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(e), 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:	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 R 17 954 and Estate Overheads Protector™ of R 9 576, 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 Client Consent

I, _____ , with Identity Number listed herein, understand and agree that I am hereby accepting and curtailing my right to privacy in order to facilitate financial and medical underwriting for the assessment of the risks, and the consideration of any Claim for Benefits under a Plan or any Application for insurance made by me, or in respect of me as the Life Assured. I acknowledge and understand that Capital Legacy Solutions (Pty) Ltd is an authorised financial services provider with a legitimate interest in obtaining my personal information. I therefore irrevocably authorise Capital Legacy Solutions (Pty) Ltd to:

a) obtain any and all information pertaining to me as may be appropriate from any Life Office or other financial and medical institution, including and via any third party, and including but not limited to Astute.
b) obtain from any person, whom I hereby so authorise and request to give, any information which Capital Legacy deems necessary.
c) obtain information from any doctor, other person or institution who may possess, or later get any information about my health and financial status (including my Plan Schedule and Plan information), to disclose such information to Capital Legacy. This request will remain in force after my death.
d) share with other insurers, and any associations of such insurers, that information and any information contained in my Application or in any related Plan or other document, either directly or through a database operated by or for such insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as may from time to time be decided by Capital Legacy or by the operators of such data.

Signed at _____ on this _____ day of _____ 20 _____

_____

Signature of Plan Holder and Life Assured

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.

Section B Debit Order Declaration

The signed Authority and Mandate refers to our contract as dated on signature hereof ("The Agreement"). I / We hereby authorise you to issue and deliver payment instructions to the bank for collection against my / our above-mentioned account at my / our above-mentioned bank (or any other branch to which I / we may transfer my / our account) on condition that the sum of such payment instructions will never exceed my / our obligations as agreed to in The Agreement, and commencing on the commencement date and continuing until this Authority and Mandate is terminated by me / us by giving you notice in writing of no less than twenty (20) ordinary working days, and sent by prepaid registered post or delivered to your address. The individual payment instructions so authorised to be issued must be issued and delivered as follows. On the day ("payment day") as indicated above of each and every month commencing on the date as indicated above for commencement of the Plan. In the event that the payment day falls on a Saturday, Sunday or recognised South African public holiday, the payment day will automatically be the very next ordinary business day. Further, if there are insufficient funds in the nominated account to meet the obligation, you are entitled to track my account and re-present the instruction for payment as soon as sufficient funds are available in my account. I / We acknowledge that all payment instructions issued by you shall be treated by my / our above-mentioned bank as if the instructions had been issued by me / us personally. I / We agree that although this Authority and Mandate may be cancelled by me / us, such cancellation will not cancel the Agreement. I / We shall not be entitled to any refund of amounts which have been withdrawn while this Authority and Mandate has been in force, if such amounts were legally owing to you. I / We acknowledge that this Authority and Mandate may be ceded to or assigned to a third party if The Agreement is also ceded or assigned to that third party, but in the absence of such assignment of The Agreement, this Authority and Mandate cannot be assigned to any third party. I / We acknowledge that the sharing of claims information and underwriting (including credit information) by Insurers is essential to enable the insurance industry to underwrite policies and assess risk fairly and reduce the incidence of fraudulent claims, in the public interest and the view to limiting premiums. I / We, hereby, waive any rights to privacy in any claims information supplied by me / us or on behalf of me / us in respect of any insurance claim made or lodged by me / us and I / We consent to such information being disclosed to any other insurance company or its agent. I / We also waive any rights of privacy and consent to the disclosure of any information relevant to claims concerning me / us or any person I / We represent. I / We also acknowledge that information provided by me / us may be verified against other legitimate sources or databases. I / We understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African Banks and I / We also understand that details of each withdrawal will be printed on my / our bank statement. Each transaction will contain a number, which must be included in the said payment instruction and if provided to you should enable you to identify The Agreement. A payment reference is added to this form before the issuing of any payment instruction. A payment reference number will reflect on your bank statement and will show as "CAP LEGACY" – followed by your unique Plan Number.

The premiums and benefits applied for herein are applicable for 2023.

By signing this Application Form, I declare that I accept and understand the conditions of the Application Form. I also confirm that information provided on this Application and the quotation as per the quote number indicated on this Application Form have been provided honestly and truthfully and have been done so voluntarily in order to facilitate the processing of this Application.

Disclaimer: By signing this Application Form, you consent to the information provided herein as well as on the quotation, as per the quote number provided, and accept what has been provided and explained to you.

Signature of Plan Holder and Payer

Signature of Alternate Payer

Replacement Advice Record

Note to Advisor:
This section has been added for your convenience if this application is to replace any other policy for life insurance. You may use an equivalent RAR if you prefer but either this or your preferred RAR must be submitted with this application if it is a replacement.

