



## LEGACY PROTECTION PLAN™

## 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      

Lead reference:

     

Legacy Blueprint™ Planner reference:

L B -           

Consultant:

Booking Agent:

Intermediary:

Intermediary code:

I N T     

Preferred time to call the Client if there are any underwriting requirements?

e.g. Monday/after 5pm

Special comments to the Takaful Fund Operator:

## CLIENT INFORMATION

## SECTION A: PERSONAL DETAILS

Title and 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:

        

Monthly income: R

     Higher of own  
or Spouse

Smoking status:

Smoking

Non-smoking

Carbon Monoxide (CO) test result:

Gender:

Male

Female

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](http://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.

Do you have any worldwide assets?  Yes  No **If so, please complete Section I.**

## SECTION B: DISTRIBUTION OF YOUR ESTATE

Please choose which School of Thought your Islamic Will should follow:

**HANAFI**

I hereby confirm that I follow the Hanafi School of Thought and that my Estate shall be distributed in the following order of priority as commanded by the Islamic Law of Succession:

1. Payment of burial and shrouding expenses in accordance with Islamic Law.
2. Payment of all my debts including expenses of administering my Estate and any deferred Mahr.
3. Payment of all my religious liabilities and obligations and Wasiyyah (bequests), if applicable.
4. Payment of the residue of my Estate to my Heirs in accordance with the Islamic Law of Succession.

If any bequest(s), exceed one-third of my net Estate, then the order of priority will be as follows:

1. Religious obligations and liabilities;
2. Specific bequest(s); then
3. Nominated charity.

**SHAFI'I**

I hereby confirm that I follow the Shafi'i School of Thought and that my Estate shall be distributed in the following order of priority as commanded by the Islamic Law of Succession:

1. Payment of burial and shrouding expenses in accordance with Islamic Law.
2. Payment of all my religious liabilities and obligations, if applicable.
3. Payment of all my debts including expenses of administering my Estate and any deferred Mahr.
4. Payment of all my Wasiyyah (bequests), if applicable.
5. Payment of the residue of my Estate to my Heirs in terms of Islamic Law of Succession.

If any specific bequest(s), excluding religious liabilities and obligations, exceed one-third of my net Estate, the bequeathed amount / items shall be abated proportionately.

**OTHER:**

Please specify:

## SECTION C: MARRIAGE TYPE

Marriage type:  Not Married  In Community  ANC (Accrual)  
 ANC (No Accrual)  Common Law  Traditionally

## SECTION D: RELIGIOUS LIABILITIES AND OBLIGATIONS

Please complete the following, if applicable:

|   |   |   |
|---|---|---|
| 1 | Unperformed Salaah (Prayers)                                    | R |
| 2 | Unpaid Zakaah (Alms)  | R |
| 3 | Unkept Saum (Fasts)   | R |
| 4 | Unaccomplished Haj (Pilgrimage)                                 | R |
| 5 | Undischarged Qurbani (Animal Sacrifice)                         | R |
| 6 | Undischarged Sadaqatul-Fitr (Charity)                           | R |
| 7 | Outstanding Kaffarah (Expiation) for unfulfilled vows and oaths | R |

The proceeds of my religious liabilities and obligations will be bequeathed to the Muslim Judicial Bodies, as selected by my Executors, for Charity.

## SECTION E: WASIYAH TO NON-ISLAMIC HEIRS

Are there any further items or cash Wasiyyah you wish to bequeath to an individual who does not qualify as an Heir in terms of the Islamic Law of Inheritance? Examples of Islamic Heirs are a Mother, Father, Husband, Wife and Daughter.

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

## SECTION F: 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 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 Beneficiary's Heirs will automatically inherit the balance of any remaining capital as per Islamic Law of Succession.

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.

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

## 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, the Takaful Fund Operator, a Muslim personal Co-Trustee should be nominated. 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  
One of your nominated Executors should be Muslim.

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:

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: GENERAL TAZKIYA™ LEGACY PROTECTION PLAN™ QUESTIONS

Please complete truthfully and honestly.

1. What is your height (cm), weight (kg)?  cm  kg
2. Have you ever been declined, charged an extra contribution 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 childbirth, dental surgery, bone fractures, gastroenteritis or an appendectomy.  Yes  No
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?  Yes  No

## SECTION B: MYLEGACY COVER™ QUESTIONS

If you selected MyLegacy Cover™, 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)?  Yes  No
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)  Yes  No
14. Have you ever suffered from or been diagnosed with any neurological disorders, such as epilepsy, multiple sclerosis, Parkinson's disease, etc.?  Yes  No
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.?  Yes  No
16. Please indicate if any of the following are applicable to you:
  - (i) Have you ever tested positive for COVID-19 or  Yes  No
  - (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?  Yes  No
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 respiratory complications due to COVID-19?  Yes  No
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?  Yes  No
19. Other than the conditions that you have already disclosed, have you had any other illness, medical, surgical treatment or special investigations?  Yes  No
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 MyLegacy Cover™ contribution to a maximum of 25% of your quoted contribution, or where applicable, an initial three-month waiting period where COVID-19 is the cause of death?  Yes  No

Should we decline your application for MyLegacy Cover™, we will automatically accept your Application as a Tazkiya™ 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: MYABILITY COVER™ QUESTIONS

If you selected MyAbility Cover™, 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?  Yes  No
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.?  Yes  No
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?  Yes  No
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.?  Yes  No
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.?  Yes  No
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)  Yes  No
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 MyAbility Cover™ contribution to a maximum of 50% of your quoted contribution?  Yes  No

