

Member number

## APPLICATION FORM FOR PPS PROVIDER™ POLICY

Professional Provident Society Limited (Limited by Guarantee) Reg No. 2001/011016/09 ("PPS Limited")  
Professional Provident Society Insurance Company Limited Reg No. 2001/017730/06 ("PPS Insurance")



**INSURANCE FOR  
PROFESSIONALS**

PPS Insurance is an Authorised Financial Services Provider – Licence No. 1044

Please ensure that you are assisted by a Financial Adviser in making this application. Your Financial Adviser must give you a Disclosure Notice in terms of the Financial Advisory and Intermediary Services Act, 2002 and explain your rights to you.

### Definitions:

**Policyholder and Life Insured:** The person to whose life, or to the functional ability or health of whose mind or body, the policy applied for in terms of this application form relates.

## PART A Personal Details

Please complete and (✓) where applicable – **Please use a black pen** –

This application is for a new PPS Provider product  additional benefits to existing PPS Provider product

A1 Membership	
Are you a current PPS Limited Member? Yes <input type="checkbox"/>	No <input type="checkbox"/> Member number <input type="text"/>

A2 Personal Particulars of the Policyholder	
1. Title: _____	2. Surname: _____
3. Maiden name/previous surname: _____	
4. First names: _____	
5. Gender: M <input type="checkbox"/> F <input type="checkbox"/>	6. Marital status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>
7. Preferred language: Eng <input type="checkbox"/> Afr <input type="checkbox"/>	8. Date of birth (dd/mm/yyyy): _____
9. National ID number/Passport if no ID: _____	
10. Resident in South Africa: Yes <input type="checkbox"/> No <input type="checkbox"/>	
11. SA citizen: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Your race: African <input type="checkbox"/> Indian <input type="checkbox"/> Coloured <input type="checkbox"/> White <input type="checkbox"/> Prefer not to disclose <input type="checkbox"/>	
12. Postal address: _____	Postal code: _____
13. Physical address: _____	Postal code: _____
I choose this physical address as my domicilium citandi et executandi.	
14. Telephone (work): (0_____) _____	15. Telephone (home): (0_____) _____
16. Fax number: (0_____) _____	17. Cellular number: (0_____) _____
18. E-mail: _____(1)	E-mail: _____(2)

**A3 Occupation of the Policyholder (Life Insured)**

1. Nominate your specific occupation? (e.g. Surgeon, Lecturer, Attorney, etc.) \_\_\_\_\_

If you are engaged in more than one specific occupation, you can only request cover in one of these. Please ensure that your nominated specific occupation reflects your primary occupation.

**Note:** This will be your nominated occupation for Occupation Specific Rider Benefit.

2. When did you start practicing your nominated specific occupation? Mm/yyyy \_\_\_\_\_

3. State the annual income that you earn from practicing your nominated specific occupation.

**Annual Gross Professional Income** \_\_\_\_\_ or **Annual Total Cost to Company** \_\_\_\_\_

Gross Professional Income is defined as your total contribution to your practice inclusive of consulting fees

Total Cost to Company is defined as annual salary plus all fringe benefits.

4. Please indicate whether you are in: Private practice  Salaried employment  Both

5. How long have you been in private practice? \_\_\_\_\_ (years)

6. State name of your practice or employer: \_\_\_\_\_

7. If you practise your occupation part-time, either in private practice or in the service of an employer, please state:

7.1 Reason why you are practising part-time? \_\_\_\_\_

7.2 Number of working hours per week? \_\_\_\_\_

## PART B Application for insurance benefits

<b>B1 PPS Sickness and Permanent Incapacity Benefit</b>		
<b>1. Sickness and Permanent Incapacity Benefit</b>	<b>Units applying for NOW:</b>	<b>Total Units:</b>
Units of Ordinary Benefit:	<input type="text"/>	<input type="text"/>
Full premium <input type="checkbox"/> Reduced premium (only prior to age 30) <input type="checkbox"/>		
Units of A Supplementary Benefit	<input type="text"/>	<input type="text"/>
Units of B Supplementary Benefit	<input type="text"/>	<input type="text"/>
Units of Deferred Benefit	<input type="text"/>	<input type="text"/>
Units of Accident Benefit	<input type="text"/>	<input type="text"/>
<b>2. Hospital Rider Benefit</b> in respect of:		
Units of Ordinary Benefit	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Units of A Supplementary Benefit	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Units of B Supplementary Benefit	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Units of Accident Benefit	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If for medical reasons the application for non-accident units is declined, PPS Insurance WILL automatically underwrite Units of Accident Benefit which provide cover for sickness and incapacity caused by an accident. Should this cover be required, please indicate    Yes <input type="checkbox"/>		
<b>3. Occupation Specific Rider Benefit™</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Note:</b> The nominated specific occupation will be as indicated in section A3 question 1.		

