CAPITAL LEGACY

Wills & Estates Specialists

EduCare™ Application Form

Advice and Distribution

New Application: ☐ Plan Amendment: ☐ Plan Number P N

Intermediary name:

FSP name:

EduCare™ quote number: E C – – –

Preferred time to call the Client if there are any underwriting requirements? e.g. Monday/after 5pm

Special comments to Capital Legacy:

Who Is doing the Will?

Capital Legacy Will Consultant ☐ The Client will be contacted by a Capital Legacy Will Consultant to draft the Will and review the Legacy Protection Plan™. ***For this selection please do not complete the Will Information section below.***

Intermediary ☐ ***Please ensure you complete the Will Information section in detail before submitting the Application Form.***

Client Information

Section A Personal Details

Title & full names:

Identity number:

If you do not have an SA ID, please complete your passport number and Date of Birth.

Passport number: Date of Birth: Y Y M M D D

Email address:

Cell number: Do you consent to being contacted by email, SMS and WhatsApp? Y

Protection of Personal Information: We are committed to protecting your personal information. Your privacy is of utmost importance to us and we take our responsibility to protect your personal information very seriously. We will take the necessary measures to ensure that any and all information, provided by you for the purpose of this Application, is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and further, is stored in a safe and secure manner. For more information on how we protect, process or store your personal information, please visit our website at **www.capitallegacy.co.za** to view our privacy notices.

Will Information

Section A Will Information Capture

Note: Please complete the Will Information Section, if you do not need one of the Testamentary Consultants to meet with your Client.

Will language: ☐ English ☐ Afrikaans Do you have any worldwide assets? Y N ***If so, please complete Section I.***

Section B Distribution of your Estate

Who do you want to have inherit your general Estate?

For example: 50% to my Children, James and Tammy Smith, and 50% to my Spouse, Mary Smith, failing which, 100% to my Children.

Please provide the name(s), surnames, relationship(s), and year(s) of birth of your Beneficiaries.

Is there something specific you want to leave to someone, other than your general Estate?

For example: Life insurance payable to my Estate; or my primary residence; or my jewellery and to whom.

If so, please specify in detail.

Section C Last Wishes

☐ Cremated: ☐ Buried: ☐ Not specified: ☐ Living Will:

Section D Trust and Inheritance Protection

Please complete the sections below, where applicable.

Legacy Children's Trust™ ☑

A Testamentary Trust is required for EduCare™. Terms and conditions will be as per the accepted EduCare™ quotation.

Legacy Provider's Trust™

It may be that a Beneficiary has special needs. In such a case, we recommend that a separate lifelong Trust be created for the interests of this Beneficiary and to provide capital and income to support this Beneficiary. The principal Beneficiary of your Will automatically inherits the balance of any remaining capital.

Please complete the information below to enable us to create such a Trust in your Will.

Income and Capital Beneficiary

Beneficiary name: Full names of the dependant with special needs Relationship: Son, Daughter, Nephew, etc. **Nephew**

Beneficiary name: Full names of the dependant with special needs Relationship: Son, Daughter, Nephew, etc. **Nephew**

Legacy Widow's Trust™

This Trust will be created for the sole income needs of the nominated Spouse with the ultimate ownership of these assets vesting with your capital nominee(s) below. A monthly income will be payable to the Spouse for the duration of his or her lifetime. The income available will be dependent on the value of the inheritance left to the Trust, to be created in terms of the Will. NO initial inheritance taxes will be payable on any value received in this Trust, only on its termination. If any directly-held capital is required by the Spouse, please specify a separate special bequest or amend life insurance Beneficiaries to effect such.

Please complete the information below to enable us to include a Legacy Widow's Trust™ in your Will.

Income Beneficiary

Spouse name: Full names of the Spouse Relationship: Fiancé, Wife, Husband, Life Partner, etc. **Life Partner**

Capital Beneficiary(ies)

Do you wish your Child(ren) to be the capital owners of these Trust assets? Y N

If '**No**', please specify who or which entity you wish to be the capital Beneficiaries.

