



ALLLIFE

BECAUSE ALL LIFE IS FOR LIVING

Authorised Financial Services Provider
Underwritten by Centriq Life Insurance Company Limited

New Advantage Life and New Advantage Life Disability

APPLICATION FORM

Fax: 010 591 6200 · Customer Service: 0861 255 5433

Email: applications@alllife.co.za

Post: AllLife (Pty) Ltd · PO Box 787159 · Sandton · 2146

- Instructions:**
1. Please complete in ink, print clearly, mark selections with X, and sign on every page where indicated.
 2. Please include a signed copy of the identity document (or residence permit) of the applicant with this application.
 3. Please include a signed copy of the indicative price sheet with this application.

A: INSURANCE REQUIREMENTS

What amount of cover are you applying for?

Example: R100 000:

What benefits are you applying for?

Life cover only: ☐ Life and Permanent Disability* cover: ☐

What product are you applying for?

Whole Life		Term		Loan Protectors	
Whole Life Cover**:	<input type="checkbox"/>	Whole Life Level Premium:	<input type="checkbox"/>	10 Year Term**:	<input type="checkbox"/>
				10 Year Level Premium	<input type="checkbox"/>
				10 Year:	<input type="checkbox"/>
				20 Year:	<input type="checkbox"/>

When would you like your cover to start? /

* The New Advantage Life Permanent Disability product accelerates the death benefit in the event of permanent disability of the Life Insured, as defined in the published terms and conditions of AllLife (Pty) Ltd. (henceforth referred to as "AllLife"). Acceleration means that payment of a permanent disability claim terminates the life policy and that no further benefits will be payable. The benefit payable in the case of permanent disability is 75% of the insured value in the case of the term cover, and whole life products, or 100% of the (declining) insured value in the case of the loan protector products.

** Premiums on 10 Year Term and Whole Life Cover options increase at 6% per annum.

I accept the monthly premium quoted by AllLife

INITIAL
HERE

B: LIFE INSURED'S DETAILS

Title:	<input type="text"/>	Initials:	<input type="text"/>	Surname:	<input type="text"/>
First name(s):	<input type="text"/>				
Maiden name:	<input type="text"/>			Marital status:	<input type="text"/>
ID no.:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Age (years):	<input type="text"/>	Date of birth:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cell no.:	<input type="text"/>	Alternative contact no.:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Postal address:	<input type="text"/>				
Residential address:	<input type="text"/>				Code: <input type="text"/>
Email address:	<input type="text"/>				
Preferred channel for correspondence:	Email: <input type="checkbox"/>		Post: <input type="checkbox"/>	Both email and post: <input type="checkbox"/>	
Highest qualification (please indicate with an 'X'):	Not Matriculated: <input type="checkbox"/>	Matriculated: <input type="checkbox"/>	Diploma: <input type="checkbox"/>	Degree: <input type="checkbox"/>	or Post Graduate: <input type="checkbox"/>
Employer name:	<input type="text"/>				
Your job title / description:	<input type="text"/>				
Industry type:	<input type="text"/>				
Gross monthly income:	<input type="text" value="R"/>	Gross monthly income of spouse:	<input type="text" value="R"/>		
Number of dependants:	<input type="text"/>				

Insured's Name:

Insured's Signature:

Title:	<input type="text"/>	Full name:	<input type="text"/>
ID / Reg. no.:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Tax status:	Natural person: <input type="checkbox"/>	Conforming company / CC: <input type="checkbox"/>	Non-conforming company / CC: <input type="checkbox"/> Contact name: <input type="text"/>
Cell no.:	<input type="text"/>	<input type="text"/>	Alternative contact no.: <input type="text"/>
Postal address:	<input type="text"/>		
Email address:	<input type="text"/>		
Please state the relationship of the Policy Owner to the Life Insured:	<input type="text"/>		

Full name: Tel / Cell:

When did you find out that you were HIV positive?	<input type="text" value="M"/> <input type="text" value="M"/> / <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
When last did you have an HIV monitoring blood test?	<input type="text" value="M"/> <input type="text" value="M"/> / <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Where was this test done? (Laboratory name and area)	<input type="text"/>
Are you on Antiretroviral Therapy (ART)?	<input type="text" value="Y"/> <input type="text" value="N"/> If 'YES', when did you start ART? <input type="text" value="M"/> <input type="text" value="M"/> / <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
If you are on ART, is this your 1 st , 2 nd or 3 rd ART drug regime?	1 st regime: <input type="text"/> 2 nd regime: <input type="text"/> 3 rd regime: <input type="text"/>
What Antiretroviral medication are you currently taking?	<input type="text"/> <input type="text"/>

I understand that this policy requires that I remain adherent in terms of the AllLife Adherence Policy and the AllLife Adherence Monitoring Policy in the document referenced NAXALSTF05. In general this requires that I go for blood tests every 6 months (*only CD4+ count prior to starting Antiretroviral Therapy ("ART") and both CD4+ count and Viral Load tests after starting ART*) and forward the results to AllLife. I will need to start appropriate ART within 60 days of having recorded a CD4+ count of below 200 cells / mm³ and, after starting ART, I must not have 2 consecutive blood tests showing a reduction in CD4+ count and / or a Viral Load above 1000 copies / ml. To prevent becoming non-adherent, I will be required to initiate Antiretroviral Therapy as prescribed by my healthcare practitioner and / or managed healthcare company and take the correct ART dose, at the correct time daily, every day. I understand that my cover will be limited to accident only cover if I am found to be non-adherent.

