SOMA Plan Application Form



INSURE INVEST HEALTH

Liberty Life Assurance Uganda Limited -

Mariba Building, 3rd Floor, Plot 17, Golf Course

Reg.No. 75913

																					Road, Kololo Kampala, Uganda PO Box 22938, Kampala, Ugan t +256 414 233 794 f +256 414 w www.liberty.co.ug								ında				
NEW APPLICATION		AMEND	MEN	Т							P	OLIC'	/ NUN	ИBER	R (Fo	r Ame	ndme	nts)															
KINDLY ANSWER ALL QUESTIONS IN F	ULL /	AND ATTA	ACH S	SUPP	ORTI	NG I	DOC	UME	NTAT	ΓΙΟΝ	I AS L	ISTE	D BE	LOW	<i>l</i> .																		
Certified copy of identity document	/ valid	d passport																															
Proof of a valid Ugandan bank accou	nt in l	Policyhold	er's n	ame																													
Proof of residence (must not be olde	r thai	n 3 month	s)																														
Proof of source of funds / wealth / in	come	9																															
Signed quotation																																	
For Amendments only attach the document related to the required amendment																																	
POLICYHOLDER DETAILS																																	
First name																									lni	tials							
Surname																																	
Date of birth	D	D -	M	M] - [Υ	Υ	Υ	Υ																	Ge	nder	М] [F			
Form of identification (tick one)		Identity	docu	ment	t			Va	lid pa	sspo	ort Date o								of is:	sue	D	D	-	М	М	_	Υ	Υ	Υ	Υ			
ID /Passport number														Marital Status																			
Telephone number (Work/ Home)																				bile													
Email address																																	
Occupation																																	
Physical address																																	
Postal address																																	
Are you a foreign citizen and/or national and																												Υ		N			
If 'Yes', and you are a U.S. citizen/national/re	sider	nt for tax p	urpos	ses in	the U	IS, pl	ease	com	olete	the 'S	Self-C	ertifi	catior	n Dec	lara	tion fo	r an Ir	ndividu	ual Fo	orm.													
CHILDREN DETAILS (Please provide	de th	e birth ce	rtifico	ite fo	or eacl	h chi	ild as	liste	d)																								
FULL NAME	S					ı	DATE	OF	BIRTI	Н				RELA	ATIC	NSHI	Р			GI	ENDE	R.			CUF	RREN	IT GR	ADE					
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POLICY DETAILS (Only complete this section for amendments)																															
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Premium	Ugx																H	remiu	ım Fr	equei	ncy (I ICK C	one)		IVIOI	nthly			Anr	nual	
Annual premium increase (Tick one) Preferred method of communication	0	%	5%	•	10'	%	15	5%	20	1%	Pei	r annı 1	ım																		
(Tick one)		Em	ıail				Pos	st				SM	S																		
SOURCE OF FUNDS / WEALTH	/ IN	COI	ME (P	leas	e att	ach p	oroo	f of sc	urce	of fu	ınds)																			
Salary		Pol	icy						Dor	natior	1						Inh	eritar	ice												
Savings		Inv	estmei	nt				Othe	r (ple	ase s	pecif	y)																			
SOURCE OF FUNDS	PROOF REQUIRED																														
Salary	An	An original or certified copy of a recent payslip (not older than 3 months)																													
Policy, Savings, Investment	Stat	Statement from the financial institution																													
Donation	Wri	Written confirmation by the donor and bank statement reflecting the deposit																													
Inheritance	Wri	Written confirmation of inheritance signed by executor / advocate / trustee																													
PAYMENT DETAILS (Always comp	lete t	his s	ection	for r	new c	appli	catic	ons, ai	nd co	omple	ete f	or am	endr	nent	if rel	evan	it. Th	e Poli	cyho	lder d	and F	Prem	ium p	oayei	r mus	t be i	the s	ame	pers	on. P	lease
indicate with a (✓) the selected payment	metl	hod.)																													
Debit order		Sto	p orde	r																											
DEBIT ORDER PAYMENT DETAILS (Complete if debit order payment is selected)																															
(Please attach a copy of the latest bank star	temer	nt – m	nust no	t be	older	thar	13 m	onths	, or c	onfirr	matio	on of	accou	ınt de	tails	from	the F	Policy	nolde	r's Ba	nk o	n the	Bank	's let	terhe	ad.)					
Name of accountholder																													<u> </u>		
Name of bank																															
Branch name																															
Account number																			Bran	nch co	de										
Reference number (if company or trust)																															
Debit order date	1	st	20 ^t	h	25	th																									
I, the undersigned authorise Liberty Life to premium on this policy is paid.	dedu	ict the	e prem	ium	for th	ne am	noun	t as sp	ecifie	ed in t	this f	orm,	from 1	this a	ccou	nt (in	cludii	ng any	/ app	licable	e pre	miun	n incr	eases	s I hav	/e agr	eed	to) ur	ntil th	e due	:
Account holder's full name and surname																												T	<u> </u>		
Account holder's signature]		Date			D	1			1			I v	
Account Holder's signature																				Date		D] -	IVI	М] -	1		1	
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STOP ORDER DETAILS (Complete if stop							- 4									D-II	de I	ala de F	1			. F		of a Las		1					
(Please attach a copy of the latest salary slip Name of employer	וווו – כן	JSLTIC	DE DE OI	uer t	LIIdii	31110	I ILI IS,	, or co		Iatioi	1016	Прю	ymen	IL II OI	II LI IE	POIIC	Lyrior	uei s i	шри	oyer c) [[]	e EIII	pioye	1 5 161	Tterri	280.)		\top	\top		
Employee salary reference																												_			
Gross monthly pay																		Ne	t mo	nthly	pay										
Current insurance deductions																															
I, the undersigned authorize Liberty Life to my salary and remit it to Liberty Life on a m	dedu	ct the	e prem sis, with	ium effe	for th	ne am om	noun	t as sp	ecifie	ed in 1	this f unti	orm (incluc i time	ding a	ny ap	oplica el this	able p	remiu ority ii	ım ind n writ	crease ting o	es I h r I su	ave s bstitı	elect	ed or is wit	any i :h a n	ncrea ew aı	ises I uthor	have	agre	ed to) from
Policyholder's full name and surname																												Т	T		
Policyholder's signature																				Date		D	D	-	М	М	-	Υ	Y	Υ	Y