Capital Beneficiary:	Name of individual or entity	Relationship:	Brother, Vivos Trust, etc.
Capital Beneficiary:	Name of individual or entity	Relationship:	Brother, Vivos Trust, etc.
Capital Beneficiary:	Name of individual or entity	Relationship:	Brother, Inter Vivos Trust, etc.

Section E Organ Donor Registration

Would you like to be an organ donor? Y N Have you been registered before? Y N Would you like us to register you? Y N

If you selected '**Yes**' for us to register on your behalf, you, herewith confirm and understand what it means to be an organ donor and you have registered by your own free will. Please note that more information can be obtained from the Organ Donor Foundation's website **www.odf.org.za** or by calling their toll-free telephone line **0800 22 66 11**.

Section F Next of kin details

Full name:		Relationship:	
Email:		Cell number:	

Section G Guardian, Trustee and Executor Nominations

In the event of both biological Parents being deceased, please provide full name(s) and relationship(s) of Guardians for your minor Children.

Guardian name:		Relationship:	Aunt
Guardian name:		Relationship:	Aunt

In addition to Capital Legacy, we strongly recommend a personal Co-Trustee. Please provide name(s) and relationship(s).

Co-Trustee name:		Relationship:	Aunt
Co-Trustee name:		Relationship:	Aunt

Do you wish for Capital Legacy to be your Executor? If no, please provide and nominate an alternative Executor. Y N

Co-Executor name:		Relationship:	Aunt
Co-Executor name:		Relationship:	Aunt

Section I Worldwide Assets

Are there assets such as business interests and fixed property outside of South Africa (i.e. are there offshore assets that stand to be inherited)? If so, a single Worldwide Will is recommended. Please complete the required information below.

Asset description:		Country:	
Asset description:		Country:	
Asset description:		Country:	

Please note that depending on the country (e.g. Portugal, Spain, France, etc.) a separate offshore Will in the relevant territory will be required for these assets. If an offshore Will is required, our Technical Advice Centre will make contact to assist with this process.

Medical Questions

Section A Mandatory

1. What is your height (cm), weight (kg)? ☐☐☐ cm ☐☐☐ kg
2. Have you ever been declined, charged an extra premium or had an exclusion applied to any previous application for insurance that has not been reversed, whether issued or not? Y N
3. Have you ever tested positive for HIV? Y N
4. Have you ever suffered from or been diagnosed with a cardiovascular disorder such as a heart attack, chronic heart failure, stroke, stent, palpitations, chest pains, heart murmurs, ischaemic heart disease or any other form of disorder of the cardiovascular system? Y N
5. Have you ever suffered from, been diagnosed with, been treated for, or had an indication of any persistent, recurrent or chronic disorder of your kidney(s) or liver such as blood or protein in the urine, kidney failure, kidney stones, chronic kidney infection, bladder problems, ulcerative colitis, liver disease, pancreatitis or hepatitis (B or C) etc.? Y N
6. Have you ever suffered from, or been diagnosed with, any blood and/or coagulation (clotting) disorder for which you have taken any medication in the last five (5) years, such as but not limited to anemia, polycythemia etc.? Y N
7. Have you ever suffered from or been diagnosed with diabetes, insulin resistance, raised blood sugar, or sugar in the urine, etc.? Y N
8. Have you ever suffered from or been diagnosed with any form of cancer that was NOT BENIGN? Y N
9. Have you ever been prescribed or cautioned of the need for any medication in order to improve the control of cholesterol levels or blood pressure levels for which, within the last six (6) months, your medical practitioner has advised that the type of medication or dosages be changed? Y N
10. In the past five (5) years, have you spent more than four (4) consecutive nights in hospital or have you been absent from work for more than three (3) consecutive weeks, due to an illness or surgery that you have not previously stated. This excludes COVID-19, childbirth, dental surgery, bone fractures, gastroenteritis or an appendectomy. Y N
11. In the next twelve (12) months, do you plan on seeing a doctor for any illness, symptoms, special investigations or treatments other than treatment for minor conditions including colds, influenza and gastroenteritis or routine dentistry? Y N

Section B Mandatory

Please complete the following truthfully and honestly.

