policy to Discovery Life as if each payment instruction came from me/us personally as the account holder.
- 3.3.8. Undertake to advise Discovery Life in writing of any changes to my/our account details and acknowledge that Discovery Life will not be held responsible or liable for any claim, loss or harm that I/we or any third party may suffer as a result of me/us providing incorrect banking details herein or if the bank account is in the name of another person or entity or as a result of my/our failure to notify Discovery Life of a change in banking details or if the bank account has insufficient funds to meet my/our obligations under or in terms of the Policy.
- 3.3.9. Know and understand that this Authority and Mandate may be ceded, assigned or made over to a third party if the Policy or a part thereof is also ceded, assigned or made over to that third party. In the absence of such assignment or cession of the Policy, this Authority and Mandate cannot be ceded, assigned or made over to a third party.
- 3.3.10. Know and understand that the withdrawals hereby authorised will be processed through a computerized system provided by South African banks. The details of each withdrawal from my/our bank account will be printed on my bank statement and must show the abbreviated user code 'DISCLIFE' and the Policy number so as to enable me/us to identify this Policy contract;
- 3.3.11. Acknowledge that although this authority and Mandate may be terminated by me/us, such termination does not necessarily terminate this Policy. In the event of such termination I/we are not entitled to any refund of any premiums or amounts due that was withdrawn by Discovery Life whilst this Authority and Mandate was in force if such premiums or amounts were legally owing to Discovery Life in terms of the Policy;
- 3.3.12. Acknowledge that by signing this Authority and Mandate I/we are bound by the payment terms applicable to this Policy.

Signed at															
Signature of accountholder							Date signed	D	D	M	M	Y	Y	Y	Y
Second signature (if applicable)							Date signed	D	D	M	M	Y	Y	Y	Y

Policy reference number

The policy number/entity number will be advised to you once the application has been accepted.

The reference on your bank statement will be: DISCLIFE, followed by the policy number.

If your debit order collection is grouped with other collections debited on the same day from the same amount, the entity number will be used instead.

4 Beneficiary details

Beneficiaries to whom the proceeds of the life cover will be paid on your death.

All information requested for each beneficiary nomination must be provided.

Natural person	<input type="checkbox"/>	Relationship to Principal	
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First name											Surname										
Title					Sex	M		F		Date of birth	D	D	M	M	Y	Y	Y	Y			
ID/Foreign passport number										Percentage share				.				%			

Natural person ☐ Relationship to Principal

First name											Surname										
Title					Sex	M		F		Date of birth	D	D	M	M	Y	Y	Y	Y			
ID/Foreign passport number										Percentage share				.				%			

Natural person ☐ Relationship to Principal

First name											Surname										
Title					Sex	M		F		Date of birth	D	D	M	M	Y	Y	Y	Y			
ID/Foreign passport number										Percentage share				.				%			

Natural person ☐ Relationship to Principal

First name											Surname										
Title					Sex	M		F		Date of birth	D	D	M	M	Y	Y	Y	Y			
ID/Foreign passport number										Percentage share				.				%			

Legal entity ☐

Type of legal entity	Company	<input type="checkbox"/>	Close corporation	<input type="checkbox"/>	Trust with natural person as beneficiary	<input type="checkbox"/>
	Trust with company as a beneficiary	<input type="checkbox"/>	Trust with non-taxable institution as a beneficiary	<input type="checkbox"/>	Non-taxable institution	<input type="checkbox"/>
	Sole proprietor ¹	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	International trust with natural person as a beneficiary	<input type="checkbox"/>
	International company	<input type="checkbox"/>	International foundation	<input type="checkbox"/>		

Name

Sole Proprietor Owner ID number

Trust/Registration/CC number

Relationship to Principal Percentage share . %

¹ Sole proprietor Owner ID number required for this type of legal entity.

Legal entity ☐

Type of legal entity	Company	<input type="checkbox"/>	Close corporation	<input type="checkbox"/>	Trust with natural person as beneficiary	<input type="checkbox"/>
	Trust with company as a beneficiary	<input type="checkbox"/>	Trust with non-taxable institution as a beneficiary	<input type="checkbox"/>	Non-taxable institution	<input type="checkbox"/>
	Sole proprietor ¹	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	International trust with natural person as a beneficiary	<input type="checkbox"/>
	International company	<input type="checkbox"/>	International foundation	<input type="checkbox"/>		

Name

Sole Proprietor Owner ID number

Trust/Registration/CC number

Relationship to Principal Percentage share . %

¹ Sole proprietor Owner ID number required for this type of legal entity.

Estate ☐ Percentage share . %

Testamentary trust ☐ Testamentary Trust's Name* Percentage share . %

Testamentary trust ☐ Testamentary Trust's Name* Percentage share . %

5 Product details

5.1 Plan details

Start date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Please note: Unless you specify a start date, the start date will default to the 1st of the month if accepted on or before the 10th, or on the 1st of the following month if accepted after the 10th.

Funding patterns	Automatic annual increases		Additional premium options
	Contribution	Benefit	
AcceleRater <input type="checkbox"/>	CPI plus AcceleRater age factor 3% plus AcceleRater age factor	CPI <input type="checkbox"/> 3% <input type="checkbox"/>	Lock-in Option after 20 years <input type="checkbox"/> at age 65 <input type="checkbox"/>
Standard <input type="checkbox"/>	CPI plus Standard age factor 6.5% plus Standard age factor 0%	CPI <input type="checkbox"/> 6.5% <input type="checkbox"/> 0% <input type="checkbox"/>	Paid-up Option Yes <input type="checkbox"/> No <input type="checkbox"/> The Paid-up Option is not available with the 100% Buy-up Cash Conversion option
FlexRater <input type="checkbox"/>	CPI plus FlexRater age factor 3% plus FlexRater age factor	CPI <input type="checkbox"/> 3% <input type="checkbox"/>	None

5.2 Integrators (please select one option only)

The benefits you select will determine whether you qualify for the Comprehensive or Core Integrator

Health <input type="checkbox"/>	Vitality <input type="checkbox"/>	Active <input type="checkbox"/>	Bank <input type="checkbox"/>
Health and Bank <input type="checkbox"/>	Vitality and Bank <input type="checkbox"/>	Active and Bank <input type="checkbox"/>	

Double PayBack option (available only to policies that qualify for Comprehensive Health, Vitality or Active Integrator) Yes ☐ No ☐

5.3 Fund details

Life fund required	R <input type="text"/>
Cash Conversion ¹	0% <input type="checkbox"/> or Buy-up option 25% <input type="checkbox"/> 50% <input type="checkbox"/> 100% <input type="checkbox"/> Notes: The 100% Buy-Up Cash Conversion option is not available if you have applied for the Paid-up Option. The 50% and 100% options are available based on the benefits and cover amounts that you have applied for.

¹ Available to policies that are Health, Vitality or Vitality Active integrated

5.4 Severe Illness Benefit

Your Severe Illness Benefit will be:	Accelerated <input type="checkbox"/> Non-accelerated <input type="checkbox"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> % of fund (not applicable if non-accelerated) R <input type="text"/>
Expiry age	65 <input type="checkbox"/> Whole of life <input type="checkbox"/>
Severity levels	Comprehensive (A - D) <input type="checkbox"/> Comprehensive Plus (A - G) <input type="checkbox"/> LifeTime (A - D) <input type="checkbox"/> LifeTime Plus (A - G) <input type="checkbox"/>
LifeTime Max (applicable to LifeTime/LifeTime Plus)	100% <input type="checkbox"/> 200% <input type="checkbox"/>

5.5 Capital Disability Benefit

Your Capital Disability Benefit will be:	Accelerated <input type="checkbox"/>	Non-accelerated <input type="checkbox"/>
	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> % of fund (not applicable if non-accelerated)	
	R <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Expiry age	65 <input type="text"/>	70 <input type="text"/>
Claim categories covered	Core (A and D) <input type="checkbox"/>	Comprehensive Plus (A - D) <input type="checkbox"/>
	LifeTime 200 (A - D) <input type="checkbox"/>	LifeTime 300 (A - D) <input type="checkbox"/>

5.6 Income Protection (If selected, please complete point 2 of the Occupation section in Annexure 1 (Underwriting questions))

5.6.1 Income Continuation Benefit

Net-of-tax cost to company per month ¹ (this is the total cost to company for salaried employees [excluding passive income], less tax)	R <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
OR	
Is the life assured self-employed? If Yes , the life assured's monthly share of:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fees for services rendered (A)	R <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Plus	
Gross profit from sales (B)	R <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Less	
Cost of sales (C)	R <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Less	
Share of business expenses (D)	R <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Less	
Tax (E)	R <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Equals	
Net-of-tax self-employed income per month (this is calculated as A+B-C-D-E)	R <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

¹ For salaried employees, the tax used in determining the net-of-tax cost to company is the PAYE tax as shown on your payslip. In all other instances the tax used in the definition above is calculated using the most recent tax tables applied to your gross income (A+B-C-D in the above).