Name of your primary doctor: _____

Doctor's location (City): _____ Doctor's phone number: [][] [][] [][] [][] [][] [][]

Insured's Name: Insured's Signature:

H: DETAILS OF CURRENT LIFE INSURANCE PRODUCTS OWNED

Do you have any existing life cover or have you applied for other life cover recently (awaiting approval)?

Y

N

If 'YES', please provide details:

	Insurance Company	Life Cover (Rands)
Existing policies:	1:	
	2:	
	3:	
Applications not yet finalised:	1:	

I: BENEFICIARY INFORMATION

	First Names	Surname	Date of Birth	ID Number	Relationship	%
1:			DD / MM / YYYY			
2:			DD / MM / YYYY			
3:			DD / MM / YYYY			
4:			DD / MM / YYYY			
5:			DD / MM / YYYY			
6:			DD / MM / YYYY			
7:			DD / MM / YYYY			
8:			DD / MM / YYYY			
9:			DD / MM / YYYY			
10:			DD / MM / YYYY			
Total:						100%

Note: Where no beneficiaries are specified or the percentage total is less than 100%, the beneficiary of the policy for any excess amount will be the estate of the Policy Owner.

J: CONSENT OF SPOUSE TO BENEFICIARY NOMINATION (IF APPLICABLE)

The consent of the spouse is required only where the Policy Owner's spouse is not nominated as the sole beneficiary, AND: a) the marriage is in community of property, and b) the policy forms part of the joint estate.

I hereby consent to the nomination of the aforementioned beneficiary(ies).

Name of Policy Owner's Spouse

Signature of Policy Owner's spouse

D

D

/

M

M

/

Y

Y

Y

Y

K: DEBIT ORDER AUTHORISATION

AllLife will only process policies where payment is by debit order (payments by credit card or cash are not accepted).

Account holder name:

Account holder ID:

Bank name:

Account number:

Account type:

What day of the month do you usually get paid:

15th

20th

25th

Last day of the month

Other (please specify):

Preferred debit order day of the month:

15th

20th

25th

Last day of the month

Insured's Name:

Insured's Signature:

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Authorised Financial Services Provider
Underwritten by Centriq Life Insurance Company Limited

K: DEBIT ORDER AUTHORISATION (CONTINUED)

I, the undersigned, request AllLife to arrange with my bank to collect premiums in terms of the policy provisions (as they may be amended from time to time) against my bank account, wherever it may be, by means of a debit order. I authorise AllLife to draw against this account all amounts due in terms of this application. This authorisation is to remain in force until terminated by AllLife or myself. I agree to advise AllLife of any changes that may occur. I warrant that the information supplied is true and correct.

I understand that if my debit order falls on a Sunday or any other non-banking day, AllLife will attempt to debit between the previous banking day and the next banking day. I acknowledge that tracking may be used in collecting my monthly premium and that this means that AllLife will endeavour to collect my monthly premium over a maximum tracking period of 32 days from my chosen debit day. I understand that if AllLife fails to successfully collect my monthly premium on my chosen debit day, the debit will recheck my available funds over the tracking period and, in that way, I will avoid RD charges if payment is made on a later tracked day. **I understand that, for confidentiality reasons, my bank statement reference will include the words "EPIC4" or "LifeCover" and will not say "AllLife".**

Signature of account holder:

D	D	/	M	M	/	Y	Y	Y	Y
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If account holder is not the insured, please state relationship to client:

L: MY MEDICAL HISTORY (EXAMPLES BELOW ARE NOT EXHAUSTIVE)

1. Do you or have you ever suffered from:

a. Any heart, circulatory or blood vessel related disorders? (Examples include: heart attack, shortness of breath, valve problems, chest pain, high blood pressure, stroke, etc.)

Y	N
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b. Any disease of the lungs? (Examples include: chronic cough, TB, pneumocystis pneumonia, etc.)

Y	N
---	---

c. Any other major organ or system disorders for which you have sought medical treatment, such as disorders of the:

i. digestive system? (Examples include: chronic diarrhoea (more than 1 month), candidiasis of the oesophagus, etc.)

Y	N
---	---

ii. pancreas or endocrine system? (Examples include: diabetes, pituitary disorders, pancreatitis, etc.)