12. Do you consume more than 45 units of alcohol per week (1 unit = 1 bottle beer (340ml) or 1 glass of wine or 1 tot of spirits)? Y N
13. Have TWO or more members of your immediate family (Biological Mother, Father, Sisters, Brothers) been diagnosed with or passed away from THE SAME genetic disease, such as heart diseases, kidney disease, cancer, diabetes or similar genetic diseases, before the age of sixty (60)? (In other words, they both had the same disease before age 60) Y N
14. Have you ever suffered from or been diagnosed with any neurological disorders, such as epilepsy, multiple sclerosis, Parkinson's disease, etc.? Y N
15. Have you ever suffered from or been diagnosed with any mental disorders, for which you are taking medication, such as depression, anxiety or because of a suicide attempt, etc.? Y N
16. Please indicate if any of the following are applicable to you: Y N
    (i) Have you ever tested positive for COVID-19 or
    (ii) In the thirty (30) days prior to this Application, did you experience any COVID-19 symptoms or were in contact with anyone who has been diagnosed with COVID-19?
17. Have you ever suffered from or been diagnosed with any respiratory or lung disorder, such as chronic asthma (defined as at least one (1) attack per week or the daily use of a pump), persistent cough, tuberculosis, chronic obstructive pulmonary disease, sleep apnoea, etc., but excluding any respiritory complications due to COVID-19? Y N
18. Have you ever suffered from or been diagnosed with any disorder of the glands or endocrine system, such as bleeding disorder, anemia (for which you are currently on medication) or thyroid problems? Y N
19. Other than the conditions that you have already disclosed, have you had any other illness, medical, surgical treatment or special investigations? Y N
20. Depending on your height and weight or if you answered 'Yes' to any of the above questions, do you agree to a loading on your EduCare™ premium to a maximum of 25% of your quoted premium, or where applicable, an initial three month waiting period where COVID-19 is the cause of death? Y N

Should we decline your application for EduCare™, we will automatically accept your Application as a Legacy Protection Plan™ Lite which has the following cover restrictions and conditions: Immediate Liquidity™ of R17 954 and Estate Overheads Protector™ of R9 576, which will both carry an initial 6-month waiting period for natural death, and no Estate Gap Cover™ will be allowed. Importantly, the value of your selected Maximum Indemnity Benefit™ will be maintained, and a 3-month waiting period applies. No Extender Benefits will be allowed.

Section C Selection Application Dependant

If you selected impairment and illness on **EduCare™**, please complete the following truthfully and honestly.

21. Are you taking or have you ever taken illegal/illicit drugs or been advised to, or participated in a rehabilitation programme for drug or alcohol abuse? Y N
22. Have you ever suffered from or been diagnosed with any disorder of the spine, joints, bones, muscles, limbs or skin such as gout, psoriasis, back problems, fibromyalgia, arthritis, dermatitis, neck problems, rheumatism, broken bones or slipped disc, etc.? Y N
23. Have you ever suffered from or been diagnosed with any disorder of the ear, nose, throat or eye, such as defective vision, hearing loss, hoarseness or other? Y N
24. Have you ever suffered from or been diagnosed with any disorder of the female organs (breasts, ovaries, uterus, cervix) including any dense breast tissue, lumps or cysts in the breasts or ovaries and/or abnormal pap smear results, etc.? Y N
25. Have you ever suffered from or been diagnosed with any disorder of the male organs (penis, prostate, testes) including an enlarged prostate, raised PSA results and/or difficulty in passing urine, etc.? Y N
26. Have you ever taken prescription drugs, tranquilisers, medicines or tablets for any reasons, other than the conditions already mentioned? (You can disregard medications for colds or flu, over the counter medication or oral contraception) Y N
27. Depending on your height and weight or if you answered 'Yes' to any of the above questions, do you agree to a loading on your EduCare™ premium to a maximum of 50% of your quoted premium? Y N

Section D Medical Conditions Detail

If you answered '**Yes**' to any of the medical questions, please provide full details below.

