



# APPLICATION FORM

Fax: 0866 126 595 · Customer Service: 0861 255 5433  
 Email: applications@alllife.co.za  
 Post: AllLife (Pty) Ltd · PO Box 787159 · Sandton · 2146

**Instructions:** 1. Please complete in ink, print clearly, mark selections with X, and sign on every page where indicated.  
 2. Please include a signed copy of the identity document (or residence permit) of the applicant with this application.

## A: INSURANCE REQUIREMENTS

What amount of cover are you applying for? Example: R100 000:

What product are you applying for?

Whole Life Cover				Loan Protection Cover	
		10 Year term	20 Year term		
Premium escalation:	0% (level) <input type="checkbox"/>	5% per year <input type="checkbox"/>	10% per year <input type="checkbox"/>	0% (level) <input type="checkbox"/>	0% (level) <input type="checkbox"/>
Cover escalation:	0% (level) <input type="checkbox"/>	0% per year <input type="checkbox"/>	3% per year <input type="checkbox"/>	Declining* <input type="checkbox"/>	Declining* <input type="checkbox"/>

\* The Loan Protector product provides a benefit that declines in line with the anticipated amortising outstanding loan balance as set out in the policy schedule (assumes loan repayments are made in accordance with the agreed repayment schedule).

I accept the monthly premium quoted by AllLife  INITIAL HERE

## B: LIFE INSURED'S DETAILS

Title:  Initials:  Surname:

First name(s):

Maiden name:  Marital status:

ID No.:  Date of birth:  /  /  /  /  /  /  /

Age (years):  Gender:  M  F Can we communicate with you via SMS?  Y  N

Telephone (h):  /  /  /  /  /  /  /  Cell:  /  /  /  /  /  /  /

Telephone (w):  /  /  /  /  /  /  /  (required) Fax:  /  /  /  /  /  /  /

Postal address:  /  /  /  /  /  /  /  Code:  /  /  /

Residential address:  /  /  /  /  /  /  /  Code:  /  /  /

Email address:

Highest tertiary qualification (please indicate with an X): Not Matriculated:  Matriculated:  Diploma:  Degree:  Post Graduate:

Please give details of qualification:  Year achieved:  /  /  /  /  /  /  /

Employer name:

Work address:  /  /  /  /  /  /  /  Code:  /  /  /

Your position:

Department:  Industry Type:

What are your primary duties?

Describe your duties in terms of percentages: Admin:  % Supervisory:  % Travel:  % Manual:  %

Monthly gross income:  Employee number (if applicable):

Are you paid via Persal (the government payroll)?  Y  N If yes, supply your Persal number:

Insured s Name:  Insured s Signature:



## G: MEDICAL INSTITUTIONS

Name of your primary doctor:				
Doctor's location (City):		Doctor's phone number:	□	□
			□	□
			□	□

## H: DETAILS OF CURRENT LIFE INSURANCE PRODUCTS OWNED

Do you have any existing life insurance cover or have you applied for other life cover recently (awaiting approval)?  Y  N

If 'YES', please provide details:

	Insurance Company	Life Cover (Rands)	Year Cover Initiated	Monthly Premium
Existing Policies:	1:			
	2:			
	3:			
Applications not yet finalised:	1:			

## I: BENEFICIARY INFORMATION

	First Names	Surname	Date of Birth	ID Number	Relationship	%
1:			D D / M M / Y Y Y Y			
2:			D D / M M / Y Y Y Y			
3:			D D / M M / Y Y Y Y			
4:			D D / M M / Y Y Y Y			
5:			D D / M M / Y Y Y Y			
6:			D D / M M / Y Y Y Y			
Total:						100%

Note: Where no beneficiaries are specified the beneficiary of the policy will be the estate of the policy holder

## J: CONSENT OF SPOUSE TO BENEFICIARY NOMINATION (IF APPLICABLE)

The consent of the spouse is required only where the beneficiary is not the Policy Owner's spouse, or the spouse and one or more other persons have been nominated as joint beneficiaries, AND: a) the marriage is in community of property, and b) the policy forms part of the joint estate. I hereby consent to the nomination of the aforementioned beneficiary(ies)

		<input type="checkbox"/> D <input type="checkbox"/> D / <input type="checkbox"/> M <input type="checkbox"/> M / <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y
Name of Policy Owner's Spouse	Signature of Policy Owner's spouse	

## K: DEBIT ORDER AUTHORISATION

AllLife will only process policies where payment is by debit order (payments by credit card or cash are not accepted).