Y	N
---	---

iii. kidneys, bladder or spleen? (Examples include: kidney stones, blood / protein in the urine and / or splenomegaly, etc.)

Y	N
---	---

iv. blood system? (Examples include: leukaemia, anaemia, etc.)

Y	N
---	---

v. reproductive organs? (Examples include: ovarian cysts, testicular problems, etc.)

Y	N
---	---

vi. liver? (Example include: hepatitis, cirrhosis, etc.)

Y	N
---	---

2. Do you or have you ever suffered from:

a. Any diseases or conditions which require or required medication? (Examples include: diabetes, high cholesterol, etc.)

Y	N
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b. Any disorders of the skin, muscles, bones, joints, or connective tissue? (Examples include: back and neck problems, gout, osteo-arthritis, rheumatoid arthritis, etc.)

Y	N
---	---

c. Any disorder of the neurological system? (Examples include: epilepsy, migraine, brain aneurysms, etc.)

Y	N
---	---

d. Any disorders of the ears, nose, throat or eyes? (Examples include: hearing loss, defective vision (other than short or long sightedness), retinal detachment, hoarseness, chronic sinusitis, etc.)

Y	N
---	---

e. Any disorders specifically related to HIV or AIDS? (Examples include: unexplained severe weight loss (over 10% of presumed or measured body weight), persistent oral candidiasis, pulmonary tuberculosis, meningitis, Kaposi sarcoma, etc.)

Y	N
---	---

3. Have you ever been diagnosed with a cancer, growth, or tumour? (Examples include: lymphoma, enlarged lymph nodes / glands, etc.)

Y	N
---	---

4. Have you ever been diagnosed with a psychiatric issue? (Examples include: depression, anxiety, etc.)

Y	N
---	---

5. Are you currently pregnant? (answer only if female)

Y	N
---	---

6. How tall are you? (meters)

7. How much do you weigh? (kilograms)

8. Have you ever been involved in any form of accident which required medical attention?

Y	N
---	---

9. Have you ever undergone, or do you intend to undergo any operations?

Y	N
---	---

Insured's Name:

Insured's Signature:

[illegible]

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M: BROKER / AGENT DETAILS (ONLY TO BE FILLED IN IF APPLICANT HAS BEEN ASSISTED BY A BROKER / AGENT)

Broker name:	<input type="text"/>	Brokerage name:	<input type="text"/>
AllLife Broker code:	<input type="text"/>	AllLife Broker code:	<input type="text"/>
Contact number:	<input type="text"/>	Email address:	<input type="text"/>
FSP number:	<input type="text"/>		

Disclosure of commission earned on this policy:

I acknowledge that I have been informed by the above Broker / Agent that (s)he (or his / her Brokerage) will receive a percentage of the sum of all my anticipated monthly premium payments in the form of a commission associated with the sale of this insurance policy as indicated on my indicative price sheet. I understand that the commission will be paid by AllLife to the Broker / Agent out of the proceeds of my monthly premiums as per the signed quotation attached.

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N: DECLARATION AND SIGNATURE