Income Continuation benefit per month	R <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Income Continuation Fund	10% (default) <input type="checkbox"/> Buy-up option of 100% <input type="checkbox"/>
Annual benefit increase & Annual Contribution increase (The relevant annual contribution increase will apply)	AcceleRater/FlexRater CPI <input type="text"/> 3% <input type="checkbox"/>
	Standard CPI <input type="text"/> 6.5% <input type="checkbox"/> 0% <input type="checkbox"/>
In-claim escalation	None <input type="checkbox"/> Inflation <input type="checkbox"/> Inflation +3% <input type="checkbox"/>
Waiting period	7 days <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 12 months <input type="checkbox"/>
Performance Bonus Protector Benefit (only available to salaried employees)	R <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Top-up Income Continuation Benefit	R <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

5.6.2 Overhead Expenses Benefit (If selected, please complete point 3 of the Occupation section in Annexure 1 (Underwriting questions))

Monthly share of qualifying overhead expenses ¹	R <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> pm
Overhead Expenses Benefit per month	R <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> pm
In-claim escalation	No escalation <input type="text"/> Inflation escalation <input type="text"/>
Annual benefit and contribution escalation	The annual benefit and contribution increase percentages selected for the Income Continuation Benefit will automatically apply to this benefit.
Waiting period	7 days <input type="text"/> 1 month <input type="text"/>
Expiry age	60 <input type="text"/> 65 <input type="text"/> 70 <input type="text"/>

¹ Your monthly share of qualifying overhead expenses will be determined as follows:

- The normal running expenses of the business incurred by you carrying out your nominated occupation
- Less: Your share of depreciation, capital repayments on any outstanding debt, lease payments where the lease is not an essential part of the business, the cost of stock or goods, professional and other fees incurred in the course of your business, drawing accounts. Your salary or other earnings (including retirement funding contributions) or the salary or other earnings of any member of your family, or another assured member who is self-employed, as well as the portion of all other expenditure related to personal expenses rather than business expenses.

6 Insurance Portfolio

6.1 Existing non-Discovery Health medical schemes

Are you a member of a health plan from a medical scheme that is not administered by Discovery Health? Yes ☐ No ☐

If **Yes**, are you on a hospital plan or more comprehensive option? Hospital plan ☐ Comprehensive ☐

6.2 Simultaneous Discovery Life policy application

Are you applying for another Discovery Life Plan in conjunction with this application form? Yes ☐ No ☐

If **Yes**, please provide details

6.3 Previous and Existing assurance

Is this application on the basis of a Discovery Group Life continuation option? If Yes please provide the withdrawal date and reason	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Withdrawal date	D	D	M	M	Y	Y	Y	Y
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Reasons

Have you had medicals done at other insurance companies within the last 12 months? If Yes , please specify the details (including the company name and policy numbers).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Details	

Details

<p>Is this application to be considered based on a policy issued at standard terms by any insurer, after being fully underwritten within the past two years? If Yes, please complete the <i>Smart Underwriting declaration form</i>.</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
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Yes ☐ No ☐

A copy of the Smart Underwriting declaration form can be found on the **Financial Adviser Zone (FAZ)** under Marketing Support> Life Insurance > Forms > Underwriting.

Please complete the table below, giving the total for which your life is currently insured, including any simultaneous applications with Discovery Life or any other assurer.

Principal life	Company name	Life cover	Severe Illness Benefit	Capital Disability Benefit	Income Continuation Benefit
Existing assurance – individual life		R	R	R	R
		R	R	R	R
		R	R	R	R
Group Life		R	R	R	R
		R	R	R	R
Simultaneous applications		R	R	R	R
		R	R	R	R

6.4 Replacement of an existing policy: (Important note: Replacement of any insurance may be to your disadvantage)

Is this proposal to replace the whole or any part of your existing insurance with any insurer? If **Yes**, the representative must discuss and complete the *Replacement Advice Record* and submit it with this proposal form.

Yes ☐ No ☐

A copy of the *Replacement Advice Record* can be found on the **Financial Adviser Zone** (FAZ) under Marketing Support> Life Insurance > Forms > New business forms.

7 Signatures

7.1 Adjustment of benefits or premiums for underwriting

[illegible]

Underwriting this application may result in the premium quoted not being sufficient to provide the benefits. In such cases, the applicant should approve the alteration in premiums or benefits

7.2 Extra conditions for Integrated Operating Model

Discovery Life's unique integrated operating model enables a more accurate assessment of a policyholder's risk through accessing additional information about their level of health and wellness through Vitality, Discovery health plan, Vitality Drive and Vitality Active. The integrated operating model provides all clients with an initial premium discount that can be further increased through positive health management and engagement or alternatively, reduced for clients who have not managed their health and wellness. For any life assured who has previously been insured on an integrated Discovery Life policy that has been lapsed within the last 12 months or has an existing policy that is lapsed within six months of the start of this policy, the integration experience from the lapsed policy may apply to this new policy.

Unless explicitly stated, no integrator experience adjustment has been allowed for on the new business premium quoted. We reserve the right to transfer any integration experience from that lapsed policy to this new policy which could result in an increase in the premium payable.

7.3 Declaration of acceptance

I/we declare that all terms and conditions, the privacy statement and declarations in this application form will bind me/us and will apply in all future dealings with Discovery Life.

1. I have read and understood the contents of this application form.
2. I confirm that the personal statement included in the medical questions section is complete and true. I understand that the statement, along with the proposal for life insurance and any other documents, will be the basis for the proposed contract of assurance. Knowing I cannot change my mind, I authorise and request any doctor, healthcare provider, other person or institution who may possess or later get any information about my health, to disclose such information to Discovery. I agree that this request will remain in force after my death.
3. I agree to be bound by the terms and conditions of this application form, the Discovery Life Plan Guide, the Policy Schedule, and any servicing alteration requests, which read together, make up the contract.
4. I agree that any commission payable in terms of the Long-term Insurance Act of 1998, as referred to in the quote, may be paid to my appointed financial adviser. These commissions have been explained to me by my appointed financial adviser.
5. I agree that any alterations made to this application form by me or my financial adviser are not binding unless Discovery agrees to accept the alterations. Acceptance will be communicated by the processing of this application form, the receipt of any monies paid to Discovery and the issuing of the Discovery Life Plan Guide.
6. I understand that the products may be subject to tax. I acknowledge that if any of the tax laws, tax regulations, the SARS practice or other laws governing the products change, this may have an effect on the products and the benefits that are payable to me. Discovery has not given me any tax advice and I undertake to take such advice if I think it necessary.
7. I understand that I bear any and all risks associated with the investment options chosen where applicable, as I have personally selected the investment options.
8. I confirm that, to the extent that Discovery is not my appointed financial adviser, Discovery has not advised me, and as such is not responsible for any choices I have made.
9. I confirm that Discovery can take instructions from my financial adviser, if I have provided the correct mandate. If Discovery acts on any instruction from my financial adviser and it is later found that my financial adviser did not act in terms of the instructions or authority that I gave them, I confirm and agree that, unless my financial adviser is an employee of Discovery, Discovery will not be liable for any loss or damage I may have suffered.
10. Discovery will not be responsible for any failure, malfunction or delay of any networks or electronic or mechanical device or any other form of communication used in the submission, acceptance and processing of applications and transactions. Discovery will not be liable to make good or compensate me or any third party for any damages (whether direct or consequential), losses, claims or expenses. It is my responsibility to ensure that this application form, any instructions that are part of the application form and subsequent instructions submitted electronically by fax or email to Discovery, have been received by Discovery. I acknowledge that Discovery does not consider a fax confirmation or printed copy of a sent email as proof of it receiving the document or instruction.
11. My spouse confirms that he/she has read and understood the terms and conditions of the application form and agrees to be bound by them, where applicable. I have acquired the permission of my spouse to nominate the beneficiaries as set out in the beneficiaries section of this application form and to transact on our collective assets as required by Chapter 3 of the Matrimonial Property Act, No. 88 of 1984. My spouse understands the legal consequences of such nomination where applicable.

12. I/we have read and understood the note included in the beneficiaries section of this application form regarding nominating minors as beneficiaries.
13. I warrant that I have disclosed all material information to Discovery and that such information is true and correct and I know and understand that if I have breached the warranty, Discovery can declare the benefits issued to me void and that I will forfeit any contributions paid.

Signed at (town or city)		Date	D	D	M	M	Y	Y	Y	Y
Signature of owner										
Signature of policy owner										
Signature of spouse (if applicable)										

8 Financial adviser details

1. Primary financial adviser

Lead reference number	<input type="text"/>	
Financial adviser name	<input type="text"/>	Code <input type="text"/>
Financial adviser house	<input type="text"/>	Code <input type="text"/>
Discovery Consulting Services branch	<input type="text"/>	
Discovery Consulting Services consultant name	<input type="text"/>	Code <input type="text"/>
PRI number	<input type="text"/>	(Mandatory for ABSA and FNB financial advisers)

I am a registered representative and represent a financial services provider authorised by the Financial Services Board in terms of the Financial Advisory and Intermediary Services Act, No 37 of 2002.

Replacement of an existing policy declaration

If this application serves to replace the cover on another Discovery Life policy, we may need to adjust the commission to take into account the commission already earned on the original cover. Any adjustment to the commission will not affect the premium on this application.

If this application is to replace an insurance policy discontinued within the past four months or to be terminated within the next four months, please discuss and complete the *Replacement Advice Record* and submit it with this application form.

I hereby declare that I have requested and recorded the client's responses to the questions (refer to the section *Insurance Portfolio*.) with regard to replacement and that the client is fully aware of the possible detrimental consequences of the replacement of an insurance policy.

