ambledown
FINANCIAL SERVICES (PTY) LTD
Ambledown is an Authorised Financial Services Provider, No. 10287

CONSTANTIA
Insurance made personal
Constantia Life & Health Assurance Company Limited Registration Number 1952/001635/06

AMBLEDOWN FUNERAL SCHEME INDIVIDUAL PAYROLL APPLICATION FORM

Underwritten by Constantia Life & Health Assurance Company Limited, Registration Number 1952/001635/06, (The Insurer)

THE MASTER POLICY ISSUED IS THE SOURCE OF ALL BENEFITS, RIGHTS, AND OBLIGATIONS AND EXCLUSIONS. TO DETERMINE YOUR INDIVIDUAL NEEDS, WE SUGGEST THAT YOU CONTACT YOUR BROKER AND REQUEST ADVICE FROM HIM / HER.

BROKER DETAILS

BROKER / CONSULTANT NAME			
NAME OF BROKERAGE			
FSP NUMBER		VAT NUMBER	
BROKER CODE		UNIQUE IDENTIFIER (IF NECESSARY)	
BROKER E-MAIL ADDRESS		BROKER CONTACT NUMBER	

PRODUCT SUMMARY

OPTION 1	LIMITED TO R30,000
OPTION 2	LIMITED TO R15,000
OPTION 3	LIMITED TO R10,000
OPTION 4	LIMITED TO R5,000

FAMILY FUNERAL COVER PROVIDES FOR THE PAYMENT OF A LUMP SUM ON THE DEATH OF THE PRINCIPAL AND THE DEFINED AND REGISTERED DEPENDANTS.

DOUBLE BENEFIT IF DEATH AS A RESULT OF AN ACCIDENT AT NO EXTRA COST

PRODUCT SELECTION

OPTION 1	☐	**R 75.00 PER FAMILY PER MONTH**	OPTION 3	☐	**R 37.00 PER FAMILY PER MONTH**
OPTION 2	☐	**R 50.00 PER FAMILY PER MONTH**	OPTION 4	☐	**R 25.00 PER FAMILY PER MONTH**

INCEPTION DATE (DATE COVER IS TO COMMENCE) D D M M Y Y Y Y

PERSONAL PARTICULARS

APPLICANT

TITLE		SURNAME	
ID OR PASSPORT NUMBER		FIRST NAMES	
DATE OF BIRTH	D D M M Y Y Y Y		
POLICY NUMBER			

EMPLOYER

NAME OF EMPLOYER		DATE EMPLOYED	D D M M Y Y Y Y

MEDICAL SCHEME

NAME OF MEDICAL SCHEME		PLAN OPTION	
DATE JOINED	D D M M Y Y Y Y	MEDICAL SCHEME NUMBER	

CONTACT DETAILS

POSTAL ADDRESS	PHYSICAL ADDRESS (IF DIFFERENT TO POSTAL)
POSTAL CODE	POSTAL CODE

HOME NUMBER	AREA CODE		WORK NUMBER	AREA CODE	
CELL NUMBER	AREA CODE		E-MAIL		

DEPENDANTS To see who qualifies as a dependant see DECLARATION b)

FIRST NAME (AND SURNAME IF DIFFERENT)	RELATIONSHIP	ID OR PASSPORT NUMBER	DATE OF BIRTH
			D D M M Y Y Y Y
			D D M M Y Y Y Y
			D D M M Y Y Y Y
			D D M M Y Y Y Y
			D D M M Y Y Y Y
			D D M M Y Y Y Y

BENEFICIARY

FIRST NAME (AND SURNAME IF DIFFERENT)	RELATIONSHIP	ID OR PASSPORT NUMBER	DATE OF BIRTH
			D D M M Y Y Y Y

PREMIUM PAYMENT

PAYROLL DETAILS

EMPLOYER NAME		EMPLOYEE NAME	
EMPLOYEE COST CENTRE		EMPLOYEE SURNAME	
DATE EMPLOYED	D D M M Y Y Y Y	EMPLOYEE NUMBER	

PLEASE NOTE THAT IF PREMIUMS ARE PAID VIA PAYROLL THEY WILL BE COLLECTED MONTHLY IN ARREARS (UNLESS OTHERWISE SPECIFIED) FOR THE CURRENT MONTH OF COVER.

Having applied for the policy detailed above, and on acceptance of my application by the Insurer, I hereby authorise my salaries/ payroll division to deduct the above premium from my salary and remit to the Insurer on a monthly basis. Such authorisation shall remain in force and effect until cancelled by myself, in writing with 30 days notice or I leave the employ of my current employer. I further authorise the Insurer to increase the amount due in terms of the policy from time to time and authorise my salaries/ payroll division to effect payment on relevant increases.

AGREEMENT OF APPLICANT DATE D D M M Y Y Y Y

DECLARATION

I declare that I have not withheld any information and I accept that this application and declaration shall be the basis of the contract of insurance between me and the Insurer, which will become effective on the first day of the month for which premiums are received. I also acknowledge that I have requested and instructed the broker not to complete a financial needs analysis. Furthermore, I understand and accept that this instruction not to proceed with a full financial needs analysis could have the effect that all my financial needs may not be properly addressed.

I further confirm that the following notable conditions have been explained to me:

a) A general 6 month waiting period is to apply from date of inception for all non-accident related death.

b) Not all your dependants on your family funeral cover are automatically covered under this policy, only your eligible spouse and your eligible children are covered as per the policy definitions.

   i. Only one spouse is allowed.

   ii. The maximum age for a child dependant is under 21 years. This age may be extended to 25 (under 26) in respect of an unmarried child who is a dependant on the Principal Insured Person's policy and is financially dependent on the Principal Insured Person.

   iii. No cover is provided for extended family members.

I confirm that although I have completed this application form, it does not constitute an insurance contract until a membership number is assigned, policy issued and premium is successfully paid.

SIGNATURE OF APPLICANT PRINTED NAME OF APPLICANT DATE D D M M Y Y Y Y

Please return to your broker or alternatively: Ambledown Financial Services (Pty) Ltd,
PO Box 1862, Cramerview, 2060
Tel Number 0861 262533, Fax Number (011) 463 1600
E-mail Address: admin@ambledown.co.za

Broker Details: [Brokerage Company Name],
FSP number: [xxxxxxxxxxx]
[Telephone number], [Mobile number], [Website address]