FLEXIBLE BENEFIT SELECTION FORM

Please return this form to your Human Resources Department.

This form should only be completed once you have obtained financial advice from a FAIS accredited, personal financial service provider.

Flexible benefits allow you to take out additional cover according to your own unique needs. As these are voluntary benefits, the following terms and conditions apply:

a. You can only select to increase your flexible benefit:
   - within one month of the date that you start your employment with the employer, if your employment start date is after the policy start date
   - within 3 months of the policy start date if you are an existing employee at the time the policy starts
   - within one month of the policy review date
   - within three months of a life-changing event (limited to the below listed):
     - having a child
     - getting married
     - getting divorced
     - becoming the main caregiver of a sick loved one

b. You may decrease your flexible benefit selection at any time.

c. If your benefit selection causes your cover to go above the maximum benefit allowed, your benefit will be restricted to the maximum benefit.

d. If your benefit selection causes your cover to go above the free cover limit, you will need to submit proof of good health before your cover, above the free cover limit, is accepted.

e. Increasing your benefits will result in an increase in the amount of premium you must pay.

MEMBER DETAILS

First names:

Surname:

Identity number:

Date of birth: Gender:

Employer:

Scheme name:

YOUR FLEXIBLE BENEFIT SELECTION

Effective date of selection: (dd/mm/yyyy)

1. Please indicate if you are increasing or decreasing your flexible benefits? Increasing ☐ Decreasing ☐

2. What is the reason for changing your flexible benefit selection?

New employee ☐ Policy review ☐

New policy ☐ Life-changing event ☐

If a life-changing event, please indicate which event applies:

Marriage ☐ Divorce ☐ Becoming a care-giver ☐ Birth of a child ☐

Please attach proof of life-changing event, i.e. a marriage, divorce decree, affidavit or birth certificate.

3. Please indicate your selected level of cover. You may only select benefits which are offered by your employer or fund, and your selection must either be a multiple of salary or a fixed Rand amount, depending on the structure of the benefits available to you.

Death benefit:	a) additional multiple of salary or b) selected rand amount	 R
Lump sum disability benefit:	a) additional multiple of salary or b) selected rand amount	 R
Critical illness benefit:	a) additional multiple of salary or b) selected rand amount	 R

PRIVACY STATEMENT

We respect the confidentiality of your personal information as well as your privacy. If necessary, we may need to share your information with third parties. These third parties are other insurance and/or reinsurance companies or service providers that may assist us in assessing and managing the risk, or servicing you. We impose the same strict confidentiality standards on these third parties as is applied by us. By providing the required personal information and signing this, you hereby confirm that you consent to us processing and sharing your personal information with other third parties. We will treat this information with caution, and we have put reasonable security measures in place to protect it. The information provided will only be used for its intended purpose and will not be shared within the Hollard Group or another organisation for marketing additional products and/or services to you.

MEMBER DECLARATION

I acknowledge that this benefit selection is made of my own free will and I accept that any benefit increase may result in an increase in premiums. I understand that an increase in benefits may necessitate underwriting and that the increased cover will only be granted if my proof of health is assessed and if I am accepted for cover at the higher amount. I understand a copy of the policy of insurance is available from the policyholder, and that it is my responsibility to ensure that I am aware of the terms and conditions for cover.

I have read, understand and agree to the privacy statement in this form which includes the collection and processing of personal information.

This form replaces all previous flexible benefit selection forms completed by me.

Signed at ☐ on this ☐ day of ☐ 20 ☐

☐

Member's signature