I further declare that, irrespective of the client's response to the questions in the section *Insurance Portfolio*, I explained the following to the client:

- The meaning of replacement
- That a replacement is potentially prejudicial
- The levying/deduction of a termination charge
- That where a replacement is considered, the client is legally entitled to comprehensive information regarding the consequences of replacement.

Signature of primary financial adviser

Date

Financial adviser fee split: . %

2. Secondary Financial adviser:

Financial adviser name	<input type="text"/>	Code <input type="text"/>
Financial adviser house	<input type="text"/>	Code <input type="text"/>
Discovery Consulting Services branch	<input type="text"/>	
Discovery Consulting Services consultant name	<input type="text"/>	Code <input type="text"/>
PRI number	<input type="text"/>	(Mandatory for ABSA and FNB financial advisers)

I am a registered representative and represent a financial services provider authorised by the Financial Services Board in terms of the Financial Advisory and Intermediary Services Act, No 37 of 2002.

Financial adviser fee split: . %

3. Additional Financial Adviser

Financial adviser name		Code												
Financial adviser house		Code												
Discovery Consulting Services branch														
Discovery Consulting Services consultant name		Code												
PRI number														(Mandatory for ABSA and FNB financial advisers)

I am a registered representative and represent a financial services provider authorised by the Financial Services Board in terms of the Financial Advisory and Intermediary Services Act, No 37 of 2002.

Financial adviser fee split:

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 %

4. Commission-specific details

Commission discount percentage required	<table><tr><td></td><td></td><td></td><td></td></tr></table> . <table><tr><td></td><td></td><td></td></tr></table> %							

01 | Underwriting questions

1. Lifestyle

1.	Please confirm the number of times per day you vape, use e-cigarettes or any tobacco product?	
	Never <input type="checkbox"/>	Less than 10 <input type="checkbox"/> 10 - 20 <input type="checkbox"/> 21 - 30 <input type="checkbox"/> More than 30 <input type="checkbox"/>
	Smoked but stopped <input type="checkbox"/>	Date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2.	On average, how frequently do you consume alcohol?	
	Daily <input type="checkbox"/>	Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually <input type="checkbox"/> No current alcohol consumption <input type="checkbox"/>
3.	On average, how many units do you consume per week? [A unit is defined as 1 beer or 1 glass of wine or 1 tot of spirits (25ml)]	
		Units <input type="text"/> <input type="text"/>
4.	Did you habitually drink more in the past? If Yes , please provide more information	
	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5.	Have you ever been advised to reduce your alcohol consumption? If Yes , please provide more information.	
	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6.	Do you or have you ever had an alcohol problem? If Yes , please provide more information	
	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7.	Have you ever been charged with drunken driving? If Yes , please provide more information	
	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8.	Have you ever used anabolic steroids for any reason? If Yes , please give details.	
	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.	Have you ever used any drugs, for example cannabis (including cannabis oil), cocaine, heroin or ecstasy for any reason? If Yes , please give details.	
	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10.	COVID Vaccination Vaccinations have proven significantly to reduce the risk of death from COVID-19. Therefore, your answer to this question will enable you to get the best terms for being vaccinated against the COVID-19 risk as per the National Department of Health's vaccine policy. "Vaccinated" is defined as being vaccinated in line with the National Department of Health's vaccine policy I am vaccinated against COVID-19 <input type="checkbox"/> If vaccinated, how many doses have you received?* Pfizer <input type="text"/> <input type="text"/> Johnson & Johnson <input type="text"/> <input type="text"/> Other <input type="text"/> <input type="text"/> If "Other" please provide name <input type="text"/> Date of last vaccination <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> I am unvaccinated <input type="checkbox"/>	
11.	Have you ever engaged in, been found guilty of, or been charged with illegal activities, such as fraud, bribery, corruption, theft, drug trafficking, extortion, gangsterism or robbery (armed or not)? If Yes , please give details.	
	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Travel

12.	Do you, for any reason, plan on spending any time outside the borders of South Africa, now or in the future, other than for recreation or holiday? If Yes , please give details.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<div></div>			

2. Occupation

1. General

1.1	Does your occupation have any associated risks, for example, infrequent or regular underground work, exposure to harmful chemicals, fumes or radiation, working at heights or on unstable terrain and exposure to low or high-voltage electrical current? If Yes , please provide more information.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<div></div>			

2. Income Continuation and Capital Disability Benefits (Complete if this benefit is being applied for)

2.1	If self-employed, how many owners does your business have?	Number	<input type="text"/>	<input type="text"/>	<input type="text"/>
2.2	Are there any other occupations you are, or may become involved in? If Yes , please give details.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<div></div>	
2.3	Is there any direct or indirect hazard associated with your current occupation? If Yes , please give details.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<div></div>	
2.4	Have you been engaged in your present occupation for less than 12 months? If Yes what was your previous occupation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<div></div>	
2.5	Is the physical address of your employer outside the borders of South Africa? If Yes , please give details.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<div></div>	
2.6	During the past three years, have you been absent from work for a continuous period of more than seven days as a result of accident or sickness? If Yes , please give details.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<div></div>	
Please give the date		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

3 Overhead Expense Benefit (Complete if this benefit is being applied for)

3.1	How many employees work at your current company?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3.2	How many employees have trade or professional qualifications at your current company?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3.3	What is your percentage interest in the business?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3.4	If self-employed, is your business based at your home? If Yes , please give details.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<div></div>	
3.5	What are your total monthly overheads?	R	<input type="text"/>	<input type="text"/>	<input type="text"/>
3.6	What is your percentage share of the overhead expense?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3.7	What is your percentage of business turnover from sales of goods and services?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

3. Medical questions

You must answer all the medical questions in this application form.

Regardless of anything else in this application form, it remains the duty of all applicants to answer all these medical questions accurately and honestly. By not giving us all the relevant, true and complete information that we ask for (even though you might be a member of a health plan from a medical scheme that is administered by Discovery Health, Discovery Vitality (Pty) Ltd and/or Discovery Bank) we may enforce the terms explained in the section titled "You confirm you have given relevant, complete and true information" (refer to the Terms and conditions), which could mean that the policy or benefits will be cancelled or the policy voided. Please study this section of the terms and conditions very carefully before you answer the questions.

Build and physical condition

Height (without shoes) m

Weight (with clothes) kg

Have you ever had unintentional weight loss of more than 5kg? If **Yes**, please give details

Yes ☐

No ☐

Date

Do you exercise regularly? If **Yes**, please give details

Yes ☐

No ☐

Medical questions

1. Do you use chronic and regular medicine? If **Yes**, please list the medicine that you use. (Please also include sleeping tablets, oral contraceptives and any non-prescription medicine, even when not used daily)

Yes ☐

No ☐

Details

Do you or have you suffered from:

2. Any benign or malignant (cancerous) tumour or growth for example moles, skin cancer, breast cancer, prostate cancer or colon cancer?

Yes ☐

No ☐

Details

Doctor

Date of last symptoms

3. Any porphyria, haemochromatosis, spleen, lymph or blood disorder, swollen glands or lymph nodes, bleeding disorder or clotting disorder, leukaemia or lymphatic cancer, for example anaemia, thalassemia, haemophilia, idiopathic thrombocytopenic purpura (ITP), protein C or S deficiency, Von Willebrand's disease, antiphospholipid syndrome, thrombocytopenia, leukaemia, lymphoma or myeloma?

Yes ☐

No ☐

Details

Doctor

Date of last symptoms

4. Any disorders of the heart, for example rheumatic fever, heart murmur or heart valve problems, palpitations or arrhythmia, chest pain, angina, heart attack, heart failure, myocarditis, cardiomyopathy, an abnormal ECG, open or keyhole heart surgery or procedures?

Yes ☐

No ☐

Details

Doctor

Date of last symptoms

5. Raised cholesterol, high blood pressure or any diseases of the blood vessels or circulatory system, for example aneurysm, pain in legs when walking, deep vein thrombosis (DVT) or pulmonary embolism?