- I understand that I am applying for a life insurance policy underwritten by Centriq Life Insurance Company Ltd., and administered by AllLife.
- I hereby confirm that I have **not** been advised to replace any existing policies by AllLife.
- I understand that **my cover will only be initiated on receipt of the first premium and that I will have 3 months from the start of the policy in which to successfully complete and pass AllLife's underwriting process.** This usually involves the submission of a blood test, but may also involve further medical, lifestyle and / or financial questions as well as other medical tests / examinations.
- I understand that I have full cover, excluding any pre-existing conditions until, I successfully complete and pass AllLife's underwriting process.
- I understand that my cover will be limited to accident only cover should I fail to complete and pass AllLife's underwriting process within the prescribed 3 month period.
- I understand that, if I do not inform AllLife of any material change in circumstances between submitting this application form, payment of my first premium, and inception of my policy, I will not be covered.
- I understand that my policy is governed by AllLife's standard business practices.
- I hereby confirm that I have read, understood and agree with all the points in both the AllLife Adherence Policy and the AllLife Adherence Monitoring Policy in the document referenced NAXALSTF05 (Please detach and keep).
- I understand that to be adherent I must comply with the AllLife Adherence and Monitoring Policies (document referenced NAXALSTF05).
- In general this requires that I go for blood tests every 6 months (only CD4+ count prior to starting ART and both CD4+ count and Viral Load tests after starting ART) and forward the results to AllLife. I will need to start appropriate ART within 60 days of having recorded a CD4+ count of below 200 cells / mm³ and, after starting ART, I must not have 2 consecutive blood tests showing a reduction in CD4+ count and / or a Viral Load above 1000 copies / ml. To prevent becoming non-adherent, I will be required to initiate Antiretroviral Therapy as prescribed by my healthcare practitioner and / or managed healthcare company, take the correct dose, at the correct time daily, every day.
- I understand that I **am responsible for funding all medical costs** associated with meeting the AllLife Adherence Policy and the AllLife Adherence Monitoring Policy including, but not limited to, the costs associated with blood tests and obtaining Antiretroviral Therapy.
- I understand that personal information, including special health information, is being collected for use by AllLife, the responsible party, for the purposes of assessing my risk related to the provision of insurance and for determining which products would be suitable for me (including, but not limited to, for the purposes of direct marketing).
- I understand that supplying such information is voluntary and that failure to provide the required information could result in failure to obtain the required product. I hereby consent to the processing of all information received by AllLife. I understand that I have the right to access my personal information that is held by AllLife.
- I hereby confirm that I **have consented to AllLife obtaining personal information relating to my historical and future blood and other medical test results.**
- I hereby confirm that I have consented to AllLife sharing my answers on this application and any data that they may receive with the appropriate regulatory authorities and, for the purpose of appropriately assessing risk, this includes, but is not limited to, sharing information with the product's reinsurer and Centriq Life Insurance Company Ltd.
- I indemnify AllLife (Pty) Ltd, Centriq Life Insurance Company Ltd., any disclosing parties, their shareholders, their directors, agents and employees against any claims arising from the above disclosure.
- I hereby confirm that I have consented to AllLife transferring this policy to any underwriter if, in their opinion, it is appropriate to do so.
- I understand that there will be an administrative charge should I rescind / cancel this policy after the first instalment has been deducted from my bank account.
- I understand that AllLife will make use of electronic communications, where available, to communicate with me with regard to the administration of this policy.
- I understand that in order to claim benefits under this policy, at least one premium must have been paid during the six month period preceding the claim event. In addition, the benefits claimable under this policy would be reduced in proportion to the number of monthly contribution(s) that were unpaid during this period (or whatever period has elapsed since policy inception, where this is less than six months).
- I understand the monthly premium and any administration fees are subject to change with 30 days notice at any time throughout the duration of the policy.
- I understand that this policy has **no surrender value** (there is no savings component), and that if I have selected a finite term policy and there is no claim within the term of the policy, there will be no payout at the end of the term.
- I understand that, if I have selected a combined Life and Permanent Disability policy, the disability benefit is an accelerated death benefit in the event of permanent disability of the life insured, as defined in AllLife's published terms and conditions. Acceleration means that payment of a permanent disability claim terminates the policy, and no further benefits will be payable. I understand that the benefit payable in the case of permanent disability of the life insured is 75% of the insured value in the case of Whole Life and Term Cover products, or 100 % of the (declining) insured value in the case of the loan protector products.
- Any policy granted and the interpretation of such policy shall be governed by the laws of the Republic of South Africa and be subject to the jurisdiction of the High Court of the Republic of South Africa.
- I warrant that the information supplied by me to AllLife is true and correct.

Signature of Life Insured:	<input type="text"/>	D	D	/	M	M	/	Y	Y	Y	Y
Signature of Policy Owner (if different):	<input type="text"/>	D	D	/	M	M	/	Y	Y	Y	Y

Please attach a signed copy of the ID Document of the applicant with this application

CONSENT TO LIMITED DISCLOSURE OF MEDICAL INFORMATION (TO BE COMPLETED BY THE LIFE INSURED)

I, the undersigned

Full Names:

ID Number:

Address:
 Code:

Hereby state as follows:

- 1: I hereby authorise AllLife to obtain medical information from any doctor, healthcare provider or organisation (such as a managed healthcare organisation) which has particulars of medical or clinical tests or examinations performed on me or will obtain particulars in performing such tests or examinations at any stage in future. I understand that such authorisation given by me will be irrevocable, i.e. that I will not be entitled at any stage to inform AllLife that they may no longer obtain or have access to such particulars.
- 2: I hereby further authorise AllLife to furnish or disclose any or all details of the medical information regarding myself, which they have obtained in terms of this authorisation, to any insurance company with which they decide to negotiate at any stage in order to endeavour to secure an insurance policy which will provide cover to me.
- 3: I acknowledge and agree that my consent and authorisation contained in this document in particular also applies to my HIV status and / or any diagnosis of and / or treatment for AIDS or HIV. This authorisation will cover the results of any past or future medical or clinical tests, including (but not limited to) blood tests known as CD4+ count and RNA viral load blood tests and related monitoring tests, which AllLife may regard as necessary to obtain or require at the application stage or on an ongoing basis.
- 4: This authorisation by me specifically also covers pathology laboratories which at any stage in the past tested and reported on or will in future test and report on blood, urine or other bodily substance or tissue obtained from me.
- 5: I am aware of the fact that, in general, disclosures made by doctors, laboratories, hospitals, other healthcare providers and organisations such as medical schemes, medical scheme administrators and managed healthcare organisations, of personal, medical details of patients to other parties without the patient's consent is not only illegal but may also be professionally unethical. I am aware that, amongst other remedies available, an aggrieved person may claim damages for such unauthorised disclosures.
- 6: I realise, however, that by giving the irrevocable consent and authorisation contained in this document, I shall have no claim whatsoever against AllLife or any doctor, pathology laboratory, hospital, other healthcare providers and / or organisations mentioned in this document who or which will furnish AllLife with the type of medical or clinical information mentioned in this document. I clearly understand that I hereby waive, i.e. abandon, any claim for damages or compensation that I might otherwise have had against such a person or organisation. In particular I also waive any claim that I might otherwise have had against employees, directors, agents, shareholders or members of AllLife as well as of any doctors or other bodies or organisations mentioned in this paragraph or their employees.
- 7: I acknowledge that before signing this document I was given the opportunity by AllLife or a person acting on its behalf, to discuss the content of this document, its implications and effect, and that all questions I have had were answered to my satisfaction.
- 8: The provisions of this document constitute the whole of the agreement between me and AllLife in respect of the matters referred to in this document and the said provisions may only be waived, varied or amended in terms of another written document signed by me and by an authorised representative of AllLife.
- 9: I acknowledge that I have read and fully understood, and freely consent to, the provisions of this document.