BENEFICIARY DETAILS (In the event of the policyholder becoming deceased, these are persons nominated by the policyholder to receive payment of benefits. Please ensure that % share adds up to 100% across all beneficiaries)

I hereby instruct that any benefits in my name which shall become due under this policy on death be paid to the beneficiaries detailed in the proportion(s) indicated against the name of each beneficiary.

For any beneficiaries under the age of 18 years (minors), please attach a birth certificate for each minor beneficiary.

FULL NAMES	DATE OF BIRTH	RELATIONSHIP	FULL NAMES OF GUARDIAN	CONTACT DETAILS	% SHARE

COMMISSION							
Specify commission percentage from 0 - 5	% (if applicable)						
DECLARATION BY THE INTERI	MEDIARY (Always	complete this section))				
By submitting an application, I declare thin accordance with the regulations set of		er. I also confirm tha	t I have verified the	identity of the policyholder			
Brokerage / Agency name							
City / Town							
Intermediary full name and surname							
Intermediary signature					Date	D D - M	M - Y Y Y Y

DECLARATION BY THE POLICYHOLDER (Always complete this section)

This declaration contains guarantees and undertakings that I, as the Policyholder:

Confirm that I understand the product/service

- I confirm that I understand the nature of the product/services, and that it meets the identified need and that the Intermediary has explained the relevant rule, terms and conditions, and marketing material.
- I understand that it is my responsibility to make sure that Liberty Life always has up-to-date contact information for me and anyone that I nominated to benefit from this policy.
- I acknowledge that this product does not guarantee that the actual education costs will be covered. Any projections provided are only estimates and are subject to change such as if investment returns are lower than expected or actual education costs are higher than expected.
- I understand the benefits provided by the product depend on the investment returns after any tax and charges have been deducted and that any particular benefit is not guaranteed.
- I understand that the retrenchment premium waiver will only cover me if I have been employed for at least 12 months and that I can claim for a total of 3 retrenchment claims during the life of the policy. I also confirm that:
 - I am not aware of any pending retrenchments or imminent dismissal at application stage.
 - I acknowledge that I understand that a retrenchment claim will not be valid if:
 - · Loss of employment is due to fraud, dishonesty, misconduct, partaking in any illegal strikes, sickness, disease, accident, injury, pregnancy, mental disorder or medical condition.
 - My employment is seasonal or unemployment is a regular feature of my working life or the employment comes to an end due to expiry of a fixed-term contract, resignation, retirement or acceptance of voluntary retrenchment or if I am a partner in a partnership, a member of a Close Corporation, the director of a company, self-employed or employed by a family-owned business.
- I understand the Liberty Life will carry out checks (including but not limited to verification of identity, sanctions screening) as required by law. My Personal Data or other information may be used in the detection and/or prevention of money laundering. I authorise Liberty Life to use my Personal Data and other information to perform the above checks in relation to my application.
- · In the event Liberty Life becomes aware of any illegal activity, Liberty Life may not be in a position to approve this application.
- I will notify Liberty Life immediately if my residency of Foreign Account Tax Compliance Act ("FATCA") or equivalent classification changes in the future, or if there are any changes in circumstances that may impact my tax residency status or FATCA classification.

Guarantee that I am giving information correctly

Where I provide Liberty Life with personal information of a third party, e.g. beneficiary nomination, I guarantee that I have the third party's consent to provide Liberty Life with their personal information.

Authorise Liberty Life, their authorised representatives and contracted third parties (local and foreign), as well as any appointed intermediaries to process my personal information as permitted by law.

I, the undersigned, confirm that the information supplied on this form is to the best of my knowledge true and correct. I further acknowledge that Liberty Life and the authorised representatives accept no responsibility or liability for the accuracy of the information provided by myself.

Policyholder name and surname																			
Policyholder's signature										Date	D	D	М	М	_	Υ	Υ	Υ	Υ