Yes ☐

No ☐

Details

Doctor

Date of last symptoms

6.	Any disorders of the nervous system, for example epilepsy or any convulsion, transient ischemic attack (TIA), stroke, brain aneurysm, blackouts, chronic or regular headaches, Parkinson's disease, multiple sclerosis, myasthenia gravis, dementia, hydrocephalus or raised intra-cranial pressure, motor neuron disease or any other type of weakness or paralysis?	Yes	No
	<div style="border: 1px solid black; height: 30px; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"> Doctor Date of last symptoms </div> <div style="display: flex; justify-content: space-between;"> <div style="border-bottom: 1px solid black; width: 40%;"></div> <div style="display: flex; justify-content: space-between; width: 55%;"> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">D</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">D</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">M</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">M</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> </div> </div>		
7.	Have you ever been diagnosed or treated for fibromyalgia, chronic fatigue syndrome or any chronic pain disorders?	Yes	No
	<div style="border: 1px solid black; height: 30px; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"> Doctor Date of last symptoms </div> <div style="display: flex; justify-content: space-between;"> <div style="border-bottom: 1px solid black; width: 40%;"></div> <div style="display: flex; justify-content: space-between; width: 55%;"> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">D</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">D</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">M</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">M</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> </div> </div>		
8.	Have you ever been diagnosed, investigated or treated (by means of counselling or medicine), for stress, insomnia, anxiety, depression, bipolar mood disorder, panic attacks, post-traumatic stress disorder, obsessive compulsive disorder, any eating disorder or any other psychiatric or emotional disorders?	Yes	No
	<div style="border: 1px solid black; height: 30px; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"> Doctor Date of last symptoms </div> <div style="display: flex; justify-content: space-between;"> <div style="border-bottom: 1px solid black; width: 40%;"></div> <div style="display: flex; justify-content: space-between; width: 55%;"> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">D</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">D</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">M</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">M</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> </div> </div>		
9.	Disorders of the digestive system, for example, oesophageal stenosis, achalasia, perforated or bleeding ulcer, Barrett's oesophagitis, any hernia, irritable bowel syndrome (IBS), spastic colon, diverticulitis, inflammatory bowel disease, Crohn's disease or ulcerative colitis, colon polyps, rectal bleeding, pancreatitis, hepatitis, chronic or recurrent diarrhea, chronic gastroenteritis, fatty liver, abnormal liver functions or coeliac disease?	Yes	No
	<div style="border: 1px solid black; height: 30px; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"> Doctor Date of last symptoms </div> <div style="display: flex; justify-content: space-between;"> <div style="border-bottom: 1px solid black; width: 40%;"></div> <div style="display: flex; justify-content: space-between; width: 55%;"> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">D</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">D</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">M</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">M</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> </div> </div>		
10.	Have you ever been diagnosed, investigated or treated for any connective tissue disorder, or any auto-immune disorder, for example rheumatoid arthritis, systemic lupus erythematosus (SLE), ankylosing spondylitis, scleroderma, sarcoidosis, Sjögren's syndrome, polymyositis, dermatomyositis, Wegener's granulomatosis, Ehlers-Danlos syndrome or Marfan syndrome?	Yes	No
	<div style="border: 1px solid black; height: 30px; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"> Doctor Date of last symptoms </div> <div style="display: flex; justify-content: space-between;"> <div style="border-bottom: 1px solid black; width: 40%;"></div> <div style="display: flex; justify-content: space-between; width: 55%;"> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">D</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">D</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">M</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">M</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> </div> </div>		
11.	Any disorders of your kidneys or bladder, like kidney stones, renal failure, nephritis, recurrent infections or abnormal urine tests (like blood or protein in the urine)?	Yes	No
	<div style="border: 1px solid black; height: 30px; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"> Doctor Date of last symptoms </div> <div style="display: flex; justify-content: space-between;"> <div style="border-bottom: 1px solid black; width: 40%;"></div> <div style="display: flex; justify-content: space-between; width: 55%;"> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">D</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">D</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">M</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">M</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> </div> </div>		
12.	Respiratory problems, for example asthma, chronic bronchitis, emphysema, persistent coughing, recurrent lung infections, cystic fibrosis, bronchiectasis, lung fibrosis, interstitial lung disease, sleep apnoea, occupational lung disease, pneumonia, sarcoidosis or an abnormal lung function test?	Yes	No
	<div style="border: 1px solid black; height: 30px; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"> Doctor Date of last symptoms </div> <div style="display: flex; justify-content: space-between;"> <div style="border-bottom: 1px solid black; width: 40%;"></div> <div style="display: flex; justify-content: space-between; width: 55%;"> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">D</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">D</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">M</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">M</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> </div> </div>		

13. Have you ever been admitted to hospital due to a COVID-19 related infection, or do you currently have a COVID-19 related infection, or have any ongoing symptoms, or require ongoing treatment/monitoring after a COVID-19 related infection? Yes ☐ No ☐

Details

Doctor Date of last symptoms

14. Have you ever been diagnosed with tuberculosis of the lungs or in any other area of the body, for example TB meningitis, urogenital TB, TB of the bones or spine? Yes ☐ No ☐

Details

Doctor Date of last symptoms

HIV questions

15. Do you know your HIV status? Yes ☐ No ☐

15.1 If **Yes**, when was your last test? Less than 1 year ago ☐
Between 1 and 2 years ago ☐
More than 2 years ago ☐

15.2 Where was the test performed? GP ☐ Lab ☐ Wellness day ☐ Insurance company ☐ Pharmacy ☐

15.3 What was your result? I am HIV positive ☐ I am HIV negative ☐

15.4 Have you ever used any treatment for HIV/AIDS? Yes ☐ No ☐
If **Yes**, what was the indication for treatment and for how long was the treatment used?

Details

16. Any back, joint, bone, muscle or chronic skin conditions, for example back or neck problems or injuries (including muscle spasms and slipped disc), osteoarthritis, gout, septic arthritis, psoriatic arthritis, fracture, joint injury, osteoporosis or osteopenia, dermatitis, eczema or psoriasis? Yes ☐ No ☐

Details

Doctor Date of last symptoms

17. Have you ever been diagnosed or treated for diabetes mellitus, impaired fasting glucose, insulin resistance or pre-diabetes, or have you ever been diagnosed or treated for thyroid, parathyroid or pituitary gland problems, or any other endocrine disorders, like diabetes insipidus, Cushing's disease or Addison's disease? Yes ☐ No ☐

Details

Doctor Date of last symptoms

18. Any eye, ear, nose or throat disorder, for example glaucoma, keratoconus, retinal detachment, optic neuritis, uveitis, scleritis, vision loss or blindness, tinnitus, hearing loss or deafness, vertigo or loss of balance or chronic hoarseness? Yes ☐ No ☐

Details

Doctor Date of last symptoms

Medical history (for male applicants)

19.	Have you ever had any abnormalities of the male genital tract, for example, prostatitis, benign prostatic hyperplasia (BPH), or abnormal prostate-specific antigen (PSA) blood test?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Details			
<div></div>			
Doctor <div></div>		Date of last symptoms <div><div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div></div>	

Medical history (for female applicants)

20.	Have you ever had any abnormality of the breasts, including abnormal mammogram or sonar, breast biopsy or surgery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Details			
<div></div>			
Doctor <div></div>		Date of last symptoms <div><div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div></div>	
21.	Have you ever had any disorders of the female reproductive organs (ovaries, fallopian tubes, uterus, cervix etc), including an abnormal Pap smear, cysts and endometriosis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Details			
<div></div>			
Doctor <div></div>		Date of last symptoms <div><div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div></div>	
22.	Have you had any complications due to a previous or current pregnancy, for example, pre-eclampsia, abnormal bleeding, miscarriages or depression?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Details			
<div></div>			
Doctor <div></div>		Date of last symptoms <div><div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div></div>	
23.	Are you currently pregnant, and if so, how many months?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Details			
<div></div>			

General health disclosure

24.	Have you ever been diagnosed with, or are you currently experiencing symptoms associated with any sexually transmitted diseases (STD): herpes, human papilloma virus (HPV), chlamydia, gonorrhoea, cytomegalovirus etc?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Details			
<div></div>			
Doctor <div></div>		Date of last symptoms <div><div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div></div>	
25.	If not already mentioned, have you had any operations (including surgery to assist in weight loss), disability, accidents with injuries, hospital admissions for medical or surgical reasons, or are you aware of any future surgery, treatment or investigations that you need?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Details			
<div></div>			
Doctor <div></div>		Date of last symptoms <div><div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div></div>	
26.	If not already mentioned, have you had any of the following special investigations: genetic testing, tumour markers, biopsy, angiogram, MRI or CT scan, normal or abnormal back or neck X-rays, abnormal X-rays of any other body part?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Details			
<div></div>			
Doctor <div></div>		Date of last symptoms <div><div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div></div>	

27.	Are you awaiting results for any special investigations that have recently been done, or are you planning to seek medical advice for any symptoms or conditions that you have?	Yes <input type="checkbox"/>	No <input type="checkbox"/>								
	Details <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>										
28.	Has a proposal for assurance for health, life, severe illness (dread disease), disability insurance, functional impairment or income continuation ever been declined, deferred or accepted with certain provisions, for example, premium loading or any exclusions?	Yes <input type="checkbox"/>	No <input type="checkbox"/>								
	Details <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>										
29.	Have you been off work for more than seven consecutive days due to medical reasons in the last two years?	Yes <input type="checkbox"/>	No <input type="checkbox"/>								
	Details <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>										
30.	Have you ever been medically boarded, or submitted a claim for short-term or long-term disability, severe illness (dread disease) or third party benefits?	Yes <input type="checkbox"/>	No <input type="checkbox"/>								
	Details <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>										
31.	Are there any aspects of your job that exacerbate or trigger any symptoms or conditions (like allergens, stress, manual work, standing or sitting for long periods or exposure to cold environments)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>								
	Details <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>										
32.	Have you ever experienced any difficulty or inability to perform your usual daily activities, (including all aspects of your occupation), or did you have to adjust your duties or activities, as a result of any medical or surgical condition?	Yes <input type="checkbox"/>	No <input type="checkbox"/>								
	Details <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>										
33.	Are there any other circumstances not disclosed on this form, which may affect the risk of insurance on your life?	Yes <input type="checkbox"/>	No <input type="checkbox"/>								
	Details <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>										
	Doctor <div style="border: 1px solid black; width: 350px; height: 20px; display: inline-block;"></div>	Date of last symptoms <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center; width: 100px;"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>		D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				