<b>B2 PPS Professional Life Provider</b>		
<b>Life Cover and Disability Cover</b>		
<b>Benefit Term</b>	<b>Sum Assured applying for NOW</b>	<b>Total Sum Assured</b>
1. Whole Life Cover	<input type="text" value="R"/>	<input type="text" value="R"/>
Disability Cover to age 66	<input type="text" value="R"/>	<input type="text" value="R"/>
Occupation Specific Rider Benefit Disability Cover		Yes <input type="checkbox"/> No <input type="checkbox"/>
-----		
2. Life Cover to age 66	<input type="text" value="R"/>	<input type="text" value="R"/>
Disability Cover to age 66	<input type="text" value="R"/>	<input type="text" value="R"/>
Occupation Specific Rider Benefit Disability Cover		Yes <input type="checkbox"/> No <input type="checkbox"/>
-----		
3. Fixed Term Life Cover _____(yrs)	<input type="text" value="R"/>	<input type="text" value="R"/>
Disability Cover	<input type="text" value="R"/>	<input type="text" value="R"/>
Occupation Specific Rider Benefit Disability Cover		Yes <input type="checkbox"/> No <input type="checkbox"/>
-----		
<b>The Disability Cover benefit term will follow the benefit term of the related Life Cover to a maximum age of 66. Disability Cover applied for cannot exceed the related Life Cover.</b>		

<b>B3 PPS Professional Health Provider</b>		
<b>Benefit Term</b>	<b>Sum Assured applying for NOW</b>	<b>Total Sum Assured</b>
1. Whole Life	<input type="text" value="R"/>	<input type="text" value="R"/>
CatchAll Cover		Yes <input type="checkbox"/> No <input type="checkbox"/>
Maternity Cover to age 44	<input type="text" value="R"/>	<input type="text" value="R"/>
-----		
2. To age 66	<input type="text" value="R"/>	<input type="text" value="R"/>
CatchAll cover		Yes <input type="checkbox"/> No <input type="checkbox"/>
Maternity Cover to age 44	<input type="text" value="R"/>	<input type="text" value="R"/>
-----		
3. Fixed Term _____(yrs)	<input type="text" value="R"/>	<input type="text" value="R"/>
CatchAll Cover		Yes <input type="checkbox"/> No <input type="checkbox"/>
Maternity Cover to age 44	<input type="text" value="R"/>	<input type="text" value="R"/>
-----		
<b>The Maternity Cover benefit term will follow the benefit term of the related Cover selected to a maximum age of 44. CatchAll Cover and Maternity Cover can only be selected at inception of the policy.</b>		

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<b>B4 PPS Professional Disability Provider</b>		
Benefit Term	Sum Assured applying for NOW	Total Sum Assured
1. Disability Cover to age 66 Occupation Specific Rider Benefit	<input type="text" value="R"/>	<input type="text" value="R"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Fixed Term Disability Cover _____ (yrs) Occupation Specific Rider Benefit	<input type="text"/>	<input type="text"/> Yes <input type="checkbox"/> No <input type="checkbox"/>

**Note: The nominated specific occupation will be as indicated in section A3 question 1.**

<b>B5 Commencement Date</b>
Preferred commencement date of benefits hereby applied for ____/____/_____ DD MM YYYY
The commencement date chosen by the policyholder can be any date within a 30 day period starting from the date of completing the application form. If the actual day of commencement is any day other than the 1st day of a month, PPS Insurance will calculate a pro rata premium with respect to the actual commencement date for that month. The pro rata premium will be collected with the first full premium. The commencement date may be changed at the discretion of PPS Insurance. Backdating is not permitted.

<b>B6 Restructuring of Sickness and Permanent Incapacity Benefit</b>
Are you restructuring your benefits? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, the appropriate replacement form must be attached.

<b>B7 Internal Replacement Policy Advice Record</b>
This section must be completed where a PPS Insurance policy is replaced by a PPS Insurance policy. To be completed in consultation with your financial adviser. Please note that this form does not serve as Cancellation of the Replaced Policy and you must complete a Cancellation Form where a Cancellation of a Policy is required.
<b>1. Reasons why replacement should be considered carefully</b> If you do replace any policy/policy benefits, we want to ensure that you make an informed choice. Please read the following information carefully and discuss with your financial adviser:
<ul style="list-style-type: none"> <li>• You will <b>pay some charges and fees twice</b> (e.g. commission, underwriting expenses and other initial charges levied by the insurer) – initially on the existing policy and once again on the new policy.</li> <li>• You may <b>pay higher premiums</b> for risk (or a bigger part of the premium) on the new policy because you are older now or your health situation might have changed.</li> <li>• Your new policy/policy benefits may not have the same cover as the existing policy/policy benefits.</li> <li>• Your new policy/policy benefits may have <b>additional exclusions, loadings, restrictions or waiting periods</b> applicable, particularly if your health has deteriorated.</li> <li>• Your new policy/policy benefits may not have the same features and benefits as your existing policy/policy benefits.</li> </ul>
<b>2. Reasons for the change of polic(y)ies/policy benefits</b> Did you establish whether the existing/terminated policy/policy benefits could be amended to provide similar benefits to the replacement policy/policy benefits? Yes/No If such amendments is/was possible, why do you regard it as appropriate that the terminated policy/policy benefits be switched to the replacement policy/policy benefits?  _____  _____  _____