Note to Plan Holder:
If you are considering taking out a new risk policy that wholly or partly replaces any existing risk policy, your Financial Advisor must complete and discuss this document with you to help you decide whether replacing your existing policy is in your best interest.
It is important that you do not sign this document without reading and having carefully considered the information it contains.

Instructions for the completion of this form

1. The Financial Advisor must complete this replacement advice record form ("Record").
2. For purposes of this form "Financial Advisor" means an "Intermediary", as defined in the Policyholder Protection Rules made under section 62 of the Long-term Insurance Act, 1998 (Act No. 52 of 1998), being the representative of the FSP concerned or sole proprietor, as the case may be, who has provided advice to the Plan Holder regarding the replacement.
3. The information required in the Record must be completed for each life insured on the Plan.
4. **If any feature is not present on the Plan, please indicate "None" or "Not Applicable" in the applicable field. Do not leave the field blank.**
5. **When completing Part 3 of the Record, please ensure that the reasons stated are specific and not general, e.g. avoid using terms like 'better benefits' or 'cheaper premiums' but rather use terms like 'better future insurability benefits'.**
6. **For purposes of Part 4, where there is no difference, indicate "same" or "no difference".** Only complete the sections under Part 4 where there is a difference between Plan Benefits of the new Plan and the replaced Plan.
7. **Where information regarding specific exclusions or premium loadings applicable to the Plan Holder / life insured, as required in Part 4 is not available at the time this Record is completed due to underwriting processes, Part 4 may be completed as "subject to underwriting".** In the event where a specific exclusion or loading is subsequently imposed, the new insurer will need to make appropriate arrangements with the Financial Advisor so that the insurer can satisfy itself that the Plan Holder has subsequently been afforded the opportunity to consider the implications of such loadings or exclusions on the suitability of the replacement.

Part 1 General Information

Full names of Plan Holder:

ID number/Company Registration Number of Plan Holder:

Full names of Financial Advisor[1]:

ID number of Financial Advisor:

Name of Financial Services Provider of the Replaced Plan(s):

FSP number:

Name of Financial Services Provider recommending the Replacement:

FSP number: Date of Inception of the Plan being replaced: D D M M Y Y Y Y

[1] For purposes of this form "Financial Advisor" means an "Intermediary", as defined in the Policyholder Protection Rules made under section 62 of the Long-term Insurance Act, 1998 (Act No. 52 of 1998), - i.e. the representative of the FSP concerned or sole proprietor, as the case may be, who has provided advice to the Plan Holder regarding the replacement. The Financial Advisor must complete this Replacement Advice Record.

Part 2 Plan Details

New Plan(s)		
Plan/Application Number	Product Name	Insurer
1.		
New Plan/Plans Being Replaced		
Plan/Application Number	Product Name	Insurer
1.		ABSA Life - 36116
2.		ABSA Life - 36116
3.		ABSA Life - 36116

Part 3 Reasons for recommending the replacement Plan(s)

List the main reason(s) why the new Plan(s) is/are considered as more suitable to the Plan Holder's needs and objectives than keeping or altering/changing the replaced Plan(s)? (If there is more than one reason, please number them.)

Could the replaced Plan(s) have been altered/changed to better meet the Plan Holder's needs and objectives? (If not, explain why.)

If the replaced Plan(s) could have been altered/changed, explain why a replacement is recommended instead of making such change.

Part 4 Difference between new and replaced Plans

Detail	Description of the difference between the new Plan and the replaced Plan
A. Specific Plan Benefits (including costs, exclusions and restrictions for each Benefit type)	
4.1 Death Benefits	
a) Cover amount	
b) Benefit premium	
c) Standard exclusions (including suicide exclusions)	
d) Waiting period(s)	
e) Benefit term/expiry age	
4.2 Lump Sum Disability Benefits	
a) Type of cover and events covered	
b) Accelerated or standalone cover	
c) Cover amount	
d) Benefit premium	
e) Standard exclusions	
f) Waiting period(s)	
g) Benefit term/expiry age	
4.3 Severe illness/Critical illness/Dread disease or Trauma Benefits	
a) Type of cover and events covered (include key differences in number, severity or definitions of covered conditions)	
b) Accelerated or standalone cover	
c) Cover amount	
d) Benefit premium	
e) Standard exclusions	
f) Waiting period(s) (including any specific exclusions)	
g) Benefit term/expiry date	
h) What diseases are covered under the new Plan(s) compared to the replaced Plan(s), and does it cover temporary or permanent disability, or both?	
4.4 Any other Plan Benefits/special features/differences	
a) Type and value of Benefits/features	
b) Cost of Benefits/features	
c) Other	