Bank Name:		Account Holder:	
Account number:		Branch Name:	
Branch code:		Account Type:	

Preferred debit order day of the month: 1<sup>st</sup>  15<sup>th</sup>  25<sup>th</sup>  Other (please specify):

When debit order falls on a weekend, what debit day would you prefer: Before:  After Weekend:

During the period 11 December to 10 January, what day would you prefer to be debited on: 15 Dec  20 Dec  28 Dec  1 Jan

Other (please specify):

I, the undersigned, request AllLife to arrange with my bank to collect premiums payable in terms of the policy provisions (as they may be amended from time to time) against my bank account (wherever it may be) in terms of a debit order. I authorise AllLife to draw against this account all amounts due in terms of this application. This authorisation is to remain in force until terminated by AllLife or myself. I agree to advise AllLife in writing of any changes that may occur. I warrant that the information supplied is true and correct.

Signature of account holder:   D  D /  M  M /  Y  Y  Y  Y

If account holder is not the insured, please state relationship to client:

Insured's Name: <input style="width: 90%;" type="text"/>	Insured's Signature: <input style="width: 90%;" type="text"/>
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## L: MY MEDICAL HISTORY (CONTINUED)

- 15: Are you currently pregnant? (answer only if female)  Y  N
- 16: Have there been any problems with previous pregnancies? (answer only if female)  Y  N
- 17: Have any of your children suffered from any birth defects or congenital abnormalities?  Y  N
- 18: Have you ever been tested for Hepatitis or any sexually transmitted disease (including HIV) or have you ever received medical advice, counseling or treatment in respect thereof?  Y  N
- 19: Did you receive any medication or other treatment uninterruptedly for longer than 6 (six) days within the past 5 (five) years, or is this the case now, for conditions NOT mentioned already? Please include dose and diagnosis.  Y  N


- 20: Height (metres):  Weight (Kilograms):
- 21: Has your weight changed by more than 5 kg in the last 12 months?  Y  N
- 22: Alcohol – quantity and type consumed per week:
- 23: Tobacco (including the past 12 months) – quantity and type per day:
- 24: Have you ever or do you use recreational drugs e.g. cannabis, mandrax etc. Have you ever received medical advice to reduce or discontinue liquor, drug or tobacco consumption?  Y  N
- 25: Have you ever been charged with drunken driving?  Y  N
- 26: Has a proposal for life, medical, disability, dread disease or impairment insurance on your life ever been declined, postponed, withdrawn or accepted on special terms or at special premium rates?  Y  N
- 27: Have you ever submitted a disability, accident, dread disease or impairment claim to any insurer or fund?  Y  N
- 28: Have your parents or siblings ever suffered from diabetes, stroke, heart complaint, high blood pressure, porphyria, mental disorders, haemophilia or any other hereditary disease? Please specify which person and what disease.  Y  N
- 29: Do you participate in or are you involved in any pursuit, avocation or occupational activity that might be considered hazardous e.g. racing (speed contests), diving, aviation, parachuting, mining, mountaineering etc.?  Y  N
- 30: Are you intending, or are you aware of a need to seek medical advice from a medical practitioner within the next 8 weeks for any condition or operation?  Y  N
- 31: Any congenital or birth defect, including, but not limited to mental insufficiency, essential defect of memory/concentration, minimal brain dysfunction etc.?  Y  N
- 32: Do you live outside the borders of the RSA or do you plan to do so continuously for a period in excess of 3 months within the following 12 months?  Y  N
- 33: Are you aware of any other health or other factors (past or present), not disclosed above, which may influence medical risk and/or the risk attached to this policy?  Y  N

Please provide details for any questions you answered yes to above (including question number, date of last symptoms, treating doctor and doctor's telephone number):

Question No.	Date of last symptoms	Doctor	Contact No.	Details

Insured's Name: <input style="width: 90%;" type="text"/>	Insured's Signature: <input style="width: 90%;" type="text"/>
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**M: BROKER/AGENT DETAILS (ONLY TO BE FILLED IN IF APPLICANT HAS BEEN ASSISTED BY A BROKER / AGENT)**

Broker Name: <input style="width: 90%;" type="text"/>	Brokerage Name: <input style="width: 90%;" type="text"/>
Broker Code: <input style="width: 90%;" type="text"/>	Brokerage Code: <input style="width: 90%;" type="text"/>
Contact Number: <input style="width: 90%;" type="text"/>	Email Address: <input style="width: 90%;" type="text"/>

Disclosure of commission earned on this policy:  
 I acknowledge that I have been informed by the above Broker/Agent that (s)he (or his/her Brokerage) will receive a percentage of the sum of all my anticipated monthly premium payments in the form of a commission associated with the sale of this insurance policy as indicated on my quote. I understand that the commission will be paid by AllLife to the Broker/Agent out of the proceeds of my monthly premiums.

INITIAL  
HERE

**N: DECLARATION AND SIGNATURE**

- I understand that I am applying for a life insurance policy underwritten by Centriq Life insurance Company Ltd, and administered by AllLife.
- I hereby confirm that I have not been advised to replace any existing policies by AllLife.
- I hereby confirm that I have given consent that my bank account may be debited for the payment of the premium amount and any administration fees.
- I understand that my cover will only be initiated on receipt of the first premium and issuance of the policy and that the premium and any administration fees are subject to change with 30 days notice at any time throughout the duration of the policy.
- I understand that, if I do not inform AllLife of any material change in circumstances between submitting this application form, payment of my first premium, and inception of my policy, I will not be covered.
- I understand that my policy is governed by AllLife s standard business practices.
- I hereby confirm that I have read, understood and agree with all the points in both the AllLife Essential LifeDiabetic Control and Control Monitoring Policy in the document referenced ESXALSTF05.
- I understand that to maintain diabetic control I must comply with the AllLife Essential Life Diabetic Control and Control Monitoring Policies (document referenced ESXALSTF05). In general this requires that I go for an HbA1C blood test every nine months and forward the results to AllLife. To prevent being designated uncontrolled I must maintain my HbA1C level of less than or equal to 8.5% by following an appropriate diabetes treatment regime designed to maintain blood glucose and HbA1C at a safe and healthy level.
- I understand that I am responsible for funding all medical costs associated with meeting the AllLife Essential Life Diabetic Control and Control Monitoring Policy including, but not limited to, the costs associated with blood tests.
- I hereby confirm that I have consented to AllLife obtaining my historical and future blood and other medical test results.
- I hereby confirm that I have consented to AllLife sharing my answers on this application and any data that they may receive with the appropriate regulatory authorities and for the purpose of appropriately assessing risk, this includes, but is not limited to, the product s reinsurer and Centriq Life Insurance Company Ltd.
- I hereby confirm that I have consented to AllLife transferring this policy to any underwriter if, in their opinion, it is appropriate to do so.
- I understand that there will be an administrative charge should I rescind/cancel this policy after the first instalment has been deducted from my bank account.
- I indemnify AllLife (Pty) Ltd, Centriq Life Insurance Company Ltd, any disclosing parties, their shareholders, their directors, agents and employees against any claims arising from the above disclosure.
- I understand that if I miss two or more payments I will no longer be covered by this policy and will need to re-apply for cover.
- I understand that this policy has no surrender value (there is no savings component), and that if I have selected a finite term policy and there is no claim within the term of the policy, there will be no payout at the end of the term.
- I understand that if I have selected a finite term policy and there is no claim within the term of the policy, there is no surrender value or payout at the end of the term.
- Any policy granted and the interpretation of such policy shall be governed by the laws of the Republic of South Africa and be subject to the jurisdiction of the High Court of the Republic of South Africa.

I warrant that the information supplied by me to AllLife is true and correct.

Signature of Life Insured:		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Signature of Policy Owner (if different):		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Please attach a signed copy of the ID Document of the applicant with this application

## CONSENT TO LIMITED DISCLOSURE OF MEDICAL INFORMATION AND TEST RESULTS (TO BE COMPLETED BY THE LIFE INSURED)

I, the undersigned

Full Names:

ID Number:

Address:   
 Code:

Hereby state as follows:

- 1 : I am aware that AllLife (Pty) Ltd ( AllLife ) is a life insurance broker and administration company.
- 2 : I am aware that AllLife may or may not be able, on account of my health condition, to obtain life insurance for me. I also understand that AllLife cannot give me any guarantee that it will succeed in obtaining affordable insurance for me.
- 3 : I fully understand that every insurance company, before deciding whether or not to offer life insurance to a person ( the applicant ) and to eventually consider the making of any payments or benefits under an insurance policy, regards it as absolutely necessary to assess its financial risk(s). In order to make such an assessment an insurance company will as a matter of routine require the applicant to furnish the company with full details regarding his or her medical history and state of health. An insurance company may also require the applicant to submit himself/herself to such medical tests as are regarded essential.
- 4 : I further understand that an insurance company may require an applicant to fill in a questionnaire in which the applicant is required to answer a series of questions on his/her general lifestyle, including diet, use of alcohol, tobacco, medicines and other substances.
- 5 : I have already been medically examined and treated by one or more doctors or other healthcare providers.
- 6 : I hereby authorise AllLife to obtain from any doctor, healthcare provider or organisation (such as a managed healthcare organisation) which has particulars of medical or clinical tests or examinations performed on me or will obtain particulars in performing such tests or examinations at any stage in future. I understand that such authorisation given by me will be irrevocable, i.e. that I will not be entitled at any stage to inform AllLife that they may no longer obtain or have access to such particulars.
- 7 : I hereby further authorise AllLife to furnish or disclose any or all details of the medical information regarding myself, which they have obtained in terms of this authorisation, to any insurance company with which they decide to negotiate at any stage in order to endeavour to secure an insurance policy which will provide cover to me.
- 8 : I acknowledge and agree that my consent and authorisation contained in this document in particular also applies to my HIV status and/or any diagnosis of and/or treatment for AIDS or HIV. This authorisation will cover the results of any past or future medical or clinical tests, including (but not limited to) blood tests known as CD4+ count and RNA viral load blood tests and related monitoring tests, which AllLife may regard as necessary to obtain or require at the application stage or on an ongoing basis.
- 9 : This authorisation by me specifically also covers pathology laboratories which at any stage in the past tested and reported on or will in future test and report on blood, urine or other bodily substance or tissue obtained from me.
- 10 : I am aware of the fact that, in general, disclosures made by doctors, laboratories, hospitals, other healthcare providers and organisations such as medical schemes, medical scheme administrators and managed healthcare organisations, of personal, medical details of patients to other parties without the patient s consent is not only illegal but may also be professionally unethical. I am aware that, amongst other remedies available, an aggrieved person may claim damages for such unauthorised disclosures.
- 11 : I realise, however, that by giving the irrevocable consent and authorisation contained in this document, I shall have no claim whatsoever against AllLife or any doctor, pathology laboratory, hospital, other healthcare providers and/or organisations mentioned in this document who or which will furnish AllLife with the type of medical or clinical information mentioned in this document. I clearly understand that I hereby waive, i.e. abandon, any claim for damages or compensation that I might otherwise have had against such a person or organisation. In particular I also waive any claim that I might otherwise have had against employees, directors, agents, shareholders or members of AllLife as well as of any doctors or other bodies or organisations mentioned in this paragraph or their employees.
- 12 : I acknowledge that before signing this document I was given the opportunity by AllLife or a person acting on its behalf, to discuss the content of this document, its implications and effect, and that all questions I have had were answered to my satisfaction.
- 13 : The provisions of this document constitute the whole of the agreement between me and AllLife in respect of the matters referred to in this document and the said provisions may only be waived, varied or amended in terms of another written document signed by me and by an authorised representative of AllLife.
- 14 : I acknowledge that I have read and fully understood, and freely consent to, the provisions of this document.

Signature:

Signed at (Place):  On:  /  /

## STATUTORY NOTICE TO LONG-TERM INSURANCE POLICYHOLDERS

### IMPORTANT: PLEASE READ CAREFULLY ¥ DISCLOSURE & OTHER LEGAL REQUIREMENTS

As a long-term insurance policyholder, or prospective policyholder, you have the right to the following information:

**1: The intermediary (insurance broker or representative) dealing with you must at the earliest reasonable opportunity disclose:**

- A: Name, physical & postal address and telephone number
- B: Legal capacity: independent or representative for brokerage
- C: Concise details of relevant experience
- D: Insurance products that may be sold
- E: Insurers whose products may be marketed
- F: Indemnity cover held – Yes/No
- G: Shareholdings in insurers if 10% or more
- H: Name of insurers from which the intermediary received 30% or more of total commission and remuneration during past calendar year

The intermediary must be able to produce proof of contractual relationship with and accreditation by the insurers concerned

**2: Your right to know the impact of the decision you elect to make:**

- A: The intermediary or insurer dealing with you must inform you of
  - (1) The premium you may be paying and
  - (2) The nature and extent of benefits you may receive
- B: If the benefits are linked to the performance of certain assets:
  - (1) How much of the premium will go towards the benefit, &
  - (2) To what portfolio your benefits will be linked
- C: The possible impact of this purchase on your finances
- D: The possible impact of this purchase on your other policies (affordability)
- E: The possible impact of this purchase on your investment portfolio (affordability)
- F: The flexibility of changes you may make to the proposed contract
- G: The contract terms of the product you intend to purchase

(It is very important that you are quite sure that the product or transaction meets your needs and that you feel you have all the information you need to make a decision)

**3: Your right when being advised to replace an existing policy:**

You may not be advised to cancel a policy to enable you to purchase a new policy or amend an existing policy unless:

- A: The intermediary identifies the policy as a replacement policy
- B: The implications of cancellation of the policy are disclosed to you such as:
  - (1) The influence on your benefits under the old policy
  - (2) The additional costs incurred with the replacement
- C: The insurer that issued the original policy will contact you. You are advised to discuss the matter with its representative

**ALLIFE DOES NOT AND HAS NOT ADVISED  
YOU TO REPLACE ANY EXISTING POLICY**

**4: Your right to be informed by the insurer:**

The insurer will forward you documentation confirming policy details as discussed in paragraph 2 of this Notice, which will also include:

- A: The name of the insurer
- B: The product being purchased
- C: The cost in Rands of the transaction and specifically:
  - The loadings, if any
  - The initial expense, and
  - The amount of commission and other remuneration being paid to the intermediary
- D: In the case of policies with an investment element, the ongoing expense and any other fees or charges payable
- E: The summary in terms of section 48 of the Long-term Insurance Act, 1998
- F: The contact number and address of the complaints and compliance officers of the insurer

**5: Your right to cancel the transaction:**

In most cases, you have a right to cancel a policy in writing within 30 days after receipt of the summary contemplated in section 48 from the insurer. The same applies to certain changes you may make to a policy. The insurer is obliged to confirm to you whether you have this right and to explain how to exercise it. Please bear in mind that you may not exercise it if you have already claimed under the policy or if the event, which the policy insures you against, has already happened. If the policy has an investment component, you will carry any investment loss.

**6: Important Warning**

- It is very important that you are quite sure that the product or transaction meets your needs and that you feel you have all the information you need before making a decision
- It is recommended that you discuss with the intermediary or insurer the possible impact of the proposed transaction on your finances, your other policies or your broader investment portfolio. You should also ask for information about the flexibility of any proposed policy
- Where paper forms are required, it is advisable to sign them only once they are fully completed. Feel free to make notes regarding verbal information, and to ask for written confirmation or copies of documents
- Remember that you may contact either the Long-term Insurance Ombudsman or the registrar of Long-Term Insurance, whose details are set out below, if you have any concerns regarding a product sold to you or advice given to you

**7: Particulars of Long-term Insurance and FAIS Ombudsmen**

Long Term Insurance Ombud  
Private Bag X45  
Claremont  
Cape Town  
7736

Tel: 0860 662 837  
Fax: (021) 674-0951  
email: info@ombud.co.za

FAIS Ombud  
P. O. Box 7451  
Lynnwood Ridge  
0040

Tel: 0860 324 766  
Fax: (012) 348-3447  
email: info@faisombud.co.za

**8: Particulars of Registrar of Long-term Insurance**

Financial Services Board  
P O Box 35655  
Menlo Park  
0102  
Tel: (012) 428-8000  
Fax: (012) 347-0221

**FSB registration details:**

AllLife (Pty) Ltd: ..... FSP 4946  
Centriq Life Insurance Company Ltd: ..... FSP 7370

Insured s Name:

Insured s Signature:

Policy Owner Name (if different):

Policy Owner Signature:

## STATUTORY DISCLOSURE NOTICE IN TERMS OF THE FINANCIAL ADVISORY AND INTERMEDIARY SERVICE ACT NO 37 OF 2002

In terms of the Financial Advisory and Intermediary Services Act, the following information must be disclosed to you as our client. Please read the information carefully.