**B7**

**Internal Replacement Policy Advice Record (continued)**

**3. Declaration (Compulsory)**

**Policyholder Declaration**

I confirm that the adviser has fully explained the consequences of the replacement of the polic(y)ies mentioned in this *Internal Replacement Policy Advice Record* and I understand the consequences of such replacement(s).

Name: \_\_\_\_\_

Contact telephone and/or e-mail address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Financial Adviser Declaration**

I confirm that I have taken all reasonable steps to confirm that the information in this *Internal Replacement Policy Advice Records (IRPAR)* is true and correct. I confirm that in pursuance of my advice to the policyholder to replace the polic(y)ies mentioned in this IRPAR, I have fully discharged my duties as set out in section 8(d) of the General Code of Conduct for Authorised Financial Services Providers and their Representatives (the Code) and have retained a record of such advice as required by section 3 of the said Code.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**4. Comparison between existing and recommended new policy**

Please ensure that you fully understand the following comparison of the conditions and benefits of your existing policy and the recommended

Policy details		Existing cover		Recommended cover	
Age of life assured at inception date					
Type of benefit			<b>Hospital benefit</b>		<b>Hospital benefit</b>
	Ordinary (Number of Benefits)		Y N		Y N
	A Supplementary (Number of Benefits)		Y N		Y N
	B Supplementary (Number of Benefits)		Y N		Y N
	Accident (Number of Benefits)		Y N		Y N
	Deferred (Number of Benefits)				
Occupation Specific Rider Benefit™		Y	N	Y	N
Life Assurance Scheme		R		R	
Disability Assurance		R		R	
PPS Professional Life Provider™		R		R	
PPS Professional Life Provider™ (DISA)		R		R	
PPS Professional Disability Provider™		R		R	
Professional Health Preserver		R		R	
PPS Professional Health Provider™		R		R	
PPS Professional Health Provider™ (CatchAll Cover & Maternity Cover)		R		R	

## PART C Underwriting

Complete sections C1, C2, C3, C4, C5 (Questions 1 – 9) when applying for Professional Life Provider™ Life Cover *only*.  
 Complete sections C1, C2, C3, C4, C5 and C6 (female only) (Questions 1-15) when also applying for Sickness and Incapacity Benefits, Occupation Specific Rider Benefit, Disability Cover (under the Professional Life Provider™) and/or Professional Health Provider™.

<b>C1 Family Medical History</b>				
	Current Age	State of Health if living	Age at death	Cause of death
Father				
Mother				
Brother(s)				
Sister(s)				

Have you or any of the above (mother, father, brothers, sisters) EVER suffered from, or been diagnosed as suffering from, or been treated in any manner, for ANY mental illness or a medical condition such as diabetes, heart trouble, high blood pressure, tremors or cancer? Yes  No

If so, please supply all known details e.g. nature of condition, names of doctors/psychologists consulted, dates consulted, nature of treatment recommended and/or given, duration of treatment and dosages.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<b>C2 Medical Details</b>	
1. What is your current Weight <input style="width: 100px;" type="text"/> kg	Height <input style="width: 100px;" type="text"/> cm
2. Measurement of abdominal girth <input style="width: 150px;" type="text"/> cm	
3. Are you a smoker <input type="checkbox"/> or a non-smoker <input type="checkbox"/>	
If a smoker, how many cigarettes do you smoke per day? _____	
4. I drink alcohol <input type="checkbox"/> I do not drink alcohol <input type="checkbox"/>	
If you drink alcohol, indicate your weekly intake for:	
Beer (units/pints) _____	
Wine (glasses) _____	
Spirits (tots) _____	
5. Please supply the name and telephone number of your usual medical attendant:	
_____	

**C3 Medical History: Past Treatment and Consultations**

*Please mark the applicable block with a (✓) if applicable and give full details in the space provided including treatment, the date of onset of the symptoms, the last time you experienced symptoms and also details of the attending doctor, hospital or institution.*

