PPS PROVIDER APPLICATION FORM

The Professional Provident Society Holdings Trust No IT 312/2011 (PPS Holdings Trust) is a Registered South African Trust.
Professional Provident Society Insurance Company Limited Reg No. 2001/017730/06 ("PPS Insurance").
PPS is a Licensed Insurer and Financial Services Provider

PART A: PERSONAL DETAILS

Please complete and (X) where applicable (Please use a black pen)

Member number:

Have any of your personal particulars in the quotation presented to you changed? YES ☐ NO ☐

If **No**, continue to 'Occupation of the Policyholder'. If **Yes**, complete any changes in 'Personal Particulars' below.

PERSONAL PARTICULARS OF POLICYHOLDER (LIFE INSURED)

Title: Surname:

First names:

Gender: Male: ☐ Female: ☐ Preferred language of communication: English ☐ Afrikaans ☐

Home Language: English ☐ Afrikaans ☐ IsiNdebele ☐ IsiXhosa ☐ IsiZulu ☐

Sepedi ☐ Sesotho ☐ Setswana ☐ SiSwati ☐ Tshivenda ☐ Xitsonga ☐

Date of birth: D D / M M / Y Y Y Y

National ID number/Passport if no ID:

For BEE Purposes, please indicate your race: Black ☐ White ☐ Coloured ☐ Asian ☐ Indian ☐ Not disclosed ☐

Email:

Home ☐ Business ☐ Postal address:

Postal Code:

Home ☐ Business ☐ Physical address:

Postal Code:

I choose this physical address as my domicilium citandi et executandi.

Cellular: 0 Tel Home/Business: 0

OCCUPATION OF THE POLICYHOLDER (LIFE INSURED)

Nominate your specific occupation? *(E.g. Neurosurgeon, Large Animal Veterinarian , Product Development Actuary)*

NOTE *You can only request cover for one specific occupation (your primary occupation) if you are engaged in more than one occupation, only reflect your primary occupation.*

When did you start practising your nominated specific occupation? D D / M M / Y Y Y Y

Do you work: Full time: ☐ Part time: ☐ Locum: ☐

PLEASE COMPLETE THE RELEVANT SECTION BELOW:

SELF-EMPLOYED

State the name of your practice / business:

How long have you been self-employed?

If you are a partner in the business, what is your percentage share in the business? %

Is your business based at your home? YES ☐ NO ☐

Do you want to cover your Actual Business Expenses? YES ☐ NO ☐

Source of funds

The information is required by legislation and is needed in order to proceed with your application. Please select one of the below:

Business Income ☐ Savings ☐ Other (specify) _____

Gross Professional Income *(Annual income from professional fees and net income from trading activities; including all overhead expenses):*

(Minus) Actual business expenses *(Expenses incurred in the running of the business that are not remunerated to the professional. Expenses that will terminate if the business is sold or closed.)*:

(Equals) Personal Income *(Gross Professional Income minus Actual business expenses)*:

SALARIED EMPLOYMENT

Source of funds

The information is required by legislation and is needed in order to proceed with your application. Please select one of the below:

Salary ☐ Savings ☐ Other (specify) _____

State the name of your employer:

Annual Total Cost to Company:

(Plus) Performance bonus *(Average over the last 3 years)***:**

(Equals) Total Gross Professional income:

PART B: APPLICATION FOR INSURANCE BENEFITS

PPS PROVIDER™ QUOTATION

- This application is only valid if accompanied by a valid PPS InTouch quotation.
- PPS will not be liable for any errors and omissions made by the applicant or financial advisor on the quotation.
- PPS will not be held liable for any errors or omissions which may have occurred in the production of the quotation.
- If there are any discrepancies between the quotation and the policy contract to be issued, the policy contract will prevail.

Quote package number:

NOTE *For your protection this application form should not be signed until all details have been completed.*

COMMENCEMENT DATE

1. 1st of the month following acceptance ☐

EG: If PPS Insurance accepts the policy on the 20th of May, the policy commences on the 1st of June. If you are under the age of 62, you will have free cover from the 20th of May until the benefit commences.

