



ESRIC
Ensuring your tomorrow, today.

LIFE ASSURANCE APPLICATION FORM (NON RISK)

In terms of the applicable AML and CFT regulation, ESRIC is required to take the prescribed steps to establish and verify your identity by completing the proposal form and submission of the required documents for verification. New policies will only be issued on receipt of a fully completed ESRIC proposal form. Please fill all spaces marked with an asterisk (*).

INTRODUCER'S DETAILS

Proposal number		Policy Number		NAME	
				CODE	

1. PERSONAL DETAILS OF APPLICANT (LIFE ASSURED)

*Title *Surname *Maiden Surname

*First Name *Second Name

*ID Number *Date of Birth

*Gender *Male *Female *Age Next Birthday *Age Admitted

*Place of Birth *Nationality by Birth

RESIDENTIAL ADDRESS

*Current Residential Address

*Postal Address *Region

*Current Citizenship

*Contact Details Cell Work Home

*Email address

*Do you have any other citizenship(s) *Yes *No

*If Yes (Please state the citizenship(s))

*Do you have a resident permit? *Yes *No

***Are you or are you related to a business associate to a current and/or former member of Parliament (MP), Senator, Senior Executive of a state-owned enterprise, a senior-government employee, judicial, military/defence or other such prominent person?**

Yes No

If Yes (Please provide details)



2. PROPOSER DETAILS IF LIFE ASSURED IS MINOR OR SPOUSE

*Title *Surname *Maiden Surname

*First Name *Second Name

*ID Number *Date of Birth

*Place of Birth

RESIDENTIAL ADDRESS

*Current Residential Address

*Postal Address *Region

*Current Citizenship

*Contact Details Cell Work Home

*Email address

*Do you have any other citizenship(s) *Yes *No

*If Yes (Please state the citizenship(s))

*Do you have a resident permit? *Yes *No

3. EMPLOYMENT DETAILS OF PREMIUM PAYER

*Employed *Not Employed *Self-Employed *Dependant

If Employed

*Name of Employer

*Employment No. Employer Tel/Cell

*Name Employer's Sector

*Employer's Postal Address

*Employer's Physical Address

*Occupation

*Designation/Position

Name of previous employer and length of service (if less than 3 years with present employer)

*If Self-Employed

*Name of Business

*Nature of Business

*Trading License No.

*Postal Address Business Cell

*Physical Address

*Number of Years in Operation

4. INCOME DETAILS OF PREMIUM PAYER

Bank Details

Account Number	<input type="text"/>	Bank Name	<input type="text"/>
Account Holder's Name	<input type="text"/>		
Branch Name	<input type="text"/>	Branch Code	<input type="text"/>

On average, during the past twelve months, how much did you earn? (tick one)

<input type="checkbox"/> 1. E0 - E3 000	<input type="checkbox"/> 4. E10 001 - E15 001	<input type="checkbox"/> 7. E25 001 - E30 000	<input type="checkbox"/> 10. E40 001 - E45 000
<input type="checkbox"/> 2. E3 001 - E7 000	<input type="checkbox"/> 5. E15 001 - E20 000	<input type="checkbox"/> 8. E30 001 - E35 000	<input type="checkbox"/> 11. E45 001 - E50 000
<input type="checkbox"/> 3. E7 001 - E10 000	<input type="checkbox"/> 6. E20 001 - E25 000	<input type="checkbox"/> 9. E35 001 - E40 000	<input type="checkbox"/> 12. Over E50 000

Other source of income (state nature & value)

Death gratuity	E	(Value)	Investment pay-out etc.	E	(Value)
Inheritance	E	(Value)	Group financial schemes	E	(Value)
Pension	E	(Value)	Rentals	E	(Value)
Other (state the proof)	<input type="text"/>				

5. MARITAL INFORMATION

Marital Status *Single *Married *Divorced *Widowed

NEXT OF KIN / CONTACT PERSON

Full Name(s)	Tel (h)	Tel (w)	Cell	Relationship
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