1. Have any one of the following ever been taken: Yes  No

X-rays  MRI Scans  CT Scans  EEG

Details: \_\_\_\_\_

2. Have you ever been admitted to one of the following: Yes  No

Hospital  Nursing home  Clinic  Health centre

2.1 Provide the dates: \_\_\_\_\_

2.2 How long was your admission? \_\_\_\_\_

3. Have you ever taken medication for a medical condition lasting longer than 10 days? Yes  No

Details: \_\_\_\_\_

4. Have you ever consulted either of the following Yes  No

Psychiatrist  Psychologist

4.1 Name of the Psychiatrist/Psychologist: \_\_\_\_\_

4.2 Provide details: \_\_\_\_\_

5. Have you in the past five years had any blood tests done for: Yes  No

Hormones  Thyroid  Sugar Levels  Immune Disorders

Cancer

Details: \_\_\_\_\_

6. Have any one of the following ever been performed: Yes  No

E.C.G.  Angiogram  Sonar  Exercise test

6.1 Name of the Specialist: \_\_\_\_\_

Details: \_\_\_\_\_

7. Have you ever attempted suicide? Yes  No

7.1 If yes, provide the date \_\_\_\_\_

8. HIV testing:

8.1 Date of the last test for HIV: \_\_\_\_\_

8.2 Result: Positive  Negative

9. Please supply the name(s) and telephone number(s) of any specialist(s) consulted during the past five years and the dates and reasons for the consultation(s):

\_\_\_\_\_

**C4 General Health Disclosure**

1 Are you aware of any condition or circumstance which might pose a health threat in the future? Yes  No

1.1 If yes, please provide details \_\_\_\_\_

\_\_\_\_\_

**C5**

**Medical Conditions**

**Have any of the following ever given rise to symptoms or been diagnosed? (Mark the appropriate box with a (✓)). If you answer Yes to any question, please answer the questions below the condition(s) indicated.**

**1. Disorders of the lungs** Yes  No

- Emphysema       Tuberculosis       Cystic fibrosis       Chronic cough   
 Sarcoidosis       Other diseases of the lungs or respiratory system

1.1 Nature of treatment(s) \_\_\_\_\_

1.2 Date of treatment(s) \_\_\_\_\_

**2. Disorders of the circulatory system** Yes  No

- Breathlessness       Fatigue       Chest pain       Swelling of the ankles   
 Palpitations       Varicose Veins

2.1 Nature of treatment(s) \_\_\_\_\_

2.2 Date of treatment(s) \_\_\_\_\_

**3. Disorders of the nervous system** Yes  No

- Anxiety neuroses       Depressive illness       Mood changes       Fits or epilepsy   
 Concussion       Eating disorders       Encephalitis/Meningitis       Polio   
 Dizziness       Any tremors (familial or not)   
 Other nervous or mental complaints

3.1 Nature of treatment(s) \_\_\_\_\_

3.2 Date of treatment(s) \_\_\_\_\_

**4. Disorders of the blood** Yes  No

- Anaemia       Purpura       Bleeding tendencies       HIV   
 Porphyria       Leukaemias       Lymphomas       Rickettsial Disease   
 Post Viral Disease       Other blood diseases       Raised blood fats/Cholesterol   
 Any abnormalities of coagulation (clotting) of the blood

4.1 Nature of treatment(s) \_\_\_\_\_

4.2 Date of treatment(s) \_\_\_\_\_

**5. Disorders of the heart** Yes  No

- Rheumatic fever       Coronary thrombosis       Angina       High blood pressure   
 Heart murmur       Enlarged heart       Chest pain   
 Irregularity of the heart-beat or extra-systoles       Abnormality of the heart valves   
 Other diseases of the heart

5.1 Date of onset of symptoms \_\_\_\_\_

5.2 Nature of treatment(s) \_\_\_\_\_

5.3 Date of treatment(s) \_\_\_\_\_

5.4 Date of last symptoms and final diagnosis \_\_\_\_\_

\_\_\_\_\_

**6. Disorders of the kidneys, bladder and sex organs** Yes  No

- Prostate abnormality/Raised PSA       Blood or protein in the urine   
 Testicular mass       Any other uro-genital disorder

6.1 Nature of treatment(s) \_\_\_\_\_

6.2 Date of treatment(s) \_\_\_\_\_

**C5**

**Medical Conditions** (continued)

**Have any of the following ever given rise to symptoms or been diagnosed? (Mark the appropriate box with a (✓)). If you answer Yes to any question, please answer the questions below the condition(s) indicated.**

**7. Disorders of the digestive system and liver** Yes  No

- Jaundice or hepatitis       Colon Polyps       Gallstones       Ulcerative colitis   
 Actual or suspected gastric or duodenal ulcer       Crohn's disease       Pancreatitis   
 Hernias       Other diseases of the stomach, liver, gall bladder or bowels

7.1 Nature of treatment(s) \_\_\_\_\_

7.2 Date of treatment(s) \_\_\_\_\_

**8. Disorders of the endocrine glands** Yes  No

- Insulin resistance       Diabetes       Thyroid abnormality   
 Any other endocrine gland abnormality