Question number	Condition / Symptom	Date of first symptom /diagnosis	Date of last symptom /diagnosis	Are you on treatment
				Y N
				Y N
				Y N
				Y N

Section E General Practitioner or Specialist Details

Please complete the General Practitioner and Specialist details below if you have answered 'Yes' to any of the medical questions or if you feel that your health is impaired, in any way, and you believe it may affect your underwriting. By submitting their details you grant us permission to contact them.

Details of General Practitioner

Full names:

Practice name: (Optional) For example: NHC Sandton

Email address:

Contact number: Suburb:

Details of Specialist

Full names:

Practice name: (Optional) For example: Sandton Mediclinic

Email address:

Contact number: Suburb:

Specialist Type: For example: Cardiologist, Psychiatrist, Neurologist, Radiologist, Pulmonologist

Please note: Should you have more than one Specialist, write this in the special comments section of this Application Form and we will contact you to gather their details.

Beneficiary Nominations

Section A Immediate Liquidity™ Beneficiary Details

Beneficiary	Relationship	Full Names and Surname	Date of Birth
Immediate Liquidity™ Beneficiary		Mandatory	

Note: If more than one (1) Beneficiary is required, please complete the Extended Beneficiary Nomination Form.

Declarations and Consent

Section A Non-Smoker Carbon Monoxide (CO) Breathalyser Test

Please note that a CO breathalyser test may be required for non-smokers. However, this may be waived at the discretion of the Underwriter. By signing this Application Form you are acknowledging the information provided and processed on the quotation, as per the quote number provided, and by declaring yourself to be a non-smoker, you may be required to complete a CO breathalyser test as confirmation of your non-smoker declaration.

Payment Details

Section A Payment Details

Note that your debit order reference will be the abbreviated name, as registered with the bank "CAP LEGACY".

Bank name: _____ Account type: ☐ Current ☐ Savings

Account number: _____ Account holder: _____

Debit day: ☐ 1st ☐ 15th ☐ 20th ☐ 25th Commencing: 0 1 / _ _ / 2 0 _ _

Total Monthly Premium: R _____

Disclaimer: By signing this Application Form, you acknowledge that you understand the information that has been provided in the quotation, as per the quote number provided, and that the above premium is the total monthly premium, as per the quotation. Premiums shown will increase as you move through the age bands, and will increase annually by inflation. Please reference your Terms and Conditions for more details.

Telephonic disclosure - premium payer debit order authorisation

Please note

Client to respond with a verbal 'Yes' where applicable.

Verbally replace the grey wording with payment details chosen specifically by the Client.

Do you authorise Capital Legacy Solutions to issue and deliver payment instructions to your Banker, for collection against your Bank account, on condition that the sum of such payment instruction will never exceed your obligations as agreed in your contract?

This method will commence effective from 1st of [COMMENCEMENT MONTH AND YEAR CHOSEN], and will continue monthly thereafter until your obligation has ended, or the Authority and Mandate is terminated by yourself by giving us notice of not less than one month.

We will collect on the [DEBIT DAY CHOSEN] of every month. In the event that the payment day falls on a Sunday or recognised South African public holiday, the payment day will automatically be the very next ordinary business day.

The Transaction may be tracked against your account.

This Authority and Mandate may be cancelled by you however; such cancellation will not cancel the Agreement. You shall not be entitled to any refund of amounts which we may have withdrawn while this Authority was in force, if such amounts were legally owing to us.

The Authority and Mandate may be ceded, or assigned to a third party only if the Agreement is also ceded or assigned to the third party.

We will confirm your Authority and Mandate in writing, prior to processing the debit order against your account.

If you have not understood and accepted what I have read to you, please direct your questions or complaints to lifeinfo@capitallegacy.co.za

A payment reference number will reflect on your bank statement and will show as "Cap Legacy" – followed by your unique Plan Number.

SUBMIT