B. General Plan features	
Detail	**Description of the difference between the new Plan and the replaced Plan**
4.5 Premiums and charges	
a) Total premium (including loyalty/add-on Benefits) investment portfolio/assets	
b) Premium pattern	
c) Basis of contractual premium increases, if applicable	
d) Basis of contractual benefit increases, if applicable	
e) Period for which the premium is guaranteed (fixed) and date of next premium review	
f) Plan administration fees	
g) Any other fees (e.g. claims administration fees, other transaction fees)	
h) Age of life insured when replaced Plan was entered into and effect of increased age or any health changes on the new Plan premium.	
4.6 Exclusions and restrictions	
4.7 Tax treatment and implications	
a) Tax treatment and tax implications	
4.8 Other material differences	
a) List any other differences (not covered elsewhere) considered material to the replacement decision.	
b) Provide details of any vested rights, guaranteed Benefits or other guarantees or advantages that will be lost as a result of the replacement, or any other potential disadvantages of the replacements not covered elsewhere.	

Note: Where it is not possible to provide any of the information required in Section 4 above, please list the relevant item(s) below and explain why the information could not be provided.

Plan Holder confirmation regarding Part 4: Description of the difference between the new Plan and the replaced Plan.
I have noted the differences between the new Plan and the replaced Plan as described in Part 4 above.

Part 5 Financial Advisor Remuneration

a) Provide the following details of any remuneration[2] or other financial interest to be earned by the Financial Advisor or the FSP concerned in relation to the replacement Plan(s):

Up-front commission: Ongoing commission:

Any other direct or indirect remuneration or other financial interest:

b) Has the Financial Advisor or FSP earned any direct or indirect remuneration or other financial interest in relation to the replaced Plan? Y N

c) If the answer to (b) is 'Yes', provide the following details of any remuneration or other financial interest earned by the Financial Advisor or FSP in relation to the replaced Plan(s) in the past five (5) years:

Up-front commission: Ongoing commission:

Any other direct or indirect remuneration or other financial interest:

Plan Holder confirmation regarding Financial Advisor remuneration

Plan Holder to initial next to either (1) or (2), as applicable.

1. I am aware of the remuneration being earned by my Financial Advisor on the new Plan(s). Initial

OR

2. I am aware that my Financial Advisor did not earn remuneration on the replaced Plan(s). Initial

   Where applicable, I am aware that my Financial Advisor also earned remuneration on the replaced Plan(s).

Plan Holder signature

[2] According to the General Code of Conduct for Authorised Financial Services Providers and Representatives made under section 15 of the Financial Advisory and Intermediary Services Act, 2004 (Act No. 37 of 2002), details of remuneration must be reflected in specific monetary terms, provided that where an amount is not pre-determinable the remuneration basis must be explained.

Part 6 Declations

6.1 Financial Advisor (intermediary) declaration

I, [Insert full name of Financial Advisor] hereby confirm that:

I have taken all reasonable steps to confirm that the information in this Replacement Advice Record is correct and complete; and Initial

I have explained the implications of the Plan replacement - including but not limited to the information provided in this Replacement Advice Record - to the Plan Holder in sufficient detail and in an appropriate manner, taking into account what I know or reasonably assume to be the Plan Holder's level of knowledge, to enable the Plan Holder to make an informed decision about the replacement. Initial

The outcome of the advice to the Plan Holder is as follows: Initial

a) The Plan Holder has elected to proceed with the replacement contrary to my recommendation that the replacement might not be in the Plan Holder's best interests, and I have alerted the Plan Holder to the associated risks and have advised the Plan Holder to take particular care to consider whether the replacement is appropriate to the Plan Holder's needs, objectives and circumstances.

OR

b) I believe that the replacement is in the Plan Holder's best interests, that the Plan Holder has the ability to financially bear any costs or risks associated with the replacement and that the new Plan(s) is/are more suitable to the Plan Holder's needs and objectives than the Plan(s) being replaced. Initial

(Financial Advisor to initial next to either (a) or (b) as applicable to advice given)

Signature of Financial Advisor Date

6.2 Plan Holder Declaration

I, We [Insert full name of Plan Holder] hereby confirm that:

The Financial Advisor who provided me with this Replacement Advice Record has explained all the information provided in it to me in a way that I understand; and Initial

I have carefully considered this information. Initial

The Financial Advisor has alerted me to risks associated with the replacement and has advised me to take particular care to consider whether the replacement is appropriate to my needs, objectives and circumstances and:

a) Despite the Financial Advisor's advice indicating that the replacement might not be in my best interest, I nevertheless wish to proceed with the replacement; Initial

b) Based on this information, I agree that the replacement is in my best interest. Initial

(Plan Holder to initial next to either (a) or (b) dependent on applicable decision.)

I am aware that this Replacement Advice Record is not a cancellation instruction and that I still have to inform the insurer(s) to cancel my Plan(s).

Signature of Plan Holder Date

CAPITAL
LEGACY

Wills & Estates Specialists

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