8.1 Nature of treatment(s) \_\_\_\_\_

8.2 Date of treatment(s) \_\_\_\_\_

**9. Have you ever been diagnosed with any of the following?** Yes  No

- Benign Tumor       Malignant Tumor

9.1 Nature of treatment(s) \_\_\_\_\_

9.2 Date of treatment(s) \_\_\_\_\_

**Questions 10 – 15 need only be completed if applying for Sickness and Incapacity Benefit, Occupation Specific Rider Benefit, Disability Cover (under Professional Life Provider™) and/or Professional Health Provider™.**

**10. Disorders of the muscles, bones and joints** Yes  No

- Backache       Sciatica       Slipped disc       Arthritis   
 Rheumatism       Repeated pains in any joints or muscles       Neck Pain   
 Muscle Fatigue       Dislocated hip or shoulder joint   
 Chronic Fatigue Syndrome/ Myalgic Encephalomyelitis

10.1 Nature of treatment(s) \_\_\_\_\_

10.2 Date of treatment(s) \_\_\_\_\_

**11. Disorders of the eyes and vision** Yes  No

- Glaucoma       Retinal detachment       Corneal ulcers   
 Any injury to, or disease of, the eyes       Astigmatism       Keratoconus

11.1 Nature of treatment(s) \_\_\_\_\_

11.2 Date of treatment(s) \_\_\_\_\_

**12. Disorders of the ears, nose and throat** Yes  No

- Impairment of hearing       Vertigo       Ringing or Tinnitus of ears   
 Any other disease of the ears, nose or throat or injury to them

12.1 Nature of treatment(s) \_\_\_\_\_

12.2 Date of treatment(s) \_\_\_\_\_

**C5****Medical Conditions** (continued)

**Have any of the following ever given rise to symptoms or been diagnosed? (Mark the appropriate box with a (✓)). If you answer Yes to any question, please answer the questions below the condition(s) indicated.**

**13. Disorders of the skin**Yes  No Acne Psoriasis Eczema Dermatitis Any allergy relating to a product or condition  Other diseases of the skin 

13.1 Have you ever consulted a dermatologist?

Yes  No 

13.2 Has a skin lesion ever been frozen, burnt or surgically removed from your body?

Yes  No 

13.3 Has Cortisone ever been prescribed to you?

Yes  No 

13.4 Nature of treatment, other than Cortisone \_\_\_\_\_

**14. Disorders of the respiratory system**Yes  No Asthma Bronchospasm 

14.1 To control the above condition(s) which of the following did you or do you presently use?

Inhaler Other medication 

14.2 Indicate the frequency of the treatment used

Regular Intermittent basis 

14.3 When did you last use medication? \_\_\_\_\_

**15. Disorders of the head and face**Yes  No Migraines Chronic headaches Facial pain 

15.1 Date of last symptoms: \_\_\_\_\_

15.2 Indicate the frequency of the attacks

Daily Weekly Fortnightly Once a month Once every six months 

15.3 Nature of treatment(s) \_\_\_\_\_

**C6****Gynaecological Medical History**

**Mark the applicable block with a (✓) and give details in the space provided.**

1. Date of most recent gynaecological examination \_\_\_\_\_

1.1 Name of the Gynaecologist \_\_\_\_\_

2. Have abnormalities of the cervix ever been diagnosed?

Yes  No 

3. Have you ever had any menstrual irregularities?

Yes  No 

4. Indicate whether any of the following have been diagnosed or treatment advised

Infertility Etopic pregnancy Ovarian malfunction 

5. Are you currently pregnant?

Yes  No 

5.1 Estimated date of delivery \_\_\_\_\_

6. Have you been diagnosed with any of the following abnormalities of the breasts?

Yes  No Enlarged breasts Fibroids of the breast Cysts Tumour 

6.1 Nature of treatment(s) \_\_\_\_\_

6.2 Date of treatment(s) \_\_\_\_\_

**D1**

**Beneficiary Nomination Form**

I, the undersigned policyholder hereby nominate the beneficiaries mentioned below to receive the benefits payable in terms of my PPS Provider™ Policy upon the death of the life insured as reflected hereunder. The beneficiaries will receive a percentage of the benefits as indicated hereunder. Where no beneficiaries are nominated with respect to a benefit or a percentage of a benefit, such benefit will be paid to the estate of the policyholder.

I know that I can revoke existing beneficiary nominations and appoint new beneficiaries. A revocation or beneficiary nomination will, however, only be valid if a **PPS Insurance Beneficiary Nomination Form** is duly completed, signed by the policyholder, and reach the head office of PPS Insurance before the insured event occurred.

**If I am an existing policyholder, this beneficiary nomination serves as a revocation of all previous beneficiary nominations in terms of all existing benefits with respect to this PPS Provider™ Policy.**

I authorise PPS Insurance to give full effect to my instructions and to pay the nominated beneficiaries.

I confirm that the terms, policy and practice of PPS Insurance for beneficiary claims are applicable to this beneficiary nomination.

