



ADVICE AND DISTRIBUTION

New Application ☐

Will Review ☐

Plan Amendment ☐

If this application is to indicate a Plan amendment, please complete the Plan Number.

Plan Number:

P

N

Intermediary:

Intermediary code:

I

N

T

Not mandatory

FOR OFFICE USE ONLY

Lead reference:

Consultant:

Booking Agent:

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:

Email address:

Cell number:

Monthly income: R

Higher of own
or Spouse

Smoking status:

Smoking

Non-smoking

Highest education:

Do you consent to being contacted by email, SMS and WhatsApp?

Yes

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

Please complete this Will Information section in detail if no Will has been drafted and therefore no information has been captured directly on the system.

Will language:

☐

English

☐

Afrikaans

Do you have any worldwide assets?

☐

Yes

☐

No

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 if minor Children are or could inherit from you.

At which age may the Trust assets vest with the Beneficiary(ies)? Vesting age: 18 years + (Recommended: 25 years)

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: Fiancée, Wife, Husband, Life Partner, etc.

Capital Beneficiary(ies)

Do you wish your Child(ren) to be the capital owners of these Trust assets? ☐ Yes ☐ No

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

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

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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.

SECTION E: ORGAN DONOR REGISTRATION

Would you like to be an organ donor? ☐ Yes ☐ No

Have you been registered before? ☐ Yes ☐ No

Would you like us to register you? ☐ Yes ☐ No

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:
Guardian name: Relationship:

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

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

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

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

SECTION H: WILL COLLECTION SERVICE

Would you like to make use of our free Will Collection Service once your printed Original Will has been finalised and signed? ☐ Yes ☐ No

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: PLEASE COMPLETE TRUTHFULLY AND HONESTLY

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? ☐ Yes ☐ No
3. Have you ever tested positive for HIV? ☐ Yes ☐ No
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? ☐ Yes ☐ No
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.? ☐ Yes ☐ No
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.? ☐ Yes ☐ No
7. Have you ever suffered from or been diagnosed with diabetes, insulin resistance, raised blood sugar, or sugar in the urine, etc.? ☐ Yes ☐ No
8. Have you ever suffered from or been diagnosed with any form of cancer that was NOT BENIGN (i.e. not cancerous)? ☐ Yes ☐ No
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? ☐ Yes ☐ No
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. ☐ Yes ☐ No

If Yes, please name condition and provide details.

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 gastro-enteritis or routine dentistry? ☐ Yes ☐ No

If Yes, please name condition and provide details.

Please note, if you answered 'Yes' to any of the above questions or your BMI is above 40.0, we will automatically accept your Application as a Legacy Protection Plan™ Lite which has the following cover restrictions and conditions: Immediate Liquidity™ of R 16 954 and Estate Overheads Protector™ of R 9 042, 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.

NOMINATIONS

Role	Relationship	Full Names and Surname	Date of Birth
Immediate Liquidity™ Beneficiary		Mandatory	
Spouse		Only complete if Extended Estate Gap Cover™ is selected	Max entry age 50
Additional Child 1		Only complete for each additional child life	Max entry age 21
Additional Child 2		Only complete for each additional child life	Max entry age 21
Additional Child 3		Only complete for each additional child life	Max entry age 21
Additional Child 4		Only complete for each additional child life	Max entry age 21
Parent 1		Only complete for each required insured life	Max entry age 75
Parent 2		Only complete for each required insured life	Max entry age 75
Parent 3		Only complete for each required insured life	Max entry age 75
Parent 4		Only complete for each required insured life	Max entry age 75

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

LEGACY PROTECTION PLAN™ - INDEMNITY PLAN™

[CLICK HERE TO VIEW THE FULL LEGACY PROTECTION PLAN™ BENEFITS AND PREMIUMS](#)