4. Family history

1.	Are you adopted or do you have limited information available regarding your family history? If Yes , please provide more information.	Yes <input type="checkbox"/>	No <input type="checkbox"/>															
	<div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>																	
2.	Have any of your family (mother, father, siblings) passed away before the age of 50 from natural causes (any disease or illness)? If Yes , please give a full description for each applicable family member, including age of death, cause of death, and all other medical conditions that this family member had.	Yes <input type="checkbox"/>	No <input type="checkbox"/>															
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 45%;">Family member (for example, father, mother and siblings)</th> <th style="width: 10%;">Age at death</th> <th style="width: 45%;">Cause of death and any other health problems prior to death</th> </tr> </thead> <tbody> <tr><td> </td><td style="text-align: center;"><div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></td><td> </td></tr> <tr><td> </td><td style="text-align: center;"><div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></td><td> </td></tr> <tr><td> </td><td style="text-align: center;"><div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></td><td> </td></tr> <tr><td> </td><td style="text-align: center;"><div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></td><td> </td></tr> </tbody> </table>			Family member (for example, father, mother and siblings)	Age at death	Cause of death and any other health problems prior to death		<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>			<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>			<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>			<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	
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	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>																	

3.	Have any members of your direct family (mother, father, siblings), whether alive or deceased, been diagnosed or treated for breast cancer, colon cancer or any other familial cancer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diagnosis			
Age at diagnosis <input type="text"/> <input type="text"/> <input type="text"/>			
4.	Have any members of your direct family (mother, father, siblings), whether alive or deceased, been diagnosed or treated before the age of 50 for coronary artery disease (for example, chest pain or heart attack), peripheral vascular disease (problematic circulation to the lower limbs) or stroke?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diagnosis			
Age at diagnosis <input type="text"/> <input type="text"/> <input type="text"/>			
5.	Have any members of your direct family (mother, father, siblings), whether alive or deceased, been diagnosed or treated for any neurological disorder, motor neuron disease or muscular dystrophy (for example, Huntington's disease, Parkinson's disease, multiple sclerosis or Alzheimer's disease)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diagnosis			
Age at diagnosis <input type="text"/> <input type="text"/> <input type="text"/>			
6.	Have any members of your direct family (mother, father, siblings), whether alive or deceased, been diagnosed or treated for polycystic kidneys?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Details			
Age at diagnosis <input type="text"/> <input type="text"/> <input type="text"/>			
7.	Have any members of your direct family (mother, father, siblings), whether alive or deceased, been diagnosed or treated for retinitis pigmentosa?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Details			
Age at diagnosis <input type="text"/> <input type="text"/> <input type="text"/>			
8.	Have two or more direct family members (mother, father, siblings), whether alive or deceased, been diagnosed or treated for diabetes?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diagnosis			
Age at diagnosis <input type="text"/> <input type="text"/> <input type="text"/>			
9.	Have any members of your direct family (mother, father, siblings), whether alive or deceased, been diagnosed or treated for any psychiatric disorders, for example schizophrenia, bipolar mood disorder or depression?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Details			
Age at diagnosis <input type="text"/> <input type="text"/> <input type="text"/>			
10.	Have any members of your direct family (mother, father, siblings), whether alive or deceased, been diagnosed or treated for any other familial diseases not mentioned above?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Details			
Age at diagnosis <input type="text"/> <input type="text"/> <input type="text"/>			

5. Medical practitioner or Outpatient clinic details

Please provide names and telephone numbers of your consulting doctors or outpatient clinic for the past five years:

Medical practitioner details

	Initials	Surname	Telephone	Years
Current doctor	<div><div></div><div></div><div></div><div></div></div>		<div><div></div><div></div><div></div><div></div><div></div><div></div></div> - <div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div>	<div><div></div><div></div></div>
Previous doctor	<div><div></div><div></div><div></div><div></div></div>		<div><div></div><div></div><div></div><div></div><div></div><div></div></div> - <div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div>	<div><div></div><div></div></div>

Or

Outpatient clinic details

Current outpatient clinic

Previous outpatient clinic

02 | DISCOVERY LIFE PRIVACY STATEMENT

Privacy Statement

When you engage with Discovery, you are entrusting us with your personal information. We are committed to protecting your right to privacy and keeping your information safe. Our Privacy Statement tells you how we collect, use and share your personal information, including personal information about your spouse, employees, dependents, beneficiaries and lives assured, where applicable. You can view our Privacy Statement on our website by following the path: www.discovery.co.za/corporate/privacy/

Alternatively, you can request a copy of the Group Privacy Statement by emailing privacy@discovery.co.za

By signing this application form and its annexures, you agree to, and understand the terms and conditions of the contract and our Privacy Statement.

03 | Terms and conditions for the Discovery Life Plan

1.1 Terms and conditions for cover

1. Key terms used

- 1.1. **"The Act"** means the Long-term Insurance Act, 1998 and any regulation or notice promulgated thereunder.
- 1.2. **"Astute"** means the Financial Services Exchange (Pty) Ltd, trading as Astute.
- 1.3. **"Discovery Group"** means Discovery Holdings Limited (registration number 1999/007789/06), a public company incorporated in South Africa the shares of which are listed on the JSE Limited, and all of its affiliates and subsidiaries from time to time including but not limited to Discovery Life Limited (registration number 1966/003901/06), Discovery Life Investment Services (Pty) Limited (registration number 2007/005969/07), Discovery Vitality (Pty) Limited (registration number 1999/007736/07), Discovery Health (Pty) Limited (registration number 1997/013480/07), Discovery Insure Limited (registration number 2009/011882/06) and Discovery Life Collective Investments (Pty) Limited (registration number 2007/008998/07).
- 1.4. **"FICA"** means the Financial Intelligence Centre Act, 31 of 2001 and any regulation or notice promulgated thereunder.
- 1.5. **"POPIA"** means the Protection of Personal Information Act.
- 1.6. **"You" and "your"** refer to the policy owner and to the persons to be assured, as set out in this application form.
- 1.7. **"We", "us" and "our"** refer to Discovery Life Limited, a public company with limited liability, as well as a licensed life insurer and authorised financial and credit services provider, registered under the company laws of the Republic of South Africa, registration number 1966/003901/06, and where applicable, Discovery Vitality (Proprietary) Limited ("Vitality"), a private company with limited liability registered under the company laws of the Republic of South Africa or both companies as the case may be. The principal place of business of both companies being 1 Discovery Place, Sandton, Johannesburg, 2196.

2. We will assess your application and let you know the results of our assessment. We may do one of the following:

- 2.1. Accept your application as it is
- 2.2. Accept your application on different or special terms, for example, with certain exclusions or higher premiums (called loadings). If we do this, we will send you a letter with these revised terms (called a counter-offer letter) which you can accept or reject
- 2.3. Decline your application
- 2.4. Ask for more information about health conditions.

3. Your cover only starts when:

- 3.1. We write to let you know or on the date you have requested cover to start
- 3.2. After we have received the first premium on the date it is due or if satisfactory arrangements have been made for the payment of the first premium.
You may give us a date on which you would like your policy to start. If you do not give us a date and we accept your application before the 10th day of the month, we will collect a double premium from your bank account in the first month. This will be for your first two months of cover. At the end of the second month, we will collect a single premium for the third month, and so on. In this case, your cover will start from the first day of the month. If we accept your application after the 10th day of the month, the start date will default to the first day of the following month, but you will be fully covered between the date we write to let you know (date of acceptance) and the start date. In this case we will only collect a premium at the start date. If you change the start date, cover will start from that date (provided that the conditions mentioned in clauses 3.1 and 3.2 have been met).

4. Your policy contract is made up of all of these documents:

- 4.1. This application form and any application form to change your policy
- 4.2. The policy schedule
- 4.3. The Life Plan Guide
- 4.4. Any changes to your policy contract
- 4.5. Any underwriting documents (for example, health, lifestyle and occupation questionnaires)
- 4.6. Any reinstatement document.

We will email your welcome pack (policy schedule, welcome letter and Life Plan Guide) to you.

It is your responsibility to ensure that this product meets your financial needs. You may request a copy of any document that has been given to us during this application.

5. You have 31 days to object to any policy contract terms

You have 31 days from the date that you receive your policy contract to tell us if you have any objections. If we do not receive an objection in this time, we are entitled to treat the absence of objection as your acceptance of the terms and conditions as they stand. You do not have the right to object to any terms and conditions after the 31-day period is over. If you do object, we may change the terms of the contract but we are not obliged to do so.

6. You confirm you have given relevant, complete and true information

- 6.1. By signing this application form, you give a formal promise (called a warranty) that:
 - 6.1.1. You have given us and will continue to give us all information relevant to your application until we have accepted risk under this policy or until this policy starts, whichever date occurs last.
 - 6.1.2. The information is true and complete.
- 6.2. You understand that if you have not given us all relevant, true and complete information, we may do any one or more of the following:
 - 6.2.1. Cancel your policy from the date we find out about the false or missing information. We will not refund any premiums in this case.
 - 6.2.2. Treat your policy as if it were never taken out (known as voiding from the start date). We will refund any premiums you have paid, less our expenses and any claims, for example the costs to issue the policy and commission.
 - 6.2.3. Revise your policy to align it with the terms we would have given to you had we known the true and complete information. This could include increasing your premiums, removing or reducing policy benefits, adding exclusions or adding loadings.