**Beneficiary(ies) for cash benefits from surplus rebate account on the death of the life insured**

Full name of beneficiary(ies)	Title	ID number	Relationship to Policyholder	Percentage Share /100%

**Beneficiary(ies) for proceeds from Whole Life Cover on the death of the life insured**

Product number (if applicable): \_\_\_\_\_

Full name of beneficiary(ies)	Title	ID number	Relationship to Policyholder	Percentage Share /100%

**Beneficiary(ies) for proceeds from Term Life Cover to age 66 on the death of the life insured**

Product number (if applicable): \_\_\_\_\_

Full name of beneficiary(ies)	Title	ID number	Relationship to Policyholder	Percentage Share /100%

**Beneficiary(ies) for proceeds from Fixed Term Life Cover on the death of the life insured**

Product number (if applicable): \_\_\_\_\_

Full name of beneficiary(ies)	Title	ID number	Relationship to Policyholder	Percentage Share /100%

Please indicate by using a (✓).

Should the **PPS Beneficiaries Trust (IT4876/01)** be utilised when effecting payment to minors? Yes  No

Please sign any alterations or deletions on this nomination in full.

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By signing this beneficiary nomination form the policyholder confirms that, at the date of signature of this beneficiary nomination form, the policyholder has not been sequestrated and to the best of his knowledge, there are no sequestration proceedings pending against him, nor will such proceedings be instituted in the near future.

**Please note that this revocation and beneficiary nomination will be invalid if the policyholder does not sign here.**

**Signature of the Policyholder** \_\_\_\_\_

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 200\_\_\_\_\_

Witnessed by (name)\_\_\_\_\_ at the time of signing.

**Signature of witness** \_\_\_\_\_

**Signature of Spouse** (Only where policyholder is married in community of property) \_\_\_\_\_

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 200\_\_\_\_\_

Witnessed by (name)\_\_\_\_\_ at the time of signing.

**Signature of witness** \_\_\_\_\_

## PART E Payment Details

E1	Payer Details
Is the payer the same person as the policyholder? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>	
If no, please specify the payer details below:	
1. Name of company/legal entity: _____	
2. Title: _____ 3. Surname: _____	
4. First name(s): _____	
5. Identity number/Registration number <sup>1</sup> : _____	
6. Contact number: (0 _____) _____	

<sup>1</sup> Registration number is compulsory for Companies and Close Corporations

E2	Debit Order Agreement
<p><b>Kindly note</b> that the onus rests with the policyholder to ensure that the debit order and the amounts owing, drawn in terms of the debit order, are in fact paid.</p>	
Name of account holder: _____	
Account type: _____	
Account number: _____	
Name of bank: _____	
Branch code: _____	
Branch: _____	
Indicate type of account:      Business <input type="checkbox"/> Private <input type="checkbox"/>	
Collection date: 1st <input type="checkbox"/> 15th <input type="checkbox"/>	
Collection frequency:      monthly <input type="checkbox"/> quarterly <input type="checkbox"/> half-yearly <input type="checkbox"/> annually <input type="checkbox"/>	
<p>If it is a business bank account or person, other than policyholder the authority to collect must be attached with proof. PPS Insurance is hereby authorised to draw monthly, or at such other periods as agreed to by PPS Insurance and myself, under the debit order system, debits against my account as specified above or, in the event of this account being closed, such other account as I may subsequently operate, in payment of any amounts due by me to PPS Insurance from time to time. It is agreed that either I or PPS Insurance can at any time terminate this agreement by written notice to this effect.</p>	
Signed at _____ this _____ day of _____ 200 _____	
<p>_____</p> <p style="text-align: center;">Authorised signature of account holder</p>	

## PART F Legal Terms and Notes

### F1 Legal Terms and Notes, Declaration and Authority Statement

**Please read this before signing**

I, the undersigned policyholder and life insured, agree and declare that:

