

PROPOSAL FOR A GROUP ASSURANCE PLAN



PROPOSER:

Name of Company / Organisation / Umbrella: _____

Scheme Name : _____

Physical Address: _____ Code: _____

Postal Address : _____ Code: _____

Telephone No : _____ Fax No: _____ E-mail Address : _____

Overall nature of business sector / industry: _____

Location of Company / Organisation (region) : _____

Type of Organisation: Company C.C. Partnership Sole Trader

Names and Identification Numbers of all members of the Partnership and Sole Trader only:

Name: _____ ID Number: _____

Name: _____ ID Number: _____

Name: _____ ID Number: _____

PROPOSAL FOR:

Fund placed with Safrican as : Direct Business Broker Business

New Fund : Date of Commencement:/...../.....

Increased Benefits / Amendment to an existing fund : Effective Date :/...../.....

New Participating Company under existing umbrella

BROKER DETAILS:

Brokerage Name: _____ E-mail address: _____

Physical Address: _____ Code: _____

Postal Address : _____ Code: _____

Broker Code : _____ Broker VAT Registration: _____

Tel No : _____ Fax No: _____

SCHEME CONTACT DETAILS:

Contact Person : _____ Tel No: _____

Fax No : _____ E-mail address: _____

COMMISSION:

Cheque Electronic Funds Transfer

Bank Account details for EFT Bank and Branch : _____

Bank Account Number: _____ Branch code: _____

Accountholder / Cheque Payee: _____

PREMIUM PAYMENTS:

Premium frequency: Monthly Annual

Contact Person responsible for payment of premiums: _____

Telephone No: _____ Fax No: _____ E-mail Address: _____

PARTICIPATION DETAILS:

Participation for all eligible persons will be : Compulsory Voluntary

This is an Employer / employee relationship : Yes No

Premium deducted from salaries / wages : Yes No

Who will be eligible to participate in the proposed plan : _____

Number of members covered under the plan at inception: _____

Category of cover requested : Full Family Member Only Dependants Only

BENEFIT: Funeral cover required: Limited Life To Death Cessation age:

Benefit structure applicable under the fund Principal Member : R _____
Spouse : R _____
Child 14 – 21 : R _____
Child 6 – 13 : R _____
Child 1 - 5 : R _____
Child 0 – 11 mths : R _____
Stillborn : R _____

** Compulsory Parent Cover : R _____ (if applicable as per quote)

Monthly Premium Rate Annual Premium Rate : R per member

ADDITIONAL BENEFITS APPLICABLE TO THIS FUND:

- Paid-up Death Benefit
- Retrenchment Benefit – period:
- Memorial Benefit
- Repatriation Benefit
- Paid-up on Disablement Benefit
- Accidental Death Benefit
- Incapacitation Benefit
- Paid-up on Retirement Benefit

PARENTS / EXTENDED FAMILY BENEFITS:

Under 65 Benefit R..... At R per additional person
65 to 74 Benefit R..... At R per additional person

DECLARATION:

I / we hereby warrant that the above information is complete and correct and that no other material information which may be relevant to Safrican Insurance Company Limited's assessment of the Proposal has been withheld. I / We understand that until Safrican has been provided with all the relevant documentation and 1st Premium, Safrican will not assume risk. Hereto attached receive:

- Quote Ref:
- 1st Premium
- Full Membership Data
- Member applications attached

Authorised Signature: _____ Official Designation: _____

Initials & Surname: _____ Date: _____

COMPANY STAMP

Safrican Consultant in attendance: _____

For Office use only

Checked by Consultant: _____ Received by Risk Management:/...../..... Received by Admin.:/...../.....

Policy No: _____ Scheme No: _____ Administrator: _____ Issue Date:/...../.....

Head Office:
PO Box 616
Johannesburg, 2000
Tel: (011) 332-6589
Fax: (011) 332-4305

Cape Town:
PO Box 4921
Cape Town, 8000
Tel: (021) 419-0090
Fax: (021) 421-0104

Port Elizabeth:
PO Box 35036
Newton Park, 6055
Tel: (041) 363-1477
Fax: (041) 363-0208

Durban:
PO Box 429
Durban, 4000
Tel: (031) 305-1800
Fax: (031) 304-3738