7. You give us permission to obtain your health and other information

- 7.1. Discovery Life needs information about you and persons assured for cover under a policy obtained by you from us.
- 7.2. The information is required to enable us to assess and underwrite the risk of insuring you and the other lives assured for cover, to administer your policy, consider and assess any claims you make, verify and determine your benefit entitlements, do a risk analysis, debt recovery and to resolve any matter pertinent to your policy and related products obtained by you from other entities within the Discovery Group like Discovery Card, your Discovery Bank account, Discovery Insure and the Managed Care integrator.
- 7.3. In order to administer your policy, we also need the following:
 - 7.3.1. For Health Integrated policies, information on you, the other lives assured for cover, the main life and spouse dependants on your health plan and the family status on your Vitality membership
 - 7.3.2. For Vitality or Active Integrated policies, information on you, the other lives assured for cover and the family status on your Vitality or Vitality Active membership (if applicable).
 - 7.3.3. Any other information from you and the other lives assured that may be required to administer the benefits selected on your policy.

- 7.4. The type of information required includes and is not limited to personal details (name and identity number) contact details and information about health (such as HIV status, pathology results, Vitality Health Check results), lifestyle, finances, credit history and worthiness, employment details, utilisation and Discovery Card and/or Bank repayments and any other information deemed necessary for the purpose set out in clause 7.2 and 7.3 and only the information relevant for the purpose.
- 7.5. By signing this application form, you acknowledge and consent to us obtaining information about you, the persons assured for cover and any other persons as set out in clause 7.2 and 7.3 from any person, Health Services Provider, or doctor and which may include Discovery Health (Pty) Ltd, your Medical Scheme administered by Discovery Health, Discovery Vitality (Pty) Ltd, and Discovery Bank Limited and instruct and authorise any other person or entity with such information (such as any healthcare provider that has been consulted with, has conducted a test or has collected information or any other financial services provider who has the information) to provide us with the information for the purpose set out in clause 7.2 and 7.3.
- 7.6. Discovery Life may be required to share the information in our possession about you, the persons assured for cover and any other persons as set out in clause 7.2 and 7.3 under a policy obtained by you from us for the purpose set out in clause 7.2 and 7.3 or in terms of any consent or instruction you may have provided to any other person or entity. By signing this application form, you authorise Discovery Life to do the following:
 - 7.6.1. Provide your personal and health information and that of your dependants to any other entity within the Discovery Group where you or your dependants already have a relationship or where you or your dependants have applied for a product or benefit. This information will be provided for the administration of your or your dependants, products or benefits.
 - 7.6.2. Provide your personal information as stated in this application or in any related document with other assurers and re-insurers. This authority extends to sharing such information directly with an assurer and through any database for assurers at any time (even after your death) and in any form, including detailed, abbreviated or coded form. This also includes sharing of information on industry registers. You are aware that you may request access to the information shared by Discovery Life on such industry registers.
- 7.7. In relation to your financial adviser, you authorise Discovery Life to do all of the following:
 - 7.7.1. Tell your financial adviser the value of your Health Fund and information about your Health Integrator (as defined by Discovery Life)
 - 7.7.2. Give your financial adviser the policy information, including your personal and health information, necessary to ensure the efficient administration of your policy and to ensure that we comply with all relevant legislation
 - 7.7.3. Share your health information with your financial adviser during any underwriting process
- 7.8. In the event that the Managed Care Integrator applies to your policy, you and your spouse consent that your special personal information (health information) may be used for purposes of administering the Managed Care Integrator. You and your spouse also consent to such information being shared with the policy owner and your financial adviser.
- 7.9. The consent given in this clause to obtain and share your personal information, shall continue after your death.
- 7.10. The lives assured agrees and consent to Discovery Life verifying their COVID-19 vaccination history against any possible source in existence at any time that may store this.
- 7.11. We reserve the right to request for adequate proof of COVID-19 vaccination history, at any time and at our sole discretion.
- 7.12. We reserve the right to reconstruct the benefit i.e. by imposing those terms we would have, had a client who has indicated his commitment to be vaccinated, but failed to do so when it became possible, or, under any misrepresentation of their vaccination history.
8. **You confirm we may do legal checks**
The law requires us to check, confirm and examine (on-going due diligence) certain information about you and the life to be assured, including identities, addresses and bank account details. This information is referred to as FICA verification information and is done to ensure that we know who you are (as our client) and understand our business with you. By signing this agreement, you authorise Discovery Limited and FirstRand Bank Limited to use FICA verification information. You agree that this authority applies throughout the duration of your policy. You further acknowledge that this authorisation cannot be withdrawn or cancelled and that it will continue after your death. If you fail to provide us with the requested FICA verification information and/or documentation within a reasonable time then we will be entitled to suspend and/or terminate this agreement, and our business relationship with you, without liability to you as a result of such termination.
9. **You agree to tell us about any factors that may affect your premium while this policy is in force**
You must tell us immediately about any factors that may affect the premiums you pay. If you do not tell us this information immediately, we are entitled to reduce your benefits by 20%, or impose an exclusion and adjust your premiums or we may refuse to pay a claim or we may in certain circumstances cancel your policy.
 - 9.1. Using tobacco: You must tell us immediately if you have started using tobacco (for example, smoking, chewing or snuffing), if you are paying premiums as if you were a non-smoker.
 - 9.2. Vaping and/or using e-cigarettes: You must tell us immediately if you have started vaping and/or using e-cigarettes if you are paying premiums as if you were a non-smoker.
 - 9.3. Using drugs: You must tell us immediately if you are using any narcotics or recreational drugs, for example, cannabis, cocaine, heroin, cat and tik (crystal meth).
 - 9.4. Hazardous activities: You must tell us immediately if you intend to take part in any hazardous activities if you are paying premiums as if you were not taking part in those hazardous activities. Examples of hazardous activities include scuba diving, parachuting, paragliding and motocross.
 - 9.5. Occupation: You must tell us immediately if your occupation changes.
 - 9.6. Changes in your circumstances: You must tell us immediately if any circumstances arise that affect your risk, for example, travelling to countries that have health risks or risks due to unrest and war.
 - 9.7. If you fail to disclose any known or should have known pre-existing conditions you know or should have known about.
 - 9.8. If you fail to disclose any material circumstances or health conditions.
10. **You confirm we may collect premiums**
 - 10.1. **You may cancel your permission**
You may cancel the permission for us to collect premiums from your bank account, but this may lead to the eventual cancellation of your policy if you do not give us new bank account details or if you stop paying premiums when they become due. However, you cannot claim any refund of any premium that we have collected from your bank account while you legally owed the premiums to us in terms of the policy contract.
 - 10.2. **You agree to tell us when any details of your bank account change**
We are not responsible for any harm or loss that you might suffer because the bank account details are incorrect or if they have changed and Discovery Life has not been notified.
 - 10.3. **Changing bank account details if there is a transfer of rights**
If you transfer your rights in this policy to another person (known as a cession), then you must tell us whether or not we may continue to collect premiums from your bank account or if the person to whom you transferred the policy will pay the premiums. If you do not tell us to stop collecting premiums from your bank account, we will continue to do so, and we will not be legally responsible for any harm or damage that flows from this.
 - 10.4. **If someone else pays the premiums**
If someone other than you pays the premiums on your policy, you confirm that you have obtained their permission to do so. On behalf of that person, you give us permission to obtain any information relating to him or her from any one or more of the following:
 - 10.4.1. Any credit bureau
 - 10.4.2. Any life assurance or credit providers industry association

10.4.3. Any other association of an industry in which we operate

This includes information related to that premium payer's creditworthiness, credit history, financial history, personal information, judgement history and default history.

It is your responsibility to verify the banking details of the premium payer, for example giving us a cancelled cheque, a bank letter or a copy of a bank statement.

11. **What happens to beneficiaries if you transfer the policy contract**

You understand that if you transfer your ownership in the policy contract to another person (called an absolute cession), then the beneficiary nomination you made will become invalid.

We will pay any proceeds under this policy to the new owner (called the cessionary) or his or her beneficiary if the new owner has nominated a beneficiary.

12. **Unclaimed benefits**

It is your responsibility to keep your contact information up to date. If a benefit is unpaid because Discovery Life cannot contact you, your beneficiaries or dependants, using the contact details provided, we are required to contact a tracing company to trace you, your beneficiaries or dependants, after a prescribed period.

You confirm that when you provide Discovery Life with personal information about any dependant or beneficiary in respect of this policy, they have given you permission to disclose that information to Discovery. This includes their permission to share their personal information with a tracing agent in order for them to help us trace you, your dependants or your beneficiaries.

Tracing fees will be deducted from the unclaimed benefit amount. This is subject to change over the policy term and will be communicated to you upon request.

In the event that we are able to locate you, your beneficiaries or dependants and pay the claim, market-related interest will be added to the benefit from the date that the benefit became payable to date of payment.

13. **Who to contact with complaints**

If you have a complaint about advice you have received or if you believe you did not receive enough information about the products, please contact our compliance department at compliance@discovery.co.za

1.2 Terms and conditions for immediate cover

While we are assessing your application for life, severe illness and capital disability cover, we give you immediate cover if certain criteria are met. The immediate cover is for a maximum of 30 days and for a maximum of R400 000. Below are the terms and conditions for immediate cover only. If we accept your application for full cover, we will send you the terms and conditions for that cover.

1. **We do not give immediate cover if we have or would have:**

- 1.1. Declined your application for full cover
- 1.2. Accepted your application for full cover on special terms (for example, loadings or exclusions)
- 1.3. Sent you a letter with revised terms (called a counter-offer letter)
- 1.4. Asked for more information about your health condition.

2. **We consider claims for immediate cover only if you meet all of the following conditions:**

- 2.1. You intended to enter into a policy and pay premiums for full life, severe illness and disability cover.
- 2.2. You have not had any applications for life, severe illness or capital disability insurance with us, or any other assurers declined or only accepted on special terms. This includes applications for increases in cover.
- 2.3. You are younger than 65 years old.
- 2.4. You have not asked for the full cover to start at a future date.
- 2.5. You have answered all the questions in this application form truthfully and completely and given us all other relevant information we may need to assess your risk.
- 2.6. You have given us all information that may affect our decision to cover you.
- 2.7. We will deduct the first premium from any payouts for immediate cover.

3. **We do not accept claims for immediate cover in any of the following circumstances:**

- 3.1. You commit suicide.
- 3.2. You deliberately caused the disability or severe illness.
- 3.3. Your death, disability or severe illness is directly or indirectly related to any conditions, illnesses or injury that existed before you applied for this cover.
- 3.4. You take part in hazardous activities that cause the death, disability or severe illness. Examples of hazardous activities include scuba diving, parachuting, paragliding or motocross.

4. **The immediate cover is for a maximum of 30 days**

If we give you immediate life, severe illness and capital disability cover, the cover starts on the date we receive your application form and ends on the earlier of:

- 4.1. Thirty days from the date we receive your application form
- 4.2. The date we accept your application for full cover.

5. **The immediate cover is for a maximum of R400 000**

If the amount of the Life Fund you have applied for on this application is less than R400 000, we will pay out a maximum of the amount you applied for if you have a successful claim. If the amount of the Life Fund you have applied for on this application is more than R400 000, we will pay out a maximum of R400 000 if you have a successful claim. We deduct any amounts that you are insured for under existing policies or applications with Discovery Life (including Group Life cover).

6. **Who receives the immediate cover payout**

For immediate life cover, we will pay the beneficiary named by the policy owner or, if no beneficiary has been nominated, we will pay the immediate life cover to the policy owner. For immediate severe illness or capital disability cover, we pay the policy owner. However, the policy owner may choose for us to pay the relevant life to be assured.

7. **After an immediate cover payout**

If we pay out for immediate life cover, severe illness or capital disability, all other cover applied for ends and we will have no further obligations. If you wish to receive cover, you must apply again.

1.3 Additional conditions for Vitality, Vitality Active and Discovery Bank (only applicable if you have applied for Vitality or a Discovery Bank product or both)

1. **Discovery Vitality, Vitality Active and Discovery Bank are separate from the Scheme and administrator**

Discovery Vitality (Pty) Ltd is a separate company from Discovery Health (Pty) Ltd ('the administrator') and Discovery Health Medical Scheme ('the Scheme'). It is formally registered under the name Discovery Vitality (Pty) Ltd, (registration number 1999/007736/07) and takes care of the administration of the Vitality Active programmes ('Discovery Vitality'), the previous Discovery Card loyalty programme, and the Vitality Money rewards programme. Discovery Bank Limited, (registration number 2015/408745/06) is responsible for all Discovery Bank products.

2. **Rules of the Vitality programme**

The full set of rules is available on www.discovery.co.za or you can call Discovery Vitality on 0860 99 88 77. In the event of a conflict between what is set out here, on our website and the rules of Vitality the rules will always apply.

3. **Extra conditions for Vitality Active and the Active Integrator**

The rules of Vitality Active are contained in the Vitality Active benefit guide and brochure, which are available on www.discovery.co.za

4. **Cancellation of Vitality membership**

Please give notice on the first day of the month if you wish to cancel your Vitality membership in that month. Otherwise your membership will only end on the last day of the next month. You must be a member of Vitality at the time of the billing cycle* (not the time of the transaction) in order to be eligible for your reward.

*Billing cycle refers to the date decided by Discovery Vitality, on which your Vitality monthly benefits are calculated. When you sign this application to join Vitality, you confirm that you have read and understood the Vitality Rules and you agree that you and those you apply for will be bound by them.

5. **Make sure you understand the terms and conditions of the relevant Discovery Bank product:**

By signing this application, you and the other lives assured understand that:

5.1. You can find the terms and conditions on the Discovery website at www.discovery.co.za under the Bank section, get them from your financial adviser or from the Discovery Bank call centre at 0800 07 96 97.

5.2. Discovery Bank may change the terms and conditions, product features and the Fees Guide from time to time. Changes that may be made by Discovery Bank will be communicated to you with prior notice. Discovery Bank Limited. Registration number 2015/408745/06. An authorised financial services and registered credit provider. FSP number 48657. NCR registration number NCRCP9997. Limits, terms and conditions apply.

04 | Appendix A

Definitions

Contact us

Tel: 0860 00 54 33, PO Box 3888, Rivonia 2128, www.discovery.co.za

Domestic prominent influential person	A domestic prominent influential person is an individual who holds, (including in an acting position for a period exceeding six months or has held at any time in the preceding 12 months), a prominent public function in South Africa.
Foreign prominent public official	A person is considered a foreign prominent public official if they hold or have held at any time in the preceding 12 months, in any foreign country, a prominent public function.
Source of funds	<p>The source of funds is the origin of the client's regular income, which is normally determined by the client's occupation or will be the result of a company or business trading and generating an income for the client. The source of funds must be obtained to ensure that the transactions of the client are consistent with the accountable institution's knowledge of the client and the client's business and risk profile.</p> <p>Source of funds can include but is not limited to:</p> <ul style="list-style-type: none"> • Salary or business proceeds • Interest payments • Dividends • Grants <p>In determining the source of funds, the following factors should be taken into consideration:</p> <ul style="list-style-type: none"> • The source of daily/monthly income/revenue • The client's various revenue streams • The business activities undertaken to give rise to the general income
Source of wealth	<p>The source of wealth is the origin of the client's entire body of wealth (total assets) to be utilised in the business relationship with Discovery. The source of wealth describes the activities that have generated the total net worth of the client.</p> <p>To establish the source of wealth, no time frame is applied and the client's background must be understood to understand the circumstances around the client's wealth, such as the source of the start-up capital to establish a business, or high-value cash purchases.</p> <p>Source of wealth can include but is not limited to:</p> <ul style="list-style-type: none"> • Maturing investments and encashment claims • Sale of shares • Sale of property • Sale of a company or interest in a company • Sale of other assets • Business proceeds • Inheritance • Legal settlements • Loan • Gift or donation
Ultimate Beneficial Owner	<p>"Beneficial owner" in respect of a legal person as the natural person who, independently or together with another person, owns the legal person or exercises effective control of the legal person. The Ultimate beneficial owner is the natural person that exercises ultimate ownership or control of the legal entity and is established in the following order:</p> <ol style="list-style-type: none"> 1. Any natural person that owns 25% or more of the legal entity 2. Any natural person that exercises 25% or more of the voting rights in the entity (if different from 1 above) 3. If the entity is owned 25% or more by another entity, the ultimate beneficial owner of that entity 4. If ultimate ownership cannot be established, the person who controls the business decisions of the entity, e.g. CEO, Director, Office Manager, etc

05 | Replacement Advice Record (individual risk policies)

Contact us

Tel: 0860 00 54 33, PO Box 3888, Rivonia 2128, www.discovery.co.za

Note to policyholder: If you are considering taking out a new risk policy that wholly or partly replaces any existing risk policy, your financial adviser must complete and discuss this document with you to help you decide whether replacing your existing policy is in your best interest. It is important that you do not sign this document without reading and having carefully considered the information it contains.

Part 1: General information

Full names of policyholder:	
ID number/company registration number of policyholder:	
Full names of financial adviser ¹ :	
ID number of financial adviser:	
Name of financial services provider of the replaced policy/policies:	
FSP number:	
Name of financial services provider recommending the replacement:	
FSP number:	
Date of inception of the policy being replaced:	

Part 2: Policy details

New policy/policies

Policy/application number	Product name	Insurer
1.		
2.		
3.		

Policy/policies being replaced

Policy number	Product name	Insurer
1.		
2.		
3.		
4.		
5.		
6.		

¹ For purposes of this form "financial adviser" means an "intermediary", as defined in the Policyholder Protection Rules made under section 62 of the Long-term Insurance Act, 1998 (Act no. 52 of 1998), ie the representative of the FSP concerned or sole proprietor, as the case may be, who has provided advice to the policyholder regarding the replacement. The financial adviser must complete this replacement advice record.

Part 3: Reasons for recommending the replacement policy/policies

3.1. List the main reasons why the new policy/policies is/are considered more suitable to the policyholder's needs and objectives than keeping or altering or changing the replaced policy/policies? (If there is more than one reason, please number them).

3.2 Could the replaced policy/policies have been altered/changed to better meet the policyholder's needs and objectives? (If not, explain why).

3.3 If the replaced policy/policies could have been altered/changed, explain why a replacement is recommended instead of making such change.

