ESRIC
Ensuring your tomorrow, today.

LIFE ASSURANCE APPLICATION FORM (WITH 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	
NAME	
CODE	

Proposal number		Policy Number	

1. PERSONAL DETAILS OF APPLICANT (LIFE ASSURED)

*Title *Surname *Maiden Surname

*First Name *Second Name

*ID Number *Date of Birth DD / MM / YYYY

*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 LIFE ASSURED IS MINOR OR SPOUSE

*Title *Surname *Maiden Surname

*First Name *Second Name

*ID Number *Date of Birth DD / MM / YYYY

*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 | Bank Name

Account Holder's Name

Branch Name | Branch Code

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

1. E0 - E3 000	4. E10 001 - E15 001	7. E25 001 - E30 000	10. E40 001 - E45 000
2. E3 001 - E7 000	5. E15 001 - E20 000	8. E30 001 - E35 000	11. E45 001 - E50 000
3. E7 001 - E10 000	6. E20 0001 - E25 000	9. E35 001 - E40 000	12. Over E50 000

Other source of income (state nature & value)

Death gratuity	E	*(Value)*	Investment pay-out	E	*(Value)*
Inheritance	E	*(Value)*	Group financial schemes	E	*(Value)*
Pension	E	*(Value)*	Rentals	E	*(Value)*
Other (state the proof)					

5. MARITAL INFORMATION

Marital Status | *Single | *Married | *Divorced | *Widowed

NEXT OF KIN / CONTACT PERSON

Full Name(s)	Home	Work	Cell	Relationship
1				
2				
3				

6. *DETAILS OF PLAN

Product Type	Term	Life Assured	Premium	Escalation if Applicable					
	Years in figures			Please tick carefully					
Endowment With 5 Yearly Cash Benefit		E	E						
Endowment With Profits		E	E						
Graduate Plan with Waiver		E	E	0%		10%		15%	
Level Cover Term Assurance		E	E	0%		10%		15%	
Lilunga Asset Builder		E	E	0%		10%		15%	
Mortgage Protection Plan		E	E	0%		10%		15%	
Other Product		E	E	0%		10%		15%	

PLEASE CONFIRM BY SIGNATURE THE TERMS ABOVE

Signature Applicant | Date DD / MM / YYYY

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. GENERAL OCCUPATION AND ACTIVITIES

		Y	N
1	Have you, in the past, made any application for life assurance to ESRIC?		
	(Please provide dates and, where applicable, proposal policy numbers)		
2	Has any application on your life ever been declined, withdrawn or accepted on special terms?		
	(Please provide date if known)		
3	Do you have a life cover with another insurer (other thant this application)?		
	(Please provide name of insurer)		
4	Are you engaged in any occupation other than that stated on page 1?		
	(If yes provide details)		
5	Have you, in the past five years, been engaged in or intend engaging in hazardous occupations or pursuits, such as mining, use of explosives, parachuting, hang-gliding, private flying, underwater diving, etc?		
	(If yes provide details)		
6	Do you, in the course of your occupation perform any duties that are not clerical or administrative?		
	(If yes provide details)		

