SAFRICAN INSURANCE COMPANY
Preparing for tomorrow, today

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

POLOKWANE
P.O. Box 1021
Polokwane 0700
Tel: 015 291 3358
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☐ NEW APPLICATION ☐ AMENDMENT

BRANCH NAME:

POLICY COMMENCEMENT DATE: Y Y Y Y M M D D

APPLICATION FOR VOLUNTARY FUNERAL ASSURANCE WITH EXTENDED FAMILY BENEFITS

1. PERSONAL DETAILS OF MAIN MEMBER

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

2. PERSONAL DETAILS OF SPOUSE

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

N O T A P P L I C A B L E

3. PRINCIPAL MEMBER'S CHILDREN

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

N O T A P P L I C A B L E

4. EXTENDED FAMILY DETAILS

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

PLEASE NOTE:
- Option to join must be within 6 (six) months of joining the Company
- Waiting period for Extended Family under age 74 years is 6 (six) months
- Where a premium is underpaid, the benefit payable in respect of a claim will be reduced in proportion to the under payment.

EXTENDED FAMILY PREMIUMS	R
FULL FAMILY PREMIUM	R
TOTAL PREMIUM	R

5. DECLARATION BY THE POLICYHOLDER OR APPLICANT

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

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

SIGNATURE OF PRINCIPAL MEMBER

DATE Y Y Y Y M M D D

FOR OFFICE USE ONLY

POLICY NUMBER:

MEMBER GROUP NUMBER:

DATE: Y Y Y Y M M D D