Part 4: Difference between new and replaced policy/policies

Detail	Description of the difference between the new policy and the replaced policy/policies
--------	---

A. SPECIFIC POLICY BENEFITS (Including costs, exclusions and restrictions for each benefit type)

4.1. Death benefits

A. Cover amount	
B. Benefit premium	
C. Standard exclusions (including suicide exclusions)	
D. Waiting period(s)	
E. Benefit term/expiry age	

4.2. Lump-sum disability benefits

A. Type of cover and events covered	
B. Accelerated or standalone cover	
C. Cover amount	
D. Benefit premium	
E. Standard exclusions	
F. Waiting period(s)	
G. Benefit term / expiry age	

4.3. Income protection benefits

A. Type of cover and events covered	
B. Cover amount	
C. Benefit premium	
D. Standard exclusions	

E. Waiting period(s)	
F. Benefit term/expiry age	
G. Does it cover temporary or permanent disability or both?	

4.4. Accident benefits

A. Type of cover and events covered	
B. Cover amount	
C. Benefit premium	
D. Standard exclusions	
E. Waiting period(s)	
F. Benefit term/expiry age	

4.5. Severe illness/critical illness/dread disease or trauma benefits

A. Type of cover and events covered (include key differences in number, severity or definitions of covered conditions)	
B. Accelerated or standalone cover	
C. Cover amount	
D. Benefit premium	
E. Standard exclusions	
F. Waiting period(s) (including any specific exclusions)	
G. Benefit term/expiry age	
H. Which diseases are covered under the new policy/policies compared to the replaced policy/policies?	

4.6. Loyalty/add-on benefits

A. Type of benefits provided	
B. Value/calculation basis of benefit	
C. Cost of benefit	
D. Conditions to qualify for benefit	
E. Is benefit optional or not?	

4.7. Investment/savings benefits (if any of the policies involved in the proposed replacement have an investment or savings component)

A. Nature of investment portfolio/assets	
B. Nature of investment risk	
C. Amount of total premium allocated to investment	
D. Investment-related fees or charges	
E. Investment performance guarantees	
F. Realisability of the benefits / accessibility of funds	
G. Benefit term / expiry age	

4.7. Investment/savings benefits (if any of the policies involved in the proposed replacement have an investment or savings component)

H. Details of the current value of the investment benefit on the replaced policy (before deduction of any termination charges or penalties):	
I. Details of termination charges / penalties due to termination of the replaced policy:	

4.8. Any other policy benefits/special features/differences

A. Type and value of benefits/features	
B. Cost of benefits/features	
C. Other	

B. GENERAL POLICY FEATURES**4.9. Premiums and charges**

A. Total premium (including for loyalty/add-on benefits)	
B. Premium pattern	
C. Basis of contractual premium increases, if applicable	
D. Basis of contractual benefit increases, if applicable	
E. Period for which the premium is guaranteed (fixed) and date of next premium review	
F. Policy administration fees	
G. Any other fees (eg claims administrations fees and other transaction fees)	
H. Age of life insured when replaced policy was entered into and effect of increased age or any health changes on the new policy premium	

4.10. Exclusions and restrictions

A. Specific exclusions or premium loadings applicable to the policyholder/life insured	
B. Any other exclusions, restrictions, special terms and conditions or circumstances in which benefits will not be provided	

4.11. Tax treatment and implications

A. Tax treatment and tax implications	
---------------------------------------	--

4.12. Other material differences

A. List any other differences (not covered elsewhere) considered material to the replacement decision	
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4.12. Other material differences

B. Provide details of any vested rights, guaranteed benefits or other guarantees or advantages that will be lost as a result of the replacement, or any other potential disadvantages of the replacements not covered elsewhere

Note: Where it is not possible to provide any of the information required in part 4 above, please list the relevant item/s below and explain why the information could not be provided.

Policyholder confirmation regarding part 4: Description of the difference between the new policy and the replaced policy/policies

I have noted the differences between the new policy and the replaced policy/policies as described in part 4 above.

Policyholder signature

Part 5: Financial adviser remuneration

(a) Provide the following details of any remuneration² or other financial interest to be earned by the financial adviser or the FSP concerned in relation to the replacement policy/policies:

Upfront commission:	
Ongoing commission:	
Any other direct or indirect remuneration or other financial interest:	

(b) Has the financial adviser or FSP earned any direct or indirect remuneration or other financial interest in relation to the replaced policy/policies? (Tick the appropriate box)

Yes ☐ No ☐

(c) If the answer to (b) is "Yes", provide the following details of any remuneration or other financial interest earned by the financial adviser or FSP in relation to the replaced policy/policies in the past five years:

Upfront commission:	
Ongoing commission:	
Any other direct or indirect remuneration or other financial interest:	

Policyholder confirmation regarding financial adviser remuneration: (Policyholder to initial next to either (1) or (2) dependent on applicable statement)

1) I am aware of the remuneration being earned by my financial adviser on the new policy/policies

Initial

OR

(2) I am aware that my financial adviser did not earn remuneration on the replaced policy/policies

Initial

Where applicable, I am aware that my financial adviser also earned remuneration on the replaced policy/policies.

Policyholder signature

Part 6: Declarations

6.1 Financial adviser (intermediary) declaration:

I [insert full name of financial adviser],
hereby confirm that:

- I have taken all reasonable steps to confirm that the information in this Replacement Advice Record is correct and complete; and
- I have explained the implications of the policy replacement - including but not limited to the information provided in this Replacement Advice Record - to the policyholder in sufficient detail and in an appropriate manner, taking into account what I know or reasonably assume to be the policyholder's level of knowledge, to enable the policyholder to make an informed decision about the replacement.
- The outcome of the advice to the policyholder is as follows:
 - (a) The policyholder has elected to proceed with the replacement contrary to my recommendation that the replacement might not be in the policyholder's best interests, and I have alerted the policyholder to the associated risks and have advised the policyholder to take particular care to consider whether the replacement is appropriate to the policyholder's needs, objectives and circumstances.

Initial

Initial

Initial

OR

- (b) I believe that the replacement is in the policyholder's best interests, that the policyholder has the ability to financially bear any costs or risks associated with the replacement and that the new policy/policies is/are more suitable to the policyholder's needs and objectives than the policy/policies being replaced.

Initial

(Financial adviser to initial next to either (a) or (b) dependent on applicable advice given)

**Signature of
financial adviser**

Date _____

e	D	D	M	M	Y	Y	Y	Y
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²According to the General Code of Conduct for Authorised Financial Services Providers and Representatives made under section 15 of the Financial Advisory and Intermediary Services Act, 2004 (Act No. 37 of 2002), details of remuneration must be reflected in specific monetary terms, provided that where an amount is not pre-determinable the remuneration basis must be explained.

6.2. Policyholder declaration:

I/we _____ [insert full name of policyholder], hereby confirm that:

- The financial adviser who provided me with this Replacement Advice Record has explained all the information provided in it to me in a way that I understand; and
- I have carefully considered this information.
- The financial adviser has alerted me to risks associated with the replacement and has advised me to take particular care to consider whether the replacement is appropriate to my needs, objectives and circumstances and

Initial

Initial

- (a) Despite the financial adviser's advice indicating that the replacement might not be in my best interest, I nevertheless wish to proceed with the replacement;

Initial

OR

- (b) Based on this information, I agree that the replacement is in my best interest.

Initial

(Policyholder to initial next to either (a) or (b) dependent on applicable decision)

I am aware that this Replacement Advice Record is not a cancellation instruction and that I still have to inform the insurer(s) to cancel my policy/policies

Signature of
policyholder

Date _____

e	D	D	M	M	Y	Y	Y	Y
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REPLACEMENT ADVICE RECORD (INDIVIDUAL RISK POLICIES)

INSTRUCTIONS FOR THE COMPLETION OF THIS FORM

1. The financial adviser must complete this replacement advice record form ("Record").
2. For purposes of this form "financial adviser" means an "intermediary", as defined in the Policyholder Protection Rules made under section 62 of the Long-term Insurance Act, 1998 (Act No. 52 of 1998), being the representative of the FSP concerned or sole proprietor, as the case may be, who has provided advice to the policyholder regarding the replacement.
3. The information required in the Record must be completed for each life insured on the policy.
4. If any feature is not present on the policy, please indicate "none" or "not applicable" in the applicable field. Do not leave the field blank.
5. For purposes of part 4, where there is no difference, indicate "same" or "no difference". Only complete the sections under part 4 where there is a difference between policy benefits of the new policy and the replaced policy.
6. Additional columns may be added as applicable where there is more than one new policy or replaced policy.
7. Where information regarding specific exclusions or premium loadings applicable to the policyholder/life insured, as required in part 4.10 is not available at the time this Record is completed due to underwriting processes, part 4.10 may be completed as "subject to underwriting". In the event where a specific exclusion or loading is subsequently imposed, the new insurer will need to make appropriate arrangements with the financial adviser so that the insurer can satisfy itself that the policyholder has subsequently been afforded the opportunity to consider the implications of such loadings or exclusions on the suitability of the replacement.
8. Customisation of the Record is allowed as follows:
 - a. The provider may add its own branding.
 - b. The colour schemes and font types may be changed, provided that there is no change to the prominence or visibility of any information contained in the form.
 - c. The number of columns or fields in the columns may be customised to accommodate the number of new policies and/or replacement policies concerned.
 - d. Fields may be added to enable insertion of information required by the provider for its own administrative purposes (eg "for office use only" type of content).
 - e. Formatting changes necessary to adapt the form for electronic completion are allowed.
 - f. Additional questions and information as required in the interest of appropriate disclosure to the policyholder may be added at the end of the Record, subject to the order and the sequencing of the Record not being changed.
9. The following format changes are not permitted:
 - a. Changes to the order or sequencing of the content of the Record.
 - b. Changes to the wording of any requirements, questions or declarations set out in the Record.
 - c. Any changes that will result in any requirements or information being obscured or made less prominent.