HEALTH STATEMENT

	Completed only where a medical examination is not being arranged.	Y/N
1	Have you, during the past five years, sought medical advice, had surgical treatment or undergone any medical investigation such as x-rays, ECGs, blood tests, specialist scans/ ultrasounds after ECGS.	
2	**If not already recorded in answer to the previous question, have you ever experienced or suffered from any of the following conditions:**	
2.1	Disorders of the heart, blood vessels, blood clots or circulation (e.g. high blood pressure, chest pains, heart murmurs, palpitations, coronary thrombosis (heart attack), tightness of chest, stroke, raised cholesterol or rheumatic fever.	
2.2	Disorders of the lungs, e.g. asthma, shortness of breath, pneumonia, tuberculosis, recurrent bronchitis etc.	
2.3	Disorders of the digestive system and/ or liver? (e.g. stomach or duodenal ulcers, gall stones, hepatitis, bleeding from the bowel, recurrent indigestion or hernia?	
2.4	Disorders of the kidneys or bladder e.g. (kidney stones, infections, blood or protein in the urine, prostatitis, or unable to pass urine?	
2.5	Diabetes, sugar in the urine, raised blood sugar, endocrine or glandular disorders (e.g. anaemia, thyroid problems, or any bleeding disorder?	
2.6	Cancer, or other growths, lumps or moles or tumours of any kind, benign or malignant?	
2.7	Tropical diseases (e.g. bilharzia or malaria?	
2.8	Disorders of the skin, joins, spine, muscles, bones or limbs (e.g arthritis, gout, rheumatism, slipped vertebra, back or neck problems?	
2.9	Eye, ear, nose or throat, disorders?	
2.10	Disorders of the central nervous system or mental complaints (e.g. depression, anxiety, stress, fits, concussion, persistent headaches, epilepsy, head injury, paralysis, multiple sclerosis or any other central nervous system abnormality?	
2.11	Have you ever received, or do you expect to receive councelling or treatment or blood tests in connection with HIV infection or AIDSs related disease, or any sexually transmitted disease (e.g. gonorrhoea, syphilis, genital sores)?	
2.12	Have you ever had symptoms of persistent fever or skin disorder, unexplained infections or swollen glands, unexplained night sweats, persistent cough, chronic or recurrent diarrhoea?	
2.13	Have you ever had a HIV Eliza test that was reactive or positive?	
2.14	Any other illness or condition, or disability or accident, that may affect the risk on your life?	
	Have you ever been medically boarded or submitted a disability claim, or been off work for more that a month in the last 3 years?	
	Do you intend consulting a doctor or medical professional in the next 8 weeks for any condition or symptoms not disclosed above, or is any future surgery planned?	
3	Are you currently taking any drugs or prescribed medicine?	
4	Do you have any form of disability e.g loss of use of any limb, impaired sight or hearing, etc?	
5	Are you aware of any other circumstances which may influence the risk of assurance on your life?	
6	**Habits:**	
6.1	Have you smoked tobacco in any form during the past 24 months?	
6.2	Do you currently smoke more than 20 cigarettes per day?	
6.3	Do you on average consume more than three alcoholic drinks per day? (1 drink= 1 tot of spirits or 1 pint of beer or 1 glass of wine)	
6.4	Have you ever been advised to stop drinking or receive medical advice or participated in a rehabilitation programme to reduce alcohol intake, if yes, require full details.	
6.5	Do you take any drugs (e.g. cocaine, cannabis), sedatives, anabolic streroids,stimulants or tranquilisers, or have you done so in the last 5 years?	
7	Is there a history in your family of diabetes, raised cholesterol, heart disease, stroke, high blood pressure, nervous or mental disorder, cancer, retinitis, haemophilia or any other hereditary disease? If yes, please state relationship, nature of disease and present age or age at death of relative	
8	Height (Specify cm)	
9	Mass (weight) (Specify)kg or lbs)	
	Has your weight altered by more than 5kgs in the past 12 months? If yes, please give details	
No	**If you have answered 'yes' in any question requireing feather details in the Health Statment, please provide the details below.**	

FEMALES ONLY

10 Have you ever had any disorder of the female organs (breasts, ovaries, uterus) or any abnormality of pregnancy or confinements e.g. caesarian section or miscarriage?

If yes, please provide full details including dates

10.1 Are you now pregnant?

If yes, please state expected date of confinement

and arrange for completion of PRIVATE MEDICAL ATTENDANT'S REPORT

DETAILS OF USUAL MEDICAL ATTENDANT

Name	Postal Address	Contact NO.	Period as your doctor

ATTACH HOSPITAL/OUTPATIENT CARD

8. 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.

9. 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 arrear 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 dealt herewith and to receive any amounts payable in terms thereof, without the consent of the Beneficiary(s) and any advance or payment bona fide 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			

10. 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.

I.....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 *(Signature)*		DD / MM / YYYY
Applicant, if other than Premium payer *(Signature)*		DD / MM / YYYY

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

11. INTRODUCER'S REPORT

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

Special Remarks

Signature Date DD / MM / YYYY

12. 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
- ☐ Inheritance
- ☐ Pension
- ☐ Other (state the proof)
- ☐ Investment pay-out, etc
- ☐ Group financial schemes
- ☐ Rentals

Officer

Full Name

Signature Date DD/ MM / YYYY

Authorized Manager

Full Name

Signature Date DD/ MM / YYYY

Authorized AGM

Full Name

Signature Date DD/ MM / YYYY