6. DETAILS OF PLAN

Product Type	Term		Premium	Escalation if Applicable					
	Years in figures			Please tick carefully					
Pure Endowment	<input type="checkbox"/>	<input type="checkbox"/>	E	0%	<input type="checkbox"/>	10%	<input type="checkbox"/>	15%	<input type="checkbox"/>
Graduate Plan	<input type="checkbox"/>	<input type="checkbox"/>	E	0%	<input type="checkbox"/>	10%	<input type="checkbox"/>	15%	<input type="checkbox"/>
5 Year Lien	<input type="checkbox"/>	<input type="checkbox"/>	E	0%	<input type="checkbox"/>	10%	<input type="checkbox"/>	15%	<input type="checkbox"/>
Other Product	<input type="checkbox"/>	<input type="checkbox"/>	E	0%	<input type="checkbox"/>	10%	<input type="checkbox"/>	15%	<input type="checkbox"/>

PLEASE CONFIRM BY SIGNATURE THE TERMS ABOVE

Signature Applicant	<input type="text"/>	Date	<input type="text"/>
Method of Payment	EFT/ Bank Debit Order	Mobile Money / E-mail	Post Office
	Govt Stop Order	Commercial Stop Order	
Method of preferred policy document delivery	Delivery	Personal Collection	E-Mail
Premium Frequency	Monthly	Quarterly	Annually



7. POLICY REPLACEMENT

Is this application to replace an existing assurance or application with this or any other assurer?

Yes

No

If Yes, please provide the name and address of the insurer

IMPORTANT: Replacement of any assurance is nearly always to the disadvantage of the applicant because it involves duplication of initial costs charged to the policy.

8. APPOINTMENT OF BENEFICIARY

1. The persons designated below has/have been duly appointed as the Beneficiary under this Policy with the effect that the Eswatini Royal Insurance Corporation will pay such benefits as are specified in the Policy as being payable in the event of the death of the Life Assured to such Beneficiary(s) instead of the person to whom they are expressed in the Policy to be payable, subject to the conditions of the Policy and this endorsement, and subject to the deduction of any amounts owing to the Eswatini Royal Insurance Corporation in respect of loans made upon the security of the Policy and of any amounts so owing for which the policy or any interest therein has been ceded as security to the Eswatini Royal Insurance Corporation and of arrears premiums and Interest thereon, and subject also to any encumbrance on the Policy or rights therein of which the Eswatini Royal Insurance Corporation has received notice before payment.
2. The Beneficiary(s) shall have no right in or to the Policy prior to the death of the Life Assured, and, until that time, the Proposer shall be free to cede, assign or surrender the Policy or any bonus thereunder, to effect loans on the security of the Policy, or otherwise to deal herewith and to receive any amounts payable in terms thereof, without the consent of the Beneficiary(s) and any advance or payment bona made by the Eswatini Royal Insurance Corporation upon or in receipt of the Policy before the date upon which written notice of the death of the Life Assured shall have been received by the Eswatini Royal Insurance Corporation at its Head Office shall be valid and effectual against the Beneficiary(s).
3. The Proposer may by notice in writing to the Eswatini Royal Insurance Corporation at its Head Office revoke the above mentioned appointment without the consent of the Beneficiary, but no revocation shall be of any force or effect unless notice is received by the Eswatini Royal Insurance Corporation at its Head Office prior to the death of the Life Assured.
4. This appointment shall automatically become null and void in the event of the Proposer ceding or assigning the Policy or any interest therein (whether as security or otherwise) or surrendering the Policy or in the event of the Beneficiary(s) predeceasing the Life Assured or the sum assured under the Policy becoming payable in terms thereof before the death of the Life Assured. This clause shall, however not apply to accession of the Policy or any interest therein in favour of the Eswatini Royal Insurance Corporation as security for a loan or any amount owing to the Eswatini Royal Insurance Corporation.
5. Any reinstatement of the Policy after it has lapsed shall have the effect of reinstating this endorsement.



REVOCABLE BENEFICIARY NOMINATION

I (full names)

hereby wish to nominate the under mentioned person(s) to receive the benefit payable by the policy in the event of my death in the proportions indicated. This form supersedes any previous nomination that I may have made.

BENEFICIARY 1

Name			% Benefit
Relationship			
ID Number			
Physical Address			
Postal Address			
Telephone (home)	Telephone (work)		
Mobile Number	Email Address		

BENEFICIARY 2

Name			% Benefit
Relationship			
ID Number			
Physical Address			
Postal Address			
Telephone (home)	Telephone (work)		
Mobile Number	Email Address		

BENEFICIARY 3

Name			% Benefit
Relationship			
ID Number			
Physical Address			
Postal Address			
Telephone (home)	Telephone (work)		
Mobile Number	Email Address		

BENEFICIARY 4

Name			% Benefit
Relationship			
ID Number			
Physical Address			
Postal Address			
Telephone (home)	Telephone (work)		
Mobile Number	Email Address		

Note: We urge you to update your beneficiary nomination form on a regular basis, particularly as and when your circumstances change

Policy Number			
Signed at	Date	DD / MM / YYYY	
Witness Signature	Signature of Proposer		
Address			

9. DECLARATION & ACCEPTANCE (PLEASE READ CAREFULLY)

It is agreed and declared that:

1. All information supplied or to be supplied in connection with this application, whether in my/our handwriting or not, is true and complete and will form the basis of the contract with the Corporation. All statements and declarations made in respect of an existing contract containing an option resulting in this application will form part of the basis of the new contract.
2. If any material information has been withheld, or any material information supplied proves to be incorrect, the contract will be invalid and all premiums/contributions paid will be forfeited.
3. The Corporation will be notified immediately of any change in the health and occupation of the life assured which occurs before cover commences so that the terms of acceptance may be reconsidered.
4. The Corporation’s standard conditions will apply to the contract and to any beneficiary nomination.
5. Any doctor, other person or institution is authorised before and after the death of the life assured to disclose any information concerning his or her health to the Corporation.
6. **Authorisation by account holder if payable by debit order:** The Corporation may draw against the account all amounts due to it in terms of this application. The authority is to remain in force until terminated by myself or the Corporation and I agree to advise the Corporation of any change in the account details.

.....by my signature hereto declare and warrant that all the information provided in this Proposal Form and all documents submitted electronic and otherwise which have been or will be signed by me in connection with obtaining any ESRIC insurance product, is to the best of my knowledge true, accurate and complete.

I authorise ESRIC to obtain any information which ESRIC deems necessary for KYC purposes and to further share with other financial institutions and regulatory bodies as required by law any information contained in this KYC Form either directly or through a database operated by such financial institutions or regulatory bodies.

I undertake to notify ESRIC within 30 days of any material change of the facts herein recited and in particular of any change of residence on my part.

Signature(s) - To be countersigned by legal guardian if life assured is under age 21 **Date**

Life Assured <i>(Signature)</i> <input style="width: 100%;" type="text"/>	DD / MM / YYYY
Applicant, if other than Premium payer <i>(Signature)</i> <input style="width: 100%;" type="text"/>	DD / MM / YYYY

If the applicant or the account holder is a business undertaking, an authorised official must sign across the business stamp

10. INTRODUCER’S REPORT

Was this application form completed by the applicant in his/her handwriting? Yes No

Special Remarks

Signature Date

11. DOCUMENTS TO BE SUBMITTED (PLEASE PROVIDE CERTIFIED COPIES)

Please tick in the box, for corresponding documents submitted

- ID (please copy both sides)
- Proof of Residence
- Proof of Income (Payslip and or current 90 days Bank Transactional statement)
- Proof of other Citizenship
- Marriage Certificate
- Birth Certificate
- Trading License
- Copy of valid Passport for non-Swazis and valid Residence Permit or valid work permit
- Proof of other source of income / source of wealth



FOR OFFICE USE ONLY

Please tick in the box, for corresponding documents received

- ID (certified copies both sides)
- Proof of residence
- Proof of income if employed (Payslip and/or Bank statement)
- Proof of income if self-employed (Bank Statement)

Proof of any other source of income

- Death gratuity
- Investment pay-out, etc.
- Inheritance
- Group financial schemes
- Pension
- Rentals
- Other (state the proof)

Officer

Full Name

Signature Date

Authorized Manager

Full Name

Signature Date

Authorized AGM

Full Name

Signature Date