FUNERAL SERVICE
APPLICATION FORM

ILONATHEMBA FUNERAL SERVICES
"Where there is Sorrow, we give Hope."

122 2ND Avenue, Chyna Town Shopping Centre, Mid-Ennerdale, 1830 +27 73 070 9730 luhlangothimbuso@gmail.com

Banking Details
Capitec Bank | Ilonithemba Services | Acc. No: 1053462999

This is the person entering into the funeral policy. The Policyholder owns the benefit and is the only person entitled to receive payment of the benefits to pay for the funerals of the insured persons.

POLICY DETAILS (OFFICE USE ONLY):

Branch Name		Bank	
Policy Option		Name	
Policy Number		Account Number	
Inception Date		Debit Day	

MAIN MEMBER DETAILS:

Full Name		Phone	
Surname		Cellphone	
Email		Physical Address	
Gender			
National Id No		Postal Code	

SPOUSE DETAILS:

Full Name :		Phone	
Surname :		Cellphone	
Email :		Physical Address	
Gender :			
National Id No :		Postal Code	

FAMLY MEMBERS:

FULL NAMES	SURNAME	ID NUMBER	AGE	RELATIONSHIP

FAMILY MEMBERS:

FULL NAMES	SURNAME	ID NUMBER	AGE	RELATIONSHIP

BENEFICIERIES DETAILS:

On the death of the Policyholder, the beneficiary stated below will receive the benefits of the policy (100%). If beneficiaries are not nominated, the benefits will be paid to your spouse (if covered) or the closest relative we have on record. The second beneficiary will only be used if the payout of the claim cannot be payed to the first beneficiary.

BENEFICIARY 1:
Full Name:
Surname :
Gender :
National Id No :

BENEFICIARY 2:
Full Name :
Surname :
Gender :
National Id No :

CLIENT DECLARATION:

1. I have received the information leaflet and summary terms and conditions containing the waiting period, rules of over insurance and the claims procedure.
2. I understand that the cover will only start when my application has been accepted and I have paid the first premium.
3. I understand that I have 30 days from the date I received the policy terms to cancel my policy. I also understand that if I do not cancel my policy within 30 days, I will be bound by the policy terms.
4. I have given all information correctly and understand that if any information is found to be untrue, my benefits may not be paid or my policy could be cancelled. I also agree to notify the underwriter in writing of any changes to the information I have provided.
5. I understand that the underwriter needs to collect and share my personal information specifically for this policy and to service, assess risks and consider claims for benefits under this policy. I also understand that this information will be kept confidential and secure for as long as the underwriter needs it.
6. I therefore authorise the staff, representatives and certain sub-contractors of the underwriter, it's holding company and subsidiaries, to collect and process the information I have provided which is relevant to my policy and to collect, process and share such information with an appointed financial adviser or other insurer either directly through us or any other institution in the financial services industry which provides a mechanism for the transmission of personal information.
7. I authorise the underwriter to communicate with me regarding my policy via Short Message System ("SMS") and/or email.
8. It is your responsibility as owner of this policy to make sure that Securitas Financial Group always has up-to-date contact information for you and anyone that can benefit on this contract.

Signature_____ Date(YYYY)_____ Month(MM)_____ Date(DD) Signature of applicant_____

Where Ilonathemba Services becomes aware that there are benefits due to be paid out on the policy, we will always first try to contact you or your beneficiaries at the last address provided to us. If we are not able to contact you at this address, we have to take other reasonable steps to try find the person that is entitled to the policy benefits. In order to do this, we may have to appoint external tracing agents. By signing this application, you agree that we need your consent to provide you with information on products and services offered by Ilonathemba Services and also to share your information within the business. Please tick the box if you agree:

To receive marketing information on products, services and special offers

To communicating other companies' products, services and special offers t me. If I respond positively to such communication, I may be contacted by the company.

To sharing my personal information withing the group for marketing purposes and the group then marketing its products, services and special offers to me.

To contacting me for research purposes. (The research companies we use follow strict codes of conduct and treat customer information confidentially)

Replacements - Replacement of any insurance may be to the disadvantage of the proposer. Is the proposal to replace the whole of or any part of your existing insurance with any insurer (whether replacement is to occur immediately or to replace insurance within the past 4 months or within the next 4 months?) Please indicate your submission:

Signature_____Date(YYYY)_____Month(MM)_____Date(DD)_____ Signature of applicant_____

I declare that I have explained the meaning and implications of replacement of an insurance policy to the policy holder and that I am fully aware of the possible detrimental consequences of the replacement of an insurance policy.

_____ _____

Advisor Name: Signature of Advisor: