KHULASIZWE CASH FUNERAL PLAN APPLICATION FORM

OFFICE:_____

MEMBERSHIP COMMENCEMENT DATE:	PRINCIPAL MEMBER COVER AMOUNT:
PLAN SELECTION (MEMBER ONLY, FAMILY, EXTENDED ETC)	PREMIUM

PRINCIPAL MEMBER'S DETAILS

SURNAME:	FIRSTNAMES:	TITLE (MR, MRS, MISS ETC):	IDENTITY NO:
DATE OF BIRTH:	CURRENT AGE	MARITIAL STATUS:	TELEPHONE NO:
CELLPHONE:	EMAIL ADDRESS:		
POSTAL ADDRESS:			CODE

SPOUSE'S DETAILS

SURNAME:	FIRST NAMES:	IDENTITY NO:	DATE OF BIRTH:
TELEPHONE:	CELLPHONE:	EMAIL ADDRESS:	

PRINCIPAL MEMBER'S CHILDREN

NAME AND SURNAME	ID NUMBER / DATE OF BIRTH	NAME AND SURNAME	ID NUMBER / DATE OF BIRTH
1		2	
3		4	
5		6	

EXTENDED FAMILY MEMBERS

NAME AND SURNAME	ID NUMBER / DATE OF BIRTH	RELATIONSHIP	COVER AMOUNT
1			
2			
3			
4			
5			
6			
7			
8			

BENEFICIARY NOMINATION

SURNAME	FIRST NAMES	RELATIONSHIP TO MEMBER	ID NUMBER	CELLPHONE NO.

DEBIT ORDER AUTHORITY:

Given by (name of Accountholder):	
Bank Account Detail	
Bank Name:	
Branch Name and Town:	
Branch Number:	
Account Number:	
Type of Account:	Current (cheque) / Savings / Transmission
Deduction Date:	
Amount:	
Abbreviated Short name to be used:	ZINTSIKAFN

I hereby authorize Zintsika Risk Solutions (Pty) Ltd, on behalf of Khulasizwe Funerals (Pty) Ltd to commence debit order withdrawal from my account on the date of the month selected above and monthly thereafter for the premium applicable for the cover selected.

PREMIUM PAYER'S SIGNATURE **DATE**

DECLARATION:
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.

MEMBER'S SIGNATURE **DATE**