Signature:

Signed at (Place): On: / /

STATUTORY NOTICE TO LONG-TERM INSURANCE POLICYHOLDERS

IMPORTANT DISCLOSURE AND OTHER LEGAL REQUIREMENTS: PLEASE READ CAREFULLY

As a long-term insurance policyholder, or prospective policyholder, you have the right to the following information:

<p>1: The intermediary (insurance broker or representative) dealing with you must at the earliest reasonable opportunity disclose:</p> <p>A: Name, physical and postal address and telephone number B: Legal capacity: independent or representative for brokerage C: Concise details of relevant experience D: Insurance products that may be sold E: Insurers whose products may be marketed F: Indemnity cover held – Yes / No G: Shareholdings in insurers if 10% or more H: Name of insurers from which the intermediary received 30% or more of total commission and remuneration during past calendar year</p> <p>The intermediary must be able to produce proof of contractual relationship with and accreditation by the insurers concerned.</p>	<p>2: Your right to know the impact of the decision you elect to make:</p> <p>A: The intermediary or insurer dealing with you must inform you of (1) The premium you may be paying and (2) The nature and extent of benefits you may receive B: If the benefits are linked to the performance of certain assets: (1) How much of the premium will go towards the benefit, & (2) To what portfolio your benefits will be linked C: The possible impact of this purchase on your finances D: The possible impact of this purchase on your other policies (affordability) E: The possible impact of this purchase on your investment portfolio (affordability) F: The flexibility of changes you may make to the proposed contract G: The contract terms of the product you intend to purchase</p> <p>(It is very important that you are sure that the product or transaction meets your needs and that you feel you have all the information you need to make a decision.)</p>		
<p>3: Your right when being advised to replace an existing policy:</p> <p>You may not be advised to cancel a policy to enable you to purchase a new policy or amend an existing policy unless:</p> <p>A The intermediary identifies the policy as a replacement policy B The implications of cancellation of the policy are disclosed to you such as: (1) The influence on your benefits under the old policy (2) The additional costs incurred with the replacement C The insurer that issued the original policy will contact you. You are advised to discuss the matter with its representative.</p> <div style="border: 1px solid black; padding: 5px; text-align: center;"> <p>ALLLIFE DOES NOT AND HAS NOT ADVISED YOU TO REPLACE ANY EXISTING POLICY.</p> </div>	<p>4: Your right to be informed by the insurer:</p> <p>The insurer will forward you documentation confirming policy details as discussed in paragraph 2 of this Notice, which will also include:</p> <p>A: The name of the insurer B: The product being purchased C: The cost in Rands of the transaction and specifically: - The loadings, if any - The initial expense, and - The amount of commission and other remuneration being paid to the intermediary D: In the case of policies with an investment element, the ongoing expense and any other fees or charges payable E: The summary in terms of section 48 of the Long-term Insurance Act, 1998 F: The contact number and address of the complaints and compliance officers of the insurer.</p>		
<p>5: Your right to cancel the transaction:</p> <p>In most cases, you have a right to cancel a policy in writing within 30 days after receipt of the summary contemplated in section 48 from the insurer. The same applies to certain changes you may make to a policy. The insurer is obliged to confirm to you whether you have this right and to explain how to exercise it. Please bear in mind that you may not exercise it if you have already claimed under the policy or if the event, which the policy insures you against, has already happened. If the policy has an investment component, you will carry any investment loss.</p>	<p>6: Important Warning</p> <ul style="list-style-type: none"> It is very important that you are sure that the product or transaction meets your needs and that you feel you have all the information you need before making a decision It is recommended that you discuss with the intermediary or insurer the possible impact of the proposed transaction on your finances, your other policies or your broader investment portfolio. You should also ask for information about the flexibility of any proposed policy. Where paper forms are required, it is advisable to sign them only once they are fully completed. Feel free to make notes regarding verbal information, and to ask for written confirmation or copies of documents. Remember that you may contact either the Long-term Insurance Ombudsman or the registrar of Long-Term Insurance, whose details are set out below, if you have any concerns regarding a product sold to you or advice given to you. 		
<p>7: Particulars of Long-term Insurance and FAIS Ombudsmen</p> <table border="0"> <tr> <td style="vertical-align: top;"> <p>Long Term Insurance Ombud</p> <p>Private Bag X45 Claremont Cape Town 7735</p> <p>Tel: 0860-662-837 / (021) 657-5000 email: info@ombud.co.za website: www.ombud.co.za</p> </td> <td style="vertical-align: top;"> <p>FAIS Ombud</p> <p>P. O. Box 74571 Lynnwood Ridge 0040</p> <p>Tel: 0860-324-766 / (012) 470-9030 Fax: (012) 348-3447 email: info@faisombud.co.za</p> </td> </tr> </table>	<p>Long Term Insurance Ombud</p> <p>Private Bag X45 Claremont Cape Town 7735</p> <p>Tel: 0860-662-837 / (021) 657-5000 email: info@ombud.co.za website: www.ombud.co.za</p>	<p>FAIS Ombud</p> <p>P. O. Box 74571 Lynnwood Ridge 0040</p> <p>Tel: 0860-324-766 / (012) 470-9030 Fax: (012) 348-3447 email: info@faisombud.co.za</p>	<p>8: Particulars of Registrar of Long-term Insurance</p> <p>Financial Services Board P O Box 35655 Menlo Park 0102 Tel: (012) 428-8000 Fax: (012) 347-0221</p> <p>FSB registration details:</p> <p>AllLife (Pty) Ltd: _____ FSP 4946 Centriq Life Insurance Company Ltd: _____ FSP 7370</p>
<p>Long Term Insurance Ombud</p> <p>Private Bag X45 Claremont Cape Town 7735</p> <p>Tel: 0860-662-837 / (021) 657-5000 email: info@ombud.co.za website: www.ombud.co.za</p>	<p>FAIS Ombud</p> <p>P. O. Box 74571 Lynnwood Ridge 0040</p> <p>Tel: 0860-324-766 / (012) 470-9030 Fax: (012) 348-3447 email: info@faisombud.co.za</p>		
<p>Insured's Name: <input type="text"/></p> <p>Policy Owner Name (if different): <input type="text"/></p>	<p>Insured's Signature: <input type="text"/></p> <p>Policy Owner Signature: <input type="text"/></p>		