1. I am applying for benefits from Professional Provident Society Insurance Company Limited ("PPS Insurance").
2. I will only be entitled to the benefits applied for in this application form if I am a member of PPS Limited or once I have become a member of PPS Limited, a policy certificate in respect of the benefits applied for in this application form has been issued and the first premium in respect of the benefits applied for in this application form has been paid or arrangements have been made to the satisfaction of PPS Insurance for provision of the premium by debit order, before the insured event occurred. A premium will be regarded as being paid if PPS Insurance's bank account has been credited and provided that payment is not subsequently reversed.
3. If this contract cannot commence on the date elected in this application form, PPS Insurance may, in its sole discretion, elect another commencement date. The commencement date will be reflected on the Policy Certificate issued by PPS Insurance.
4. I understand that no insurer or financial adviser may require, permit or allow an applicant to sign any blank or partially completed form for the purpose of an insurance transaction, where another person will be required, permitted or allowed to fill in other required detail, or conclude any such transaction where any such signing and providing of detail has occurred. I acknowledge that it is my duty to complete this application form in full before signing it and not to require, permit or allow any other person to fill in further information on this application form after I signed it. If I do not act in terms of the aforementioned duty, PPS Insurance will not be liable for any loss or damage that may result.
5. I will inform PPS Insurance in writing at its head office if my income, occupation, smoking status or health circumstances change before the commencement date reflected on the Policy Certificate issued in respect of the benefits applied for in this application form. Upon failure to inform PPS Insurance as aforesaid, PPS Insurance will, once it becomes aware of such failure, be entitled to add premium loadings or exclusions to the benefits or to cancel the benefits issued in terms of this application form, or, if applicable, to cancel all benefits issued to me previously. I also risk losing membership of PPS Limited upon failure to inform PPS Insurance as aforesaid.
6. For the continuance of my contractual relationship with PPS Insurance, I will inform PPS Insurance in writing at its head office of a change in my occupation or if I am no longer substantially practising my occupation as indicated on this application form. I will inform PPS Insurance as aforementioned within 30 days from the date on which I changed my occupation or from the date on which I no longer substantially practice my occupation. PPS Insurance is entitled, in its sole discretion, to cancel the policy, products or benefits in terms of the policy from the end of the month during which I changed my occupation or no longer substantially practice my occupation. If I fail to inform PPS Insurance as aforesaid, and PPS Insurance becomes aware of the fact that I changed my occupation or no longer substantially practice my occupation, PPS Insurance may, in its sole discretion, cancel the policy, products or benefits in terms of the policy as aforesaid and return premiums paid after the end of the month during which I changed my occupation or no longer substantially practice my occupation. PPS Insurance will be entitled to deduct from the refunded premiums all costs incurred directly or indirectly as a result of my failure to notify PPS Insurance as aforesaid.
7. All the information provided in this application form and signed statements made, or to be made, which relate to this application in any way are warranted complete, true and correct, whether in my handwriting or not, and together with any written statements supplied to PPS Insurance by me or any other party with my consent, are to form the basis of the proposed contract with PPS Insurance and deemed incorporated therein. I understand that if any of the information supplied as aforementioned is found not to be complete, true and correct, I could lose the policy, products or benefits in terms of the policy or, if applicable, I could lose all benefits issued to me previously. I also risk losing membership of PPS Limited.
8. I agree that the post is the authorised means for PPS Insurance to communicate the acceptance of my offer to contract as contained in this application form. I will be deemed to have received such correspondence sent to me by PPS Insurance within 7 days from the date on which PPS Insurance sent the correspondence to my postal address and I will carry the risk of such communication.
9. PPS Insurance may, in its discretion, deal with me and my affairs electronically and may treat electronic communication (e-mail, fax, telephone, etc.) as being the same as written communication. I agree that where I choose to use electronic methods to transact with PPS, that I will carry the risk of such use.
10. I will comply with the underwriting requirements of PPS Insurance.
11. PPS Insurance may ask me to undertake a variety of blood and medical tests, including tests for the HIV virus. I indemnify PPS Insurance against any claim of whatever nature, which may be made against it as a result of, or arising out of any such test.
12. Based on the disclosures as contained in this application form together with subsequent information obtained by PPS Insurance to assess the risk, PPS Insurance can reject this application for the policy, products or benefits in terms of the policy or accept it subject to premium loadings or exclusions. PPS Insurance is authorised to, if the offer to contract as contained in this application form is not acceptable to PPS Insurance, communicate its counteroffer to me via post to my postal address. I will be deemed to have received the counteroffer within 7 days from the day the counteroffer was posted to me by PPS Insurance and I will carry the risk of such communication. If PPS Insurance makes a counteroffer to me, the payment of any premium in terms of such counteroffer must be regarded as acceptance of the counteroffer by me.
13. I have the right to cancel this insurance transaction by written cancellation notice sent to PPS Insurance at its head office within 30 days from receipt of a summary of the policy as contemplated in section 48 of the Long Term Insurance Act, or from a reasonable date on which it can be deemed that I received the aforementioned document. In such event PPS Insurance will refund any premiums paid with respect to the cancelled insurance transaction, subject to the deduction of the cost of any risk cover actually enjoyed.

