



# FELDDTA Funeral Policy APPLICATION FORM



I, the undersigned hereby apply for benefits, as indicated on **FELDDTA Funeral Policy** flyer.

**New application**  or **Alteration** on your existing membership  **Policy No:** \_\_\_\_\_

## 1. PERSONAL DETAILS OF MAIN MEMBER

Title	Full names										Surname								
ID No												Marital Status				Date of Birth			
Physical Address										Postal Address									
Cell No										Tel No (H)					Tel No (O)				
Work Name					Job/Occupation					E-Mail									

## 2. PERSONAL DETAILS OF SPOUSE

Title	Full names										Surname				
ID No												Date of Birth			

## 3. DEPENDANT CHILDREN

Names and Surname	Sex	Identity number or Date of Birth										Relationship					
1																	
2																	
3																	
4																	
5																	
6																	

## 4. EXTENDED MEMBERS

Names and Surname	Sex	Identity number or Date of Birth										Relationship					
1																	
2																	
3																	
4																	
5																	
6																	

## 5. BENEFICIARY

Names	Surname										Id no			
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Current Main Member's Age \_\_\_\_\_

Taxi Association name \_\_\_\_\_

**Member Plan**  **Staff Plan**

**Total Premium R** \_\_\_\_\_

## 6. DECLARATION

I, the undersigned hereby declare and warrant all information supplied herein, to be true and complete. I am aware, of any non-disclosure or misrepresentation of information which is material to the determination of the risk by SAFRICAN Insurance Company, may lead to the policy being declared null and void, in which case all premiums paid, will be forfeited. I am certain that the product which I am applying for meets my needs and feel that I have all the necessary information in order to make an informed decision in respect of the purchase thereof. I have been advised on the product features, premiums and all its terms and conditions. I was given a flyer which includes product features, premiums and all product terms and conditions. I also confirm that I have read and understood all the terms and conditions. I am fully aware that non payment of premiums will stop the cover and my claims might be declined.

**Signature of Main Member:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