STATUTORY DISCLOSURE NOTICE IN TERMS OF THE FINANCIAL ADVISORY AND INTERMEDIARY SERVICE ACT NO 37 OF 2002

In terms of the Financial Advisory and Intermediary Services Act, the following information must be disclosed to you as our client. Please read the information carefully.

Information on the Financial Services Provider and Binder Holder:

Name: All Life (Pty) Ltd. (AllLife)
 Trading name: AllLife
 Registration number: 2004 / 008283 / 07
 FSP Registration number: 4946
 Postal address: P O Box 787159, Sandton, 2146
 Physical address: 14th Floor, Libridge Building, 25 Ameshoff Street, 2001
 Telephone number: 0861 255 543
 Facsimile number: 0866 126 595
 Internet address: www.alllife.co.za
 E-mail address: customercare@alllife.co.za
 Compliance Officer: Avron Urison / Yvette Du Plessis
 Telephone number: 0861 255 543

Information on the Product Supplier:

Name: Centriq Life Insurance Company Limited (Centriq)
 Registration number: 1943 / 016409 / 06
 FSP Registration number: 7370
 Postal address: P O Box 55674, Northlands, 2116.
 Physical address: The Oval, Second Floor, 52 Corlett Drive, Illovo, 2196
 Telephone number: 011 268 6490
 Compliance Officer: The internal compliance officer is assisted by Compli-Serve (SA) (Pty) Ltd
 Facsimile number: 011 268 6495
 E-mail address: compliance@centriq.co.za
 Telephone number of Complaints Department: 011 268 6490
 E-mail address: faiscomplaints@centriq.co.za /
 claimscomplaints@centriq.co.za

AllLife (Pty) Ltd is a company registered in terms of the Companies Act and is an authorised Financial Services Provider. AllLife has appointed representatives to act on its behalf in rendering financial services to its clients. Should an AllLife representative physically call on you, please ask the representative to show you his / her letter of authorisation. AllLife accepts responsibility for the activities of duly authorised representatives that are performed under the supervision of an AllLife key individual, within the scope of and in the course of their employment as a representative of AllLife.

AllLife has been authorised to provide financial advisory and intermediary services in respect of Long-term Insurance: Categories A and B. The licence conditions or restrictions as well as any exemptions which are applicable to AllLife are listed below.