**F1 Legal Terms and Notes, Declaration and Authority Statement (continued)**

14. I agree that I have a continuous duty of good faith whenever dealing with PPS Insurance for the duration of this contract. I also understand that PPS Insurance will be entitled to cancel the policy, products or benefits in terms of the policy from inception if I breach this duty of good faith in any way.
15. I have not been charged with or found guilty of a professional or criminal offence or serious complaint, or incurred the formal sanction of a professional association or registration body.
16. I am financially solvent.
17. I have full legal capacity to enter into this contract.
18. I warrant that the premiums paid with respect to this policy do not constitute the proceeds of unlawful activity, including, but not limited to, tax evasion and breach of exchange control regulations.
19. I have made an informed decision to purchase the product indicated in this application and I am aware of the risks, liquidity restrictions, financial and tax consequences, if any, of such a purchase.
20. I ; or the financial adviser ; or I and the financial adviser together ; completed the application form.
21. If a PPS Insurance policy is replaced with a PPS Insurance policy B7 must be completed.
22. This question relates to the replacements of policies issued by an insurer **other than PPS Insurance**.  
Tick one of these boxes.
- This proposal is not intended to replace the whole or any part of my existing insurance with any insurer other than PPS Insurance (whether replacement is to occur immediately or to replace insurance discontinued within the past four months or within the next four months).
- OR
- This proposal is intended to replace the whole or any part of my existing insurance with any insurer other than PPS Insurance (whether replacement is to occur immediately or to replace insurance discontinued within the past four months or within the next four months). The financial adviser must discuss and complete a Replacement Policy Advice Record with me and attach it to this proposal form. I am aware that potentially the replacement of any insurance may be to my disadvantage.
23. Some of the information requested in terms of this application is requested in terms of, and is subject to, statutory requirements.
24. I appoint (name) \_\_\_\_\_ as my financial adviser.
25. I accept that I am hereby curtailing my right of privacy, but to facilitate the assessment of the risks, and the consideration of any claim for benefits, under a policy related to this or any other proposal for insurance made, I irrevocably authorise PPS Insurance to, during my lifetime and thereafter:
- obtain from any person or institution, whom I hereby authorise and request to give, any information which PPS Insurance deems necessary; and
  - to share with other insurers and their representative body that information and any information contained in this application or in any related policy or other document, either directly or through a database operated by, or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as may from time to time be decided by PPS Insurance or by the operators of such database;
  - to disclose any information to PPS Insurance's holding company, subsidiaries, affiliates, Profmed or other persons provided that PPS Insurance consider such disclosure necessary in order to properly underwrite, manage or service the policy, the policy assets or me. PPS Insurance may also be required through the operation of law to disclose information regarding a specific policy or policyholder to regulatory and government agencies;
  - obtain credit information from any person or institution; or
  - I specifically authorise PPS Insurance to provide medical details with respect to loadings and exclusions placed on benefits to my financial adviser.

While PPS Insurance intends receiving parties to keep the aforementioned information confidential, PPS Insurance cannot be held liable if this does not happen.

By signing this form I confirm that I have read and understood the contents of this application form and that I agree to all the terms and conditions contained in this application form. Any contractual relationship that may be formed arising from PPS Insurance's acceptance of my offer is subject to the terms and conditions of the Products and or Benefits I applied for, copies of which are available at PPS Insurance's head office and which I am deemed to have read, understood and agreed to.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 200 \_\_\_\_\_

Signature of policyholder \_\_\_\_\_

(Note: to be signed by the legal guardian in the case of a minor or person under legal disability).

<b>F2</b>	<b>Declaration by Financial Adviser</b>
I, the undersigned, confirm and declare that:	
1. My personal details are as follows:	
Surname _____	Initials _____
Financial adviser number _____	Company Reference number _____
Financial Services Provider name _____	Financial Services Provider number _____
Contact telephone number (0 _____) _____	E-mail _____
Branch _____	
2. I am authorised to sell the PPS products available in terms of this policy.	
3. I have given a Disclosure Notice in terms of the Financial Advisory and Intermediary Services Act, 2002 to the policyholder and explained its contents and the policyholder's rights.	
4. I have explained the use and contents of this form.	
5. I have explained the eligibility criteria for membership and the relevant PPS product range, including the Surplus Rebate Account, as required.	
6. I have undertaken a needs analysis with the policyholder.	
7. I hereby declare that I have explained the meaning and implications of replacing existing insurance to the policyholder and that I am fully aware of the possible detrimental consequences of the replacement of an insurance policy.	
8. Where the policyholder has indicated that this application is intended to be a replacement whether such replacement is to occur immediately or to replace an insurance policy discontinued within the past four months or within the next four months, I will submit an appropriate completed replacement form with this application form.	
9. I have given the policyholder a quotation and explained its contents.	
10. In my opinion, the products that the policyholder is applying for are appropriate to the policyholder's circumstances and needs.	
11. All information disclosed to me by PPS Limited and PPS Insurance and the policyholder will remain confidential and will only be used for the purpose of providing financial services to the applicant/member.	
12. I, on my own <input type="checkbox"/> ; or the policyholder <input type="checkbox"/> ; or we together <input type="checkbox"/> ; filled out the application form.	
13. Where I have filled out the application form, I have accurately and comprehensively recorded all answers, information and disclosures made to me by the policyholder.	
Signed at _____ this _____ day of _____ 200 _____	
Signature of financial adviser _____	