2. 1 month after the date in point 1 ☐

EG: If PPS Insurance accepts the policy on the 20th of May, the policy commences on the 1st of July. If you are under the age of 62, you will have free cover from the 1st of June until the benefit commences.

BENEFICIARY NOMINATION

I nominate the following beneficiaries to receive a percentage of the total benefit amount(s) of the product(s), or the Immediate Needs benefit(s) of the product(s) indicated below upon my death.

Should the PPS Beneficiaries Trust (IT 4876/01) be utilised when effecting payment to minors? YES ☐ NO ☐

NOTE *Where cessionaries are registered, the cessionary(ies) will be paid before the beneficiary(ies). A secondary beneficiary will receive the benefit (in the same %) if the primary beneficiary is unwilling- or unable to receive the benefit, or if the primary beneficiary passes away within 14 days of the life insured due to the same incident. Where no beneficiaries are nominated, the benefit will be paid to the estate.*

Professional Life Provider (PLP) Accidental Death Benefit (ADB) Life and Disability Policy (LA)					**Product Numbers:**			
			Full name & Surname	**ID number**	**Relationship to policyholder**	**PLP %**	**ADB %**	**LA %**
Main benefit	1.	Primary						
		Secondary						
	2.	Primary						
		Secondary						
	3.	Primary						
		Secondary						
	4.	Primary						
		Secondary						
	5.	Primary						
		Secondary						
Immediate Needs (PLP/LA)	1.	Primary						
		Secondary						

Professional Life Provider (PLP) Accidental Death Benefit (ADB) Life and Disability (LA)					Product Numbers:			
			Full name & Surname	ID Number	Relationship to policyholder	PLP %	ADB %	LA %
Main benefit	1.	Primary						
		Secondary						
	2.	Primary						
		Secondary						
	3.	Primary						
		Secondary						
	4.	Primary						
		Secondary						
	5.	Primary						
		Secondary						
Immediate Needs (PLP/LA)	1.	Primary						
		Secondary						

PPS Profit-Share Account Death Value						
			Full name & Surname	ID Number	Relationship to policyholder	%
Main benefit	1.	Primary				
		Secondary				
	2.	Primary				
		Secondary				
	3.	Primary				
		Secondary				
	4.	Primary				
		Secondary				
	5.	Primary				
		Secondary				

GENERAL NOTICE *This beneficiary nomination will revoke and replace any existing nomination(s) in respect of the products listed above. Beneficiary nominations on any other product(s), not included in this beneficiary nomination section, will remain unchanged. A separate PPS Beneficiary Nomination Form must be completed to change such beneficiaries. A revocation or beneficiary nomination change will only be valid if such PPS Beneficiary Nomination Form is duly completed, signed and reached PPS Insurance Head Office before the insured event occurred.*

PART C: PAYMENT DETAILS

Have your banking details changed since the last application? YES ☐ NO ☐

If **NO**, please continue to Part D.

Please amend the debit order details on all my PPS Products YES ☐ NO ☐

Is the Payer the same person as the policyholder? YES ☐ NO ☐

If **YES**, please complete section C1.

If **NO**, and third party is a natural person, please complete section C1 and C2.

If **NO**, and third party is a juristic person, please complete section C1 and C3.

NOTE *If the payer is a third party, please attach proof of banking details.*

NOTE *The payer / authorised signatory(ies) must sign the declaration on page 12.*

C1: PAYER DETAILS

Name of payer:

Account type:

Account number:

Name of bank:

Branch code:

Branch:

Indicate type of account: Business ☐ Private ☐ Collection date: 1st ☐ 15th ☐ 25th ☐

KINDLY NOTE *That the onus rests on the policyholder to ensure that the debit order and the amounts owing, drawn in terms of the debit order, are in fact paid.*

C2: THIRD PARTY DETAILS - NATURAL PERSON

Third party ID Number:

C3: THIRD PARTY DETAILS - JURISTIC PERSON

Name of Organisation:

Organisation Type: Trust ☐ Close Corporation ☐ Company ☐ Other

Registration number:

Name and Surname of Authorised Signatory:

ID Number:

Capacity:

Name and Surname of Authorised Signatory:

ID Number:

Capacity:

PART D: UNDERWRITING

FINANCIAL UNDERWRITING

Do you have any existing benefits or pending applications with other insurance companies? YES ☐ NO ☐

If **YES** please provide details below.

	Personal Benefit		Business Benefit	
	Existing	Pending	Existing	Pending
Death				
Disability - Lump sum				
Disability - Monthly Income				
Sickness - Monthly Income				
Critical Illness				

UNDERWRITING INFORMATION

Please indicate if PPS may instruct a travelling nurse to collect medical requirements at an address convenient to you. YES ☐ NO ☐

Please indicate if you would prefer a tele-underwriter to contact you to complete the medical underwriting section below. YES ☐ NO ☐

If **YES**, please indicate the time slot most convenient for the tele-underwriter to contact you and proceed to complete Part E of this application form.

07:00 - 10:00 ☐ 10:00 - 13:00 ☐ 13:00 - 16:00 ☐ 16:00 - 19:00 ☐

If **NO**, please proceed to complete the medical underwriting section below.

Tele-underwriting is the same as normal underwriting. It neither amounts to assistance nor advice. The outcome will be the same and full disclosure is required in both instances.

MEDICAL UNDERWRITING

1. Please supply the name

and contact number of your usual Medical Attendant

2. Please indicate if any of your immediate family members have ever suffered from any of the following medical conditions. If yes, please indicate the age of onset. YES ☐ NO ☐

	Father	Mother	Sibling	Age at onset		Father	Mother	Sibling	Age at onset
Tremors					Huntington's Chorea				
Heart attack					Mental Illness before age 25				
Angina					Polycystic kidneys				
Diabetes					Stroke				
Haemochromatosis					Cancer				
Suicide					Cancer				
Attempted Suicide					Cancer				

If you selected cancer above, please specify:

3. What is your Weight kg Height cm Abdominal Girth cm ?

3.1 Have you lost more than 10 % of your body weight other than as part of a weight loss plan? YES ☐ NO ☐

4. Have you ever sought medical advice, counselling or been tested for HIV apart from routine insurance investigations? YES ☐ NO ☐

4.1 If yes, what was the date of the test? D D / M M / Y Y Y Y

4.2 If yes, what was the result of the test? Positive ☐ Negative ☐

5. Have you used tobacco products or vapour devices (for example e-cigarettes) in the previous 12 months? YES ☐ NO ☐

6. Do you drink alcohol? YES ☐ NO ☐

6.1 If **YES**: Quantity Type Daily ☐ Weekly ☐

7. Have you ever been diagnosed with high cholesterol? YES ☐ NO ☐

8. Have you ever been diagnosed with high blood pressure? YES ☐ NO ☐

9. Please indicate if you currently suffer from or if you have ever suffered from, any of the following medical conditions or have ever suffered symptoms related to such conditions, by marking the appropriate box with an X.

If you indicated a condition, please complete the table at the bottom of each relevant page.

9.1 **Tumours** YES ☐ NO ☐

(a) ☐ Benign growth / lesions

(b) ☐ Malignant tumours / cancer

9.2 **Respiratory Disorders** YES ☐ NO ☐

(a) ☐ Asthma other than childhood
(b) ☐ Chronic emphysema
(c) ☐ Cystic fibrosis
(d) ☐ Sarcoidosis
(e) ☐ TB (Lung)
(f) ☐ TB (other)

9.3 **Circulation or blood disorders** YES ☐ NO ☐

(a) ☐ Bleeding / Clotting disorders
(b) ☐ DVT / Blood clots
(c) ☐ Haemochromatosis
(d) ☐ Iron deficiency anaemia (if male)
(e) ☐ Polycythaemia
(f) ☐ Porphyria
(g) ☐ Purpura / ITP
(h) ☐ Raynaud's syndrome
(i) ☐ Systemic Lupus Erythematosus

9.4 **Central Nervous system or Brain Disorders** YES ☐ NO ☐

(a) ☐ Bell's Palsy with consequences
(b) ☐ Concussion
(c) ☐ Encephalitis
(d) ☐ Facial Pain
(e) ☐ Fits / Epilepsy
(f) ☐ Headaches (not Migraines)
(g) ☐ Meningitis
(h) ☐ Migraines
(i) ☐ Multiple Sclerosis
(j) ☐ Neuralgia / Myalgia
(k) ☐ Sleep Apnoea
(l) ☐ Stroke
(m) ☐ Syncope / Fainting
(n) ☐ Tremors
(o) ☐ Vertigo / Dizziness

9.5 **Cardiovascular Disease** YES ☐ NO ☐

(a) ☐ Angioplasty
(b) ☐ Aortic valve disorders
(c) ☐ Atrial Fibrillation
(d) ☐ Barlow's syndrome / Mitral valve prolapse
(e) ☐ Chest pain (heart related)
(f) ☐ Coronary Artery Bypass Graft
(g) ☐ Enlarged heart
(h) ☐ Heart attack
(i) ☐ "Hole in the heart"
(j) ☐ Irregular heart beat / Palpitations
(k) ☐ Mitral valve disorders
(l) ☐ Myocarditis
(m) ☐ Pericarditis
(n) ☐ Rheumatic Fever
(o) ☐ Stent

Question	Treating Doctor	Treatment *	Date of onset of symptoms	Date of last symptoms (Leave blank if on-going)	Were there any complications? (X if YES)

* *Where applicable, please specify the affected side / part of the body (for example: Total loss of hearing in left ear)*

9.6 **Kidneys and Bladder Disorders** YES ☐ NO ☐

(a) ☐ Recurrent urinary tract infections
(b) ☐ Blood in urine
(c) ☐ Polycystic kidney disease
(d) ☐ Kidney stones
(e) ☐ Nephritis
(f) ☐ Protein in urine

9.7 **Gastrointestinal tract – including liver, spleen and pancreas** YES ☐ NO ☐

(a) ☐ Acid reflux disorder (GORD)
(b) ☐ Barrett's Oesophagitis
(c) ☐ Colon polyps
(d) ☐ Crohn's disease
(e) ☐ Diverticular disease of colon
(f) ☐ Gallstones
(g) ☐ Gastritis
(h) ☐ Hepatitis A
(i) ☐ Haemorrhoids
(j) ☐ Hepatitis B
(k) ☐ Hepatitis C
(l) ☐ Hiatus Hernia
(m) ☐ Incisional hernia
(n) ☐ Inguinal hernia
(o) ☐ Irritable bowel syndrome / spastic colon
(p) ☐ Liver cirrhosis
(q) ☐ Pancreatitis
(r) ☐ Peptic ulcers
(s) ☐ Ulcerative colitis
(t) ☐ Umbilical hernia

9.8 **Endocrine Disorders** YES ☐ NO ☐

(a) ☐ Insulin dependent diabetes mellitus
(b) ☐ Insulin resistance
(c) ☐ Non-insulin dependent type 2 diabetes mellitus (including raised blood sugar)
(d) ☐ Thyroid gland (overactive)
(e) ☐ Thyroid gland (underactive)

9.9 **Muscles, bones, joints, limbs, spine** YES ☐ NO ☐

(a) ☐ Ankylosing spondylitis
(b) ☐ Backache / back injury
(c) ☐ Bone fractures
(d) ☐ Curvature of the spine
(e) ☐ Disorders of feet and fingers
(f) ☐ Gout
(g) ☐ Inherited physical defects
(h) ☐ Injured / painful joint
(i) ☐ Neck pain / neck injury
(j) ☐ Osteoporosis / osteopaenia
(k) ☐ Rheumatoid arthritis
(l) ☐ Slipped disc
(m) ☐ Spinal stenosis
(n) ☐ Temperomandibular joint problem
(o) ☐ Whiplash injury
(p) ☐ Fibromyalgia
(q) ☐ Chronic regional pain syndrome

9.10 **Visual and eye disorders** YES ☐ NO ☐

(a) ☐ Cataract
(b) ☐ Corneal defects
(c) ☐ Glaucoma
(d) ☐ Keratoconus
(e) ☐ Loss of vision in one eye
(f) ☐ Macular Degeneration
(g) ☐ Optic neuritis
(h) ☐ Severe astigmatism
(i) ☐ Severe short-sightedness (above 6 dioptres)
(j) ☐ Retinal detachment
(k) ☐ Retinal problems

Question	Treating Doctor	Treatment *	Date of onset of symptoms	Date of last symptoms (Leave blank if on-going)	Were there any complications? (X if YES)
					☐
					☐
					☐
					☐
					☐

* *Where applicable, please specify the affected side / part of the body (for example: Total loss of hearing in left ear)*

9.11 **Mental health disorders** YES ☐ NO ☐

(a) ☐ Anxiety disorders
(b) ☐ Bipolar disorder
(c) ☐ Depression
(d) ☐ Eating disorders
(e) ☐ Post traumatic stress disorder
(f) ☐ Stress requiring treatment
(g) ☐ Suicide attempt
(h) ☐ Adult ADHD
(i) ☐ Schizophrenia
(j) ☐ Obsessive compulsive disorder (OCD)

9.12 **Post-viral syndromes / Malaise and fatigue syndromes** YES ☐ NO ☐

(a) ☐ Chronic fatigue syndrome
(b) ☐ Chronic Rickettsial/ Tick bite fever symptoms
(c) ☐ Espstein Barr Virus/ Glandular fever
(d) ☐ Guillaine Barre syndrome with consequences
(e) ☐ Myalgic encephalitis
(f) ☐ HIV

9.13 **Ear / Nose / Throat disorders** YES ☐ NO ☐

(a) ☐ Chronic sinusitis
(b) ☐ Hoarseness / vocal cord abnormalities
(c) ☐ Menière's disease / balance disorders
(d) ☐ Otosclerosis
(e) ☐ Hearing impairment
(f) ☐ Ringing or tinnitus
(g) ☐ Tonsillitis (recurrent)

9.14 **Skin disorders** YES ☐ NO ☐

(a) ☐ Dermatitis / Eczema
(b) ☐ Psoriasis
(c) ☐ Substance sensitivity / contact allergy
(d) ☐ Urticaria
(e) ☐ Benign skin lesions (e.g. basal cell carcinoma)

Question	Treating Doctor	Treatment *	Date of onset of symptoms	Date of last symptoms (Leave blank if on-going)	Were there any complications? (X if YES)

* *Where applicable, please specify the affected side / part of the body (for example: Total loss of hearing in left ear)*

General Health Disclosures

If you answer **YES** to a question, please complete the table below question 22.

10. Are you aware of any current or past medical condition or symptoms **not already mentioned**? YES ☐ NO ☐
11. Have you in the last 5 years consulted a medical practitioner, for any reason other than routine examinations or annual medicals? YES ☐ NO ☐
12. Have you in the last 5 years consulted one of the following practitioners? YES ☐ NO ☐

    Biokineticist ☐ Physiotherapist ☐ Chiropractor ☐
13. Have you ever consulted one of the following practitioners - other than for marriage counselling? YES ☐ NO ☐

    Psychiatrist ☐ Psychologist ☐ Counsellor ☐
14. Have you been admitted to one of the following facilities for any treatment surgery or investigations? YES ☐ NO ☐

    Hospital/Day Clinic ☐ Nursing home ☐ Rehabilitation facility ☐ Psychiatric unit ☐ Emergency Department ☐

15. Have you been advised that surgery or medicine may be required in future for any past or current condition? YES ☐ NO ☐
16. Have you ever been prescribed or been advised to take treatment (including over the counter medication) for any symptoms or condition where such treatment or symptoms lasted longer than 10 days? YES ☐ NO ☐
17. Have you ever used any illegal substances? YES ☐ NO ☐
18. Are you currently using any illegal substances? YES ☐ NO ☐
19. Have you ever been treated for an addiction? YES ☐ NO ☐
20. Have you ever used anabolic steroids? YES ☐ NO ☐
21. Have you ever been convicted of any alcohol (or drug) related transgressions? YES ☐ NO ☐
22. Have you ever been diagnosed with a psychiatric disorder (not mentioned in question 9.11)? YES ☐ NO ☐

Question	Treating Doctor	Treatment *	Date of onset of symptoms	Date of last symptoms (Leave blank if on-going)	Were there any complications? (X if YES)

* *Where applicable, please specify the affected side / part of the body (for example: Total loss of hearing in left ear)*

23. Have you ever undergone any of the following medical examinations / special investigations? If yes, indicate which of the medical examinations / special investigations was performed and whether the result was abnormal YES ☐ NO ☐

Examination	Reason	Result abnormal (X if yes)	Date
Angiogram			
Barium study			
Blood sugar test			
Bone density scan			
Colonoscopy			
Cystoscopy			
ECG or exercise test for heart			
EEG of brain			
Gastroscopy			
Genetic testing			
Intravenous pyelogram			
Laparoscopy			
Lung function test			
Mammogram/Breast Sonar			
MRI Scan/CT Scan			
Prostate blood test/examination			
Sonar/ultra sound or echo examination apart from during pregnancy			
Chest X-ray			
Biopsy			
Bone X-ray - which bone?			

Female applicants only

If you answer **YES** to question 25 / 26, please complete the table at the bottom of the page.

24. Are you currently pregnant? YES ☐ NO ☐

If **YES**, when is your expected date of delivery? D D / M M / Y Y Y Y

25. Have there been any problems with current or previous pregnancies? YES ☐ NO ☐

26. Have you ever had any of the following conditions or procedures? YES ☐ NO ☐

(a) ☐ Abnormal menstrual bleeding
(b) ☐ Breast hypertrophy / enlargement (not cosmetic surgery)
(c) ☐ Breast lumps
(d) ☐ Cervix abnormalities (including abnormal papsmear)
(e) ☐ Endometriosis
(f) ☐ Ovarian cysts
(g) ☐ Polycystic ovarian syndrome
(h) ☐ Tubal ligation
(i) ☐ Infertility treatment
(j) ☐ Hysterectomy

Male applicants only

If you answer **YES** to the question, please complete the table below.

27. Have you ever had any of the following? YES ☐ NO ☐

(a) ☐ Benign prostatic hypertrophy
(b) ☐ Bladder infection
(c) ☐ Testicular mass
(d) ☐ Prostatitis
(e) ☐ Gynaecomastia

Question	Treating Doctor	Treatment *	Date of onset of symptoms	Date of last symptoms (Leave blank if on-going)	Were there any complications? (X if YES)

* *Where applicable, please specify the affected side / part of the body (for example: Total loss of hearing in left ear)*

PART E: LEGAL TERMS AND NOTES, DECLARATION AND AUTHORITY STATEMENT

POLICY REPLACEMENT

Please read this before signing

Some of the information requested in terms of this application is requested in terms of, and is subject to, statutory requirements. As the undersigned policyholder and life insured:

Will this policy replace whole or part of an existing policy you have with any insurer (whether immediately or within 6 months prior to or following the application)? YES ☐ NO ☐

If YES, and it is an external replacement (replacement of other insurers' business) or internal replacement (replacement of PPS business), then the advisor must discuss and complete the Replacement Advice Record.

A. YOU CONFIRM THAT YOU:

1. Appoint: _____ (name) as your financial adviser.
2. ☐ Consent ☐ Do Not Consent that PPS Insurance may communicate information regarding your medical underwriting to your financial adviser. Your financial adviser's e-mail address is:

   _____

2. Are applying for benefits from Professional Provident Society Insurance Company Limited ("PPS Insurance").
3. Have made an informed decision to purchase the product indicated in this application form. You understand the content of relevant marketing material and the application form, nature and terms and conditions of the product, financial and tax consequences of purchase.
4. Have received the quote with the quote package number indicated in Part B of this application. You read the quote, understand the contents therein and the quote accurately reflects the benefits as proposed.
5. Understand that you have to be an ordinary member of the PPS Holdings Trust, a policy certificate has to be issued by PPS Insurance and the first premium paid before you will be entitled to the benefits applied for. A premium is regarded as paid if the PPS Insurance bank account has been credited and the payment not subsequently reversed.
6. Acknowledge that you may not be required to sign a blank or partially completed application form. It is your duty to complete this application form in full before signing it and not to require, permit or allow any other person to fill in further information after you signed it. If you do not act in terms of the aforementioned duty PPS Insurance will not be liable for any loss or damage that may result.
7. Understand that if you do not comply with section B1 and B2 below, PPS Insurance will be entitled to add premium loadings, exclusions or to cancel the benefits reflected in the Policy Certificate. You also risk losing previously issued benefits and membership of the PPS Holdings Trust.
8. Will comply with the underwriting requirements of PPS Insurance. PPS Insurance may ask you to undertake a variety of blood and medical tests, including tests for the HIV virus. You indemnify PPS Insurance against any claim of whatever nature, which may be made against it as a result of, or arising out of any such test.
9. Understand that with the disclosures in your application form and risk assessment of subsequent information, PPS Insurance may accept or reject your application for benefits, with or without premium loadings or benefit exclusions. If PPS Insurance makes a Counter Offer, you must accept or reject and return the signed Counter Offer letter within 30 days of the due date of the offer, otherwise your application will not be proceeded with.
10. Understand that you have a cooling-off right which affords you the ability to cancel the insurance transaction within 30 days from receipt of the Policy summary, subject to terms and conditions further described within the Policy summary.
11. Understand it remains your responsibility to advise PPS Insurance in writing of a change in your occupation within 30 days of such change.

B. YOU GUARANTEE THAT:

1. All the information provided in this application form and signed statements are warranted complete, true and correct and form the basis of the proposed contract with PPS Insurance and deemed incorporated therein.
2. You will inform PPS Insurance in writing of any changes to your income, occupation, smoking status or health circumstances before the commencement date reflected on the Policy Certificate issued in respect of this application form.
3. You have not been charged with or found guilty of a professional or criminal offence or serious complaint, or incurred the formal sanction of a professional association or registration body.
4. You have full legal capacity to enter into this agreement, is financially solvent and as far as you know have no sequestration proceedings pending or expect them to be instituted against you in the near future.
5. The premiums paid in respect of this policy does not originate from unlawful activity, including, but not limited to, tax evasion and breach of exchange control regulations.

C. YOU AUTHORISE PPS INSURANCE TO:

1. Give full effect to your beneficiary nomination instruction and to pay the nominated beneficiaries.
2. Communicate with you about your affairs electronically (e-mail, fax, telephone, etc.), such communication will be deemed the same as written communication and received by you 2 days after being sent.
3. Obtain from any person or institution, any information which PPS deems necessary to assess an insurance risk or to consider a claim. Share with other insurers and their representative body any information in the possession of PPS Insurance, either directly or through a database operated by, or for insurers as a group, at any time (even after my death).
4. Obtain credit information from any person or institution.
5. Provide medical details with respect to loadings and exclusions placed on benefits to your Financial Advisor.
6. Use and share with any 3rd party all your personal- and contact information to facilitate the payment of unclaimed benefits.

D. YOU AUTHORISE PPS HOLDINGS TRUST TO:

1. Deal with you electronically as described in C2 above in accordance with Article 28 and defined in the Trust Deed.
2. Provide your personal information to any of its subsidiaries or strategic partners and their representatives, to protect any of your rights or interests.

E. PAYMENT DECLARATION

PPS Insurance is hereby authorised to draw monthly, or at such other periods as agreed to by PPS insurance and myself, under the debit order system debits against my account as specified on page 4. In the event of this account being closed, such other account as I may subsequently operate, in payment of any amounts due by me to PPS Insurance from time to time. It is agreed that either I or PPS Insurance can at any time terminate this agreement by written notice to this effect.

F. CONSENT TO OBTAINING, RETAINING AND FURTHER PROCESSING OF PERSONAL INFORMATION WITHIN THE PPS GROUP*:

ADMINISTRATIVE CONSENT

1. I hereby acknowledge that:
   1.1 Appropriate financial advice can only be provided after full disclosure of my relevant personal information for purposes of evaluating and advising me on my financial situation and on suitable financial products in line with my objectives;
   1.2. PPS require relevant personal information to accept, issue and service policies I apply for;
   1.3. I must be informed about improvements and/or changes to my current PPS financial products
2. I hereby agree and specifically give consent to the PPS Group, for purposes of processing, including but not limited to, obtaining, sharing, and retaining records of my personal information relating to my membership and any products of the PPS Group:

(tick X the appropriate box)

I consent: ☐ I do not consent: ☐

Should you be unable to provide us with your consent herein we will not be able to proceed with your application or offer you additional products.

MARKETING CONSENT

PPS operates under the ethos of mutuality and all PPS' profits are allocated to PPS members with qualifying products on an annual basis by way of allocations to their PPS Profit-Share Accounts. It is in your best interest, as a member, to be informed of changes that could benefit you. In order to comply with the requirements of POPI Act and respect your choices, PPS Group requires your consent to contact you regarding new products and services which may be beneficial to you, including promotions and research.

YES ☐ NO ☐

NOTE *No marketing communications will be sent where the no box has been ticked. However, please note that communications may be sent regarding changes or enhancements to any existing products that you may have with us.*

SIGNATURE(S)

I hereby agree to the Legal Terms and Notes, Declaration and Authority Statement

Signature of the policyholder

Signed at ____ this ____ day of ____ 20 ____

As the elected Third Party Payer I / We hereby agree to Section E (Payment Declaration) of the Legal Terms and Notes, Declaration and Authority Statement

Authorised signature(s) of account payer

Signed at ____ this ____ day of ____ 20 ____

PART F: DECLARATION BY FINANCIAL ADVISER

I, the undersigned, confirm and declare that:

1. My personal details are as follows:

Surname: ____ Initials: ____

Financial adviser number: ____ Company Reference number: ____

External Reference Number: ____ *This number must be completed if the FSP requires it for payment of commission*

Financial Services Provider name: ____

Financial Services Provider no.: ____

Contact telephone number: 0 ____ ____

Email: ____

2. I complied with the Policyholder Protection Rules and FAIS Act.
3. I have explained to the client:
   - the meaning, implications and possible charges of replacing existing insurance and recorded the clients responses to the Policy Replacement questions on page 11.
   - A replacement is potentially prejudicial and where considered, the attached Replacement Advice Record has been completed to ensure the client receives comprehensive information regarding the consequences.
4. I have/have not *(delete whichever is not applicable)* met directly with the client or the person acting on behalf of the client recorded in this application, and confirm that he/she bears a likeness to the photograph on his/her identity document; and I have verified his/her identity with original acceptable documentation, copies of which are attached. A certified copy of the identity document will be attached where I have not met the client face-to-face.

Signature of financial adviser:

Signed at ____ this ____ day of ____ 20 ____

**** PPS, its subsidiaries and Strategic Partners, collectively referred to as 'The PPS Group' consists of:*** *PPS Holdings Trust, PPS Insurance Company Limited, PPS Investments (Pty) Ltd, Professional Medical Scheme Administrators (Pty) Ltd, PPS Insurance Company Limited (Namibia), PPS Marketing Services (Pty) Ltd, PPS Black Economic Empowerment SPV (Pty) Ltd, PPS Multi Manager (Pty) Ltd, PPS Management Company (Pty) Ltd (RF), PPS Property Fund Trust, PPS Retirement Annuity Fund, Profmed, PPS Beneficiaries Trust, PPS Preservation Fund, PPS Preservation Pension Fund, PPS Personal Pension Retirement Annuity Fund or their successor in title.*