AllLife holds professional indemnity insurance to the value of R 3 million. AllLife is not required to and nor does it hold guarantees or fidelity insurance cover.

AllLife designs, distributes and administers its unique set of life insurance products through a cell arrangement with Centriq Life Insurance Company Limited, which provides the regulatory framework necessary for AllLife to provide insurance. There are no conditions or restrictions imposed by Centriq in respect of the financial products or services that may be rendered by AllLife. AllLife does not have contractual relationships with any other product supplier (AllLife earns more than 30% of its total remuneration from Centriq).

In order to manage and deliver life insurance products to people living with HIV, AllLife offsets its costs against earnings of R0.25 per rand of premium in the form of binder fees which includes policy management, underwriting management and claims processing fees. In addition, AllLife earns adherence management fees of R0.25 per rand of premium and commission of R0.04 per rand of premium. The policy fee covers the cost of premium collection and associated administration.

In terms of the conflict of interest provisions of the FAIS Act 37 of 2002, no actual or potential conflicts of interest were identified. This is reviewed at least annually and reported on to the Financial Services Board. A conflict of interest management policy is available to clients upon request. AllLife's complaints process and policy are also available to clients from AllLife's offices upon request.

Conditions and Restrictions of Licence

1: The licence authorises the licensee to carry on business in respect of

Financial advisory services as Financial Services Provider in respect of the following products:

Long-term Insurance: Category A, B

Financial intermediary services as Financial Services Provider in respect of the following products:

Long-term Insurance: Category A, B

2: Further conditions / restrictions:

- A: The financial services provider must inform the Registrar in writing, by facsimile or in an appropriate electronic format, within 15 days after the change has taken place, of any change in respect of business information of the financial services provider as provided in Form FSP1, FSP3, FSP4, FSP9, FSP10, FSP10A or FSP11, respectively, of the Application Form which was submitted by the provider for purposes of obtaining a licence, and in particular relating to the provider's representatives, auditor, compliance officer or any foreign clearing firm or foreign forex service provider involved (if any) and nominee company or independent custodian involved or the shareholders, directors or trustees of any such company or custodian (if any).
- B: The financial services provider must at all times during the currency of the provider's licence maintain the services of any key individual or key individuals mentioned in the information submitted on the said Application Form, and must as regards changes in respect of such information relating to a key individual, or appointment of a new key individual, of the provider, in addition to acting also in such cases in accordance with the procedure and time limit set out in Condition 1, also ensure full compliance with section 8(4)(b) of the Act, the provisions of which must be regarded as included in this Condition.
- C: The financial services provider must within one month of the date contemplated in section 7 of the Act, submit a copy of the register kept in terms of section 13(3) of the Act to the Registrar, and must thereafter in accordance with the procedure and time limit set out in Condition 1, inform the Registrar of any change effected to the details as contained in that register.
- D: The financial services provider must not in any manner change the name of the financial services business as reflected on the licence concerned, or carry on any financial services business under such a changed name, unless- (a) the provider has fully complied with the provisions of any other law than the Act which regulates such change of business name (if any); (b) the provider has fully disclosed to the Registrar the details of such compliance with such other law; (c) the Registrar is satisfied that such change of name is otherwise lawful and has approved such change of name; and (d) the Registrar has issued to the provider an appropriately amended licence under the provisions of section 8(5)(b)(i) of the Act.
- E: The financial service provider must at all times ensure that any financial product in respect of which the provider intends to render a financial service, qualifies as a financial product contemplated in the Act and is or will be lawfully issued by the relevant product supplier by virtue of an authority, approval or right granted to such supplier under a law as contemplated in the definition of 'product supplier' in section 1(1) of the Act.

3: Further conditions / restrictions:

Exemption of licensees as regards display certified copies of licensees (Board Notice 40 of 2004).

Exemption of licensees as regards references to licensees in business documentation (Board Notice 71 of 2004).

Insured's Name:

Insured's Signature:

Policy Owner Name (if different):

Policy Owner Signature:

ALLIFE ADHERENCE AND ADHERENCE MONITORING POLICY

PLEASE KEEP THIS PAGE FOR YOUR RECORDS

This Adherence and Adherence Monitoring Policy can change on 30 days notice at AllLife's sole discretion, based on reasonable medical practice.

A: AllLife Adherence Policy

The following adherence protocol must be followed to maintain benefit levels under the Advantage Life product range. Please note that, while the AllLife adherence policy requires that the Life Insured goes for tests every 6 months, the HIV Clinicians Society recommends testing every 3 months. The Life Insured should discuss more regular testing with their treating doctor and / or managed health care company.