### Information on the Financial Services Provider:

Name: All Life (Pty) Ltd  
 Trading name: ALL Life  
 Registration number: 2004/008283/07  
 FSP Registration number: 4946  
 Postal address: P O Box 787159, Sandton, 2146  
 Physical address: 39 Wierda Road, Wierda Valley, Sandton, 2196  
 Telephone number: 0861 255 5433  
 Internet address: www.alllife.co.za  
 E-mail address: info@alllife.co.za  
 Compliance Officer: Paul Stanley  
 Telephone number: 0861 255 543

### Information on the Product Supplier:

Name: Centriq Life Insurance Company Ltd  
 Registration number: 1943/016409/06  
 FSP Registration number: 7370  
 Postal address: P O Box 55674, Northlands, 2116.  
 Physical address: First Floor, 4 Fricker Road, Illovo, 2196.  
 Telephone number: 011 268 6490  
 Compliance Officer: Adli Mallick  
 Telephone number: 011 268 6495  
 E-mail address: compliance@centriq.co.za  
 Telephone number of Complaints Department: 011 268 6490

AllLife (Pty) Ltd is a company registered in terms of the Companies Act and is an authorised Financial Services Provider. AllLife has appointed representatives to act on its behalf in rendering financial services to its clients. Should an AllLife representative physically call on you, please ask the representative to show you his/her letter of authorisation. AllLife accepts responsibility for the activities of duly authorised representatives that are performed within the scope of and in the course of their employment as a representative of AllLife.

AllLife has been authorised to provide financial advisory and intermediary services in respect of Long-term Insurance: Categories A and B. The licence conditions or restrictions as well as any exemptions which are applicable to AllLife are listed below.

AllLife holds professional indemnity insurance to the value of R 3 million. AllLife is not required to and nor does it hold guarantees or fidelity insurance cover.

AllLife designs, distributes and administers its unique set of life insurance products through a cell arrangement with Centriq Life Insurance Company Limited (a subsidiary of Santam and Kagiso), which provides the regulatory framework necessary for AllLife to provide insurance. There are no conditions or restrictions imposed by Centriq in respect of the financial products or services that may be rendered by AllLife. AllLife does not have contractual relationships with any other product supplier (AllLife earns more than 30% of its total remuneration from Centriq).

AllLife's complaints process and policy are available to clients from AllLife's offices upon request.

### Conditions and Restrictions of Licence

1: The licence authorises the licensee to carry on business in respect of

Financial advisory services as Financial Services Provider in respect of the following products:

Long-term Insurance: Category A, B

Financial intermediary services as Financial Services Provider in respect of the following products:

Long-term Insurance: Category A, B

2: Further conditions / restrictions:

A: The financial services provider must inform the Registrar in writing, by facsimile or in an appropriate electronic format, within 15 days after the change has taken place, of any change in respect of business information of the financial services provider as provided in Form FSP1, FSP3, FSP4, FSP9, FSP10, FSP10A or FSP11, respectively, of the Application Form which was submitted by the provider for purposes of obtaining a licence, and in particular relating to the provider's representatives, auditor, compliance officer or any foreign clearing firm or foreign forex service provider involved (if any) and nominee company or independent custodian involved or the shareholders, directors or trustees of any such company or custodian (If any).

B: The financial services provider must at all times during the currency of the provider's licence maintain the services of any key individual or key individuals mentioned in the information submitted on the said Application Form, and must as regards changes in respect of such information relating to a key individual, or appointment of a new key individual, of the provider, in addition to acting also in such cases in accordance with the procedure and time limit set out in Condition 1, also ensure full compliance with section 8(4)(b) of the Act, the provisions of which must be regarded as included in this Condition.

C: The financial services provider must within one month of the date contemplated in section 7 of the Act, submit a copy of the register kept in terms of section 13(3) of the Act to the Registrar, and must thereafter in accordance with the procedure and time limit set out in Condition 1, inform the Registrar of any change effected to the details as contained in that register.

D: The financial services provider must not in any manner change the name of the financial services business as reflected on the licence concerned, or carry on any financial services business under such a changed name, unless- (a) the provider has fully complied with the provisions of any other law than the Act which regulates such change of business name (if any); (b) the provider has fully disclosed to the Registrar the details of such compliance with such other law; (c) the Registrar is satisfied that such change of name is otherwise lawful and has approved such change of name; and (d) the Registrar has issued to the provider an appropriately amended licence under the provisions of section 8(5)(b)(i) of the Act.

E: The financial service provider must at all times ensure that any financial product in respect of which the provider intends to render a financial service, qualifies as a financial product contemplated in the Act and is or will be lawfully issued by the relevant product supplier by virtue of an authority, approval or right granted to such supplier under a law as contemplated in the definition of 'product supplier' in section 1(1) of the Act.

3: Further conditions / restrictions:

Exemption of licensees as regards display certified copies of licensees (Board Notice 40 of 2004).

Exemption of licensees as regards references to licensees in business documentation (Board Notice 71 of 2004).

Insured's Name:

Insured's Signature:

Policy Owner Name (if different):

Policy Owner Signature:

## ALLIFE ESSENTIAL LIFE DIABETIC CONTROL AND CONTROL MONITORING POLICY

PLEASE KEEP THIS PAGE FOR YOUR RECORDS

Note that this Diabetic Control and Control Monitoring Policy can change on 30 days notice at AllLife's sole discretion, based on reasonable medical practice.

### A: AllLife Essential Life Diabetic Control Policy

The following diabetic control protocol must be followed to maintain benefit levels under the AllLife Essential Life product range.

The Life Insured is required to go for regular blood tests as specified below, and to ensure that AllLife is provided with copies of these test results. Make sure to include AllLife as a copy doctor when you fill in the form at the testing Laboratory in order for the Laboratory to forward a copy of your results to AllLife:

- A: The Life Insured is required to be tested for, and to provide to AllLife, their Glycosylated Haemoglobin (HbA1C) test result every 9 months.
- B: The Life Insured must follow a recognised and accepted *diabetes mellitus* treatment regime, designed to achieve control of blood glucose levels.
- C: The Life Insured's blood test results must be as specified in the Essential Life Diabetic Control Monitoring Policy in order to remain controlled.
- D: Although AllLife will endeavour to access the above blood test results directly from the testing laboratory or the Life Insured's managed health care company (if any), it will be the responsibility of the Life Insured to provide the data to AllLife on a 9 monthly basis. If AllLife does not receive the blood test results, the Life Insured will be defined as uncontrolled.

### B. Essential Life Diabetic Control Monitoring Policy

Diabetic control is defined as the conformance to a prescribed *diabetes mellitus* treatment regime designed to maintain blood glucose and HbA1C levels at a safe and healthy level. AllLife utilises the following protocol to check diabetic control of the life insured:

The Life Insured will be deemed to be uncontrolled if their Glycosylated Haemoglobin (HbA1C) test result is greater than 8.5% for any 2 consecutive scheduled tests (scheduled tests occur every 9 months, although the Life Insured may undergo more frequent testing if required by their treating doctor).

In addition, if no blood test is conducted within thirty days of the stipulated date (every 9 months), then the Life Insured is deemed to be uncontrolled until they provide AllLife with appropriate test results. Where appropriate test results are provided within 9 months of the stipulated test date the Life Insured will be considered to be controlled, the testing interval will however remain that of the original and will not be based off of the new test date. Where this deemed uncontrolled period exceeds 9 months, the Life Insured is deemed to be irreversibly and permanently uncontrolled. Where the Life Insured is deemed to be uncontrolled, whether temporarily or permanently, cover is limited to accidental causes of death only as defined in AllLife's terms and conditions.

In cases where laboratory results are unusual or discrepant in the opinion of AllLife, these will be evaluated on a case-by-case basis by AllLife and, if necessary, repeat tests may be required.

All HbA1C tests must be done at SANAS or LOA approved laboratories.

Please note: Rulings in regard to the above protocol will be subject to appeal. All appeals must be lodged in writing with AllLife within sixty (60) days of any diabetic control ruling being communicated to the Life Insured.