## 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                                     |
|-----------------|---------------------|-----------------------------------|----------------------------------|--|
|                 |                     |                                   |                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                 |                     |                                   |                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                 |                     |                                   |                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                 |                     |                                   |                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                 |                     |                                   |                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

## 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, please note 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

| NOMINATIONS                      |              |   |                  |
|----------------------------------|--------------|---|------------------|
| Beneficiary                      | 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 Covered Life            | Max entry age 75 |
| Parent 2                         |              | Only complete for each required Covered Life            | Max entry age 75 |
| Parent 3                         |              | Only complete for each required Covered Life            | Max entry age 75 |
| Parent 4                         |              | Only complete for each required Covered Life            | Max entry age 75 |

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

## SECTION B: MYLEGACY COVER™ BENEFICIARY DETAILS

Please complete the table below nominating your Beneficiaries.

If you would like the MyLegacy Cover™ Beneficiary to be the Estate, simply write Estate in the Relationship column. Please note: anything going to the Estate will be bequeathed to Islamic Heirs in accordance with Shari'ah principles.

If you would like a Living Trust or Company to be the Beneficiary, provide the name of the entity and the IT/registration number.

If you would like the MyLegacy Cover™ Benefit to be paid to a Trust created in terms of your Will, please complete all the Beneficiaries' details in the columns below, and select 'Y' in the 'In Trust in terms of my Will' column.

| NOMINATIONS  |              |                              |                            |                                       |                                      |
|--------------|--------------|------------------------------|----------------------------|---------------------------------------|--------------------------------------|
| % Allocation | Relationship | In Trust in terms of my Will |                            | Full Names and Surname or Entity Name | Date of Birth or Registration Number |
|              |              | <input type="checkbox"/> Y   | <input type="checkbox"/> N |                                       |                                      |
|              |              | <input type="checkbox"/> Y   | <input type="checkbox"/> N |                                       |                                      |
|              |              | <input type="checkbox"/> Y   | <input type="checkbox"/> N |                                       |                                      |
|              |              | <input type="checkbox"/> Y   | <input type="checkbox"/> N |                                       |                                      |

# 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, 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:  1<sup>st</sup>  15<sup>th</sup>  20<sup>th</sup>  25<sup>th</sup> Commencing:  0  1 /   /  2  0  2

Total monthly contribution as per your Legacy Blueprint™ Planner:

Disclaimer: By signing this Application Form, you acknowledge that you understand the information that has been provided in the Legacy Blueprint™ Planner and that the above contribution is the total monthly contribution, as per the Legacy Blueprint™ Planner referenced herein. Contributions 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

### TELEPHONIC DISCLOSURE - CONTRIBUTION 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 1<sup>st</sup> 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](mailto: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

# CONSULTATION AGENDA

Takaful Fund Member's full name:

## INTRODUCTION



### 1. Consultant

- Your Consultation Guide - Emailed and Explained
- Discuss: Where are you now, Intermediary Disclosure, Letter of Authority and Important Contact Details



### 2. Capital Legacy – The Takaful Fund Operator

- Introduce the Takaful Fund Operator and discuss the information available on the folder.

## TO BE DISCUSSED AND CONCLUDED DURING THIS MEETING



### 1. Shari'ah-compliant Last Will and Testament draft

- Tazkiya™ Legacy Protection Plan™ Application and Shari'ah-compliant Will Information
- Drafting of your Shari'ah-compliant Last Will and Testament
  - On-site drafting (preferable)
- Signing and Safekeeping Guidelines explained
- Free Will Collection Service explained



### 2. Calculation of legal fees and associated costs upon death

- Tazkiya™ Legacy BluePrint™ calculation done and explained (compulsory – must be logged onto Client profile)
- Discuss Plan Value and each Benefit



### 3. Tazkiya™ Legacy Protection Plan™ – Solution to the legal fees and associated costs

- Product information explained
- Application Form (compulsory – must be completed)
- Start date and debit order dates explained (Note: discuss 45-day free cover, if applicable)



### 4. Expect to receive the following:

- Shari'ah-compliant Last Will and Testament to be concluded and mailed after the consultation
- Tazkiya™ Legacy BluePrint™ Planner calculation – To be emailed and explained
- Plan Schedule and Plan Terms and Conditions to be mailed after consultation

## POST-MEETING PROCEDURES



### 1. Assistant Consultant

- Amendments to be done to the Shari'ah-compliant Last Will and Testament
- Follow up on missing information



### 2. Signing and Safekeeping

- Signing and Safekeeping Guidelines explained
- Email the scanned copy of your Islamic Will to us at [signedwills@tazkiya.co.za](mailto:signedwills@tazkiya.co.za). We will check it to ensure it has been signed correctly and we will keep a copy of your scanned Islamic Will linked to your profile.
- Place your original Last Will and Testament in the folder provided and keep it in a safe place. Communicate its whereabouts with your loved ones.
- For additional peace of mind, we recommend that you print and sign a second copy of your Islamic Will, which we will keep in our vault for you. To action this please courier, deliver or post your Last Will and Testament to us as per the Signing and Safekeeping Guidelines.



### 3. Free Will Collection Service

- Discuss the process of the Free Will Collection Service



### 4. Religious Liabilities and Obligations

- Discuss the need to update and communicate Religious Liabilities and Obligations, with your family.

Disclaimer: I hereby confirm that I have received my "Consultation Guide" electronically that contains all Disclosures, Intermediary information as well as Statutory Notices and contact information.

\_\_\_\_\_  
Contributing Member's signature

\_\_\_\_\_  
Consultant's signature