The Life Insured is required to go for regular blood tests as specified below, and to ensure that AllLife is provided with copies of these test results. **Make sure to include "AllLife" as a "copy doctor" when you fill in the form at the testing Laboratory for the testing Laboratory to forward a copy of your results to AllLife:**

- a. Prior to initiating ART, the Life Insured is required to be tested for, and to provide to AllLife, their CD4+ count every 6 months.
- b. The Life Insured must enrol on ART within sixty (60) days after a CD4+ count of below 200 cells / mm³ has been recorded (the HIV Clinicians Society recommends starting ART at a CD4+ count of 350 cells / mm³ or below), or the Life Insured has contracted an AIDS defining illness. Details of the original ART regimen must be provided to AllLife within 30 days of initiation of ART (all ART regimens must include 3 or more antiretroviral agents, capable of suppressing HIV virus replication and must be as prescribed by a clinician).
- c. After starting ART, the Life Insured is required to be tested for, and to provide to AllLife, their RNA viral load and CD4+ count every 6 months.
- d. The Life Insured's blood test results after initiating ART must be as specified in the Adherence Monitoring Policy in order to remain adherent.
- e. Although AllLife will endeavour to access all blood test results directly from the testing laboratory or the Life Insured's managed health care company (if any), it will be the responsibility of the Life Insured to provide the data to AllLife on a 6 monthly basis. If AllLife does not receive the blood test results, the Life Insured will be defined as non-adherent.
- f. The Life Insured must provide AllLife with proof that they have started ART by providing a receipt for purchase of anti-retrovirals within 90 days of receiving test results indicating a CD4+ count of below 200 cells / mm³. Such proof must:
 - i. be computer generated
 - ii. include the Life Insured name
 - iii. include the name of the selling or providing entity
 - iv. include the date of the sale or provision of the anti-retrovirals
 - v. include the details of the antiretroviral drugs purchased
- g. The process described in (f) above must be repeated at each change of ART regimen.

B. AllLife Adherence Monitoring Policy

Adherence, as defined, is the taking of all appropriate ART medication (defined as medication which prevents viral replication and is approved by the HIV Clinicians Society) in the appropriate dosage at the appropriate time every day. AllLife utilises the following protocol to check adherence after the Life Insured has started ART: Either of the RNA viral load condition or the CD4+ count condition shall be sufficient to indicate non-adherence.

The Life Insured will be deemed to be non-adherent, unless they are on their third ART regimen, if either:

- a. the RNA viral load test results do not show a reduction in RNA viral load of at least 1 log (measured against their RNA viral load prior to starting ART), and a RNA viral load of below 5000 copies / mL, by the second scheduled test post ART initiation, unless the Life Insured has changed their regimen before the second scheduled test (scheduled tests occur once every 6 months, although the Life Insured may undergo more frequent testing if required by their treating doctor). In the case where the Life Insured has changed their ART regimen, the Life Insured must show a reduction in RNA viral load of at least 1 log (measured against their RNA viral load prior to initiating ART), and an RNA viral Load of below 5000 copies / mL, by their third scheduled test post ART initiation. Proof will need to be submitted regarding change of regimen; or
 - b. from 12 (twelve) months after initiating ART, the RNA viral Load is over 1000 copies / mL for any two consecutive scheduled tests.
- OR IF:**
- c. CD4+ count drops by more than 50 cells / mm³ or 20% of baseline* whichever is smaller over a 12 month (or shorter) period; and
 - d. Two consecutive blood tests have shown a downward trend in the Life Insured's CD4+ count.

Then the Life Insured will be deemed to be non-adherent unless the Life Insured is on their third ART regimen.

In addition, if no blood test is conducted within thirty days of the stipulated date (every 6 months), then the Life Insured is deemed to be non-adherent until they provide AllLife with their test results (irrespective of having started ART). If these test results show that CD4+ count has dropped by less than 50 cells / mm³ or 20% of baseline* whichever is smaller, then the Life Insured will be deemed to be adherent and their cover will be restored appropriately. The testing interval will remain that of the original and will not be based off of the new test date.

In cases where laboratory results are unusual or discrepant in the opinion of AllLife, these will be evaluated on a case-by-case basis by AllLife and, if necessary, repeat tests may be required.

All CD4+ count and RNA viral Load tests must be done at SANAS or ASISA approved laboratories.

AllLife must be informed of any changes in ART regimen and such change may only be with the written approval or instruction of the Life Insured's healthcare provider.

The Life Insured will be defined as adherent should their RNA viral Load be below 500 copies / mL and their CD4+ count be above 500 cells / mm³, irrespective of variations in their CD4+ count as described above.

Please note: Rulings in regard to the above protocol will be subject to appeal. All appeals must be lodged in writing with AllLife within sixty (60) days of any non-adherence ruling being communicated to the Life Insured.

*Each customer has a baseline CD4+ count determined as the higher of (i-iii) as follows:

- i. CD4+ count at initiation of ART (must initiate at CD4+ count less than 200 cells / mm³)
- ii. Highest post ART initiation test score; or
- iii. If already on ART at inception of cover, CD4+ count at initiation of cover or highest test score post initiation of cover, whichever is higher.