LEGACY PROTECTION PLAN™

Plan Type	Select	Initial Waiting Period (months)	Plan Value	Maximum Indemnity Benefit™ and %	Integrated or Cash Benefits	Age Dependent Monthly ENTRY Premium (Age Next Birthday)				
						Age 18 - 30	Age 31 - 45	Age 46 - 50	Age 51 - 55	Age 56 - 60
INDEMNITY PLAN™										
CorePlan™	<input type="radio"/>	0	25% of Fees	25%	R 0	R 0	R 0	R 0	R 0	R 0
FeePlan™ - Lite	<input type="radio"/>	3	75% of Fees	75%	R 0	R 108.55	R 108.55	R 108.55	R 108.55	R 108.55
FeePlan™ - Classic	<input type="radio"/>	3	90% of Fees	90%	R 0	R 152.49	R 152.49	R 152.49	R 152.49	R 152.49
Bronze	<input type="radio"/>	0	R 167 280	R 141 284	R 25 996	R 87.31	R 100.29	R 115.63	R 145.13	R 188.77
Silver	<input type="radio"/>	0	R 356 035	R 282 568	R 73 467	R 108.55	R 123.89	R 142.76	R 179.34	R 233.61
Gold	<input type="radio"/>	0	R 1 537 169	R 847 704	R 124 329	R 129.79	R 148.66	R 171.08	R 214.73	R 279.62
Platinum	<input type="radio"/>	0	R 2 983 918	R 1 695 408	R 1 582 238	R 169.90	R 194.67	R 224.17	R 280.80	R 365.75
Diamond	<input type="radio"/>	0	R 5 272 718	R 3 390 816	R 1 864 494	R 211.19	R 241.87	R 278.44	R 348.04	R 453.05
Unlimited	<input type="radio"/>	0	Unlimited	Unlimited	R 1 864 494	R 303.22	R 348.04	R 401.14	R 501.42	R 652.43
IMMEDIATE LIQUIDITY™										
Principal - Lite	<input type="radio"/>	0	R 56 513	R 28 256	R 28 256	R 25.96	R 29.50	R 34.22	R 43.66	R 57.81
Principal - Classic	<input type="radio"/>	0	R 113 027	R 56 513	R 56 513	R 47.20	R 53.10	R 61.36	R 76.69	R 100.29
Principal - Premium	<input type="radio"/>	0	R 226 054	R 113 027	R 113 027	R 92.03	R 105.00	R 121.53	R 152.20	R 198.21
Family - Lite	<input type="radio"/>	6	R 56 513	R 28 256	R 28 256	R 47.20	R 53.10	R 61.36	R 76.69	R 100.29
Family - Classic	<input type="radio"/>	6	R 113 027	R 56 513	R 56 513	R 83.77	R 95.57	R 110.91	R 139.22	R 181.69
Additional Child	<input type="radio"/>	6	R 20 000	R 10 000	R 10 000	R 12.50	R 12.50	R 12.50	R 12.50	R 12.50
Parent	<input type="radio"/>	12	R 56 513	R 28 256	R 28 256	R 147.48	R 175.79	R 281.98	R 451.87	R 723.22
ESTATE OVERHEADS PROTECTOR™										
Principal - Lite	<input type="radio"/>	0	R 50 862	n/a	R 8 477	R 40.12	R 46.02	R 53.10	R 67.26	R 88.49
Principal - Classic	<input type="radio"/>	0	R 101 724	n/a	R 16 954	R 69.61	R 79.05	R 92.03	R 115.63	R 151.02
Principal - Premium	<input type="radio"/>	0	R 203 448	n/a	R 33 908	R 132.14	R 151.02	R 174.61	R 218.27	R 284.34
ESTATE GAP COVER™										
Joint Life - Lite	<input type="radio"/>	0	R 1 130 272	Unlimited	R 1 130 272	R 56.63	R 64.89	R 81.41	n/a	n/a
Joint Life - Classic	<input type="radio"/>	0	R 2 260 544	Unlimited	R 2 260 544	R 108.55	R 123.89	R 155.74	n/a	n/a
Joint Life - Premium	<input type="radio"/>	0	R 3 390 816	Unlimited	R 3 390 816	R 154.56	R 176.98	R 221.81	n/a	n/a

WILL.U.REFER

Refer your friends and family members to draft their Last Will and Testament with us and take an optional Legacy Protection Plan™. You could get up to R 2 250 for three (3) successful referrals. By completing the details below, I authorise Capital Legacy to contact my friends and family members, as specified, to offer a complimentary consultation to draft their Last Will and Testament, calculate their real cost of dying and offer an optional Legacy Protection Plan™ to cater for the legal fees and expenses at death. Enter their details below.

Referee 1

First name

Relationship

Cell number

Email address

Referee 2

First name

Relationship

Cell number

Email address

Referee 3

First name

Relationship

Cell number

Email address

TERMS AND CONDITIONS: • Payment per successful referral R750, • Maximum amount of three (3) referrals per Client, • Payment conditions paid directly to the premium payer's bank account, • Referral conditions limited to referrals initiated directly by you, • Successful referral – a referee must take a premium paying Legacy Protection Plan™

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:	<input type="text"/>	Account type:	<input type="checkbox"/> Current	<input type="checkbox"/> Savings
Account number:	<input type="text"/>	Account holder:	<input type="text"/>	
Debit day:	<input type="text"/>	Commencing:	<input type="text"/>	<input type="text"/>

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 policy. 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 2022.

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 has been provided honestly and truthfully and has been done so voluntarily in order to facilitate the processing of this Application.

Signed at _____ on this _____ day of _____ 20 _____

Signature of Plan Holder and Payer

Signature of Alternate Payer

SEND TO CLIENT

SUBMIT