

## FREESTANDING GROUP LIFE ASSURANCE BENEFICIARY NOMINATION

EMPLOYER NAME \_\_\_\_\_

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### MEMBER DETAILS

MEMBER NO. \_\_\_\_\_ EMPLOYEE NO. \_\_\_\_\_

SURNAME \_\_\_\_\_ FIRST NAMES \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ IDENTITY NUMBER \_\_\_\_\_

RESIDENTIAL ADDRESS \_\_\_\_\_

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POSTAL ADDRESS \_\_\_\_\_

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TEL NO. (\_\_\_\_\_) \_\_\_\_\_ CELL PHONE NO. \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

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### NOTES

- The information disclosed within this document will be treated as confidential and will only be used for the purpose for which it is intended in terms of applicable legislation.
- In terms of the policy, the benefits will be paid to dependants and / or nominees, depending on the circumstances at your death.
- Please complete a new nomination form if you wish to make any changes to your previous nomination.
- Please provide contact details i.e. addresses and phone numbers of all dependants or nominees in the space provided.
- You may nominate a Trust or Beneficiary Fund in respect of a benefit payable to a minor beneficiary or a major beneficiary who is recognized in law as being unable to meet their daily care needs. Should you have nominated such a Trust or Beneficiary Fund please indicate these details overleaf.
- If you believe that there is any additional information of which the employer should be made aware of, please note this under "Additional Information" overleaf.
- This form should be completed in legible writing (please print) and must be returned to the employer. If the form has not been signed and dated, it will not serve as a valid nomination form.
- This form should always be updated and returned to the employer if any of your circumstances change, i.e. birth of a child, death of a spouse, etc.

EMPLOYER NAME \_\_\_\_\_ SURNAME AND INITIALS \_\_\_\_\_ IDENTITY NUMBER \_\_\_\_\_

**Dependants / Nominees**

A. Full Names	B. Relationship	C. Date of Birth	D. ID Number	E. Dependent or Nominee	F. Nature of Financial Dependence (if any)	G. % of Benefit	H. Residential Address	I. Contact Telephone Number
<b>Total</b>						<b>100%</b>		

ADDITIONAL INFORMATION: \_\_\_\_\_

**Trust (Full details of beneficiary in respect of whom a Trust has been created, is to be included under "Dependants / Nominees" above)**

Nominated Trust	Contact Details of Nominated Trust	A. Full Names of Beneficiary	B. Relationship of Beneficiary	C. Date of Birth of Beneficiary

**Column A:** Insert the person's surname and full names.  
**Column B:** Indicate your relationship with the person, i.e. spouse, son, etc.  
**Column C:** The date of birth should be indicated as follows: YYYY/MM/DD.  
**Column D:** Insert the person's identity number.  
**Column E:** State if financially dependent or a nominee

**Column F:** State the nature of financial dependence (if any).  
**Column G:** Indicate the % of the total benefit payable to the person i.e. 10%, 25%, etc. The total proportion must equal 100%.  
**Column H:** Insert the person's full address, if not the same as yours.  
**Column I:** Insert the person's contact phone number together with the area code, if not the same as yours.

SIGNED AT \_\_\_\_\_

DATE 

D	D	M	M	Y	Y	Y	Y
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MEMBER'S SIGNATURE \_\_\_\_\_