International Life Insurance
Application Form

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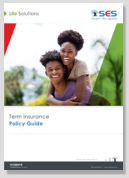
International Life Insurance
Application Form

THANK YOU FOR CHOOSING SES – A LEADING PROVIDER OF INTERNATIONAL LIFE INSURANCE SOLUTIONS

This Application should be used for the following SES products:



Term Insurance

Decreasing Term Insurance

Important Information

SES Life Insurance contracts are insurance products insured by Specialty Emergency Services Limited (SES Limited). SES Limited is registered in and subject to the laws of Zambia and is authorised and regulated by the Pensions and Insurance Authority. SES Life Insurance contracts are governed by the laws of Zambia and all disputes relating to an SES Life Insurance Policy shall be subject to the jurisdiction of the courts of Zambia, except as otherwise expressly agreed by the parties in writing.

The information provided in our documentation is based on the understanding of SES Limited of current Zambia law as at January 2022, which may change in the future. No liability can be accepted for any personal taxation consequence of this insurance scheme or for the effect of future changes to tax, insurance or other applicable legislation.

Personal Data
All personal data collected in this application form will be treated as strictly Private and Confidential in line with our Data Protection Policy and our Website Privacy Policy. These policies can be viewed at www.ses-unisure.com

Your financial adviser or insurance broker is an Intermediary who is appointed by SES Limited to act on your behalf to assist you with any administration which may be required in the processing of your application. The Intermediary and its authorised employees will therefore have access to and knowledge of the personal data in this application form, and any medical information provided.

SES Limited may pass this personal data, and any medical information provided, to medical examiners and practitioners, underwriters, claims investigation companies, life insurance or reinsurance companies, data processors, and to any company or agency appointed for these purposes to allow for the proper administration of your application and your policy.

In some limited circumstances, SES Limited may be legally required to share certain personal data, which might include yours, if we are involved in legal proceedings or complying with legal obligations, a court order, or the instructions of a government authority

Cooling Off Period
We understand that sometimes people change their minds about the decisions they have made, so we have provided for a reasonable cooling off period after your policy starts, which allows you the freedom to cancel if you no longer want your policy.

You have 30 days from the start date of your policy to write to us and ask us to cancel your policy. If you decide to cancel within this period, we will refund any premiums you have paid, net of any medical examination costs we have incurred in assessing your health during the underwriting process.

If you decide to cancel your policy after the cooling off period, we will not refund any money you may have paid, and your cover will continue until the due date of your next premium.

Intermediary Details (to be completed by the intermediary)

Intermediary Company Name and Address (or stamp)	Intermediary Number									
	Adviser Name									
	Email Address									
	Telephone									

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 1 - Introduction

Before you complete this form, we recommend that you read all product literature including Policy Terms and Conditions, Policy Guide and your quotation, fully and carefully, and seek guidance from your financial adviser or insurance broker regarding the suitability of the Policy to your own particular circumstances.

Once your Policy has started, you will receive an electronic copy of your application and your Policy schedule, which you should also read fully and carefully during the cooling off period. You are entitled to ask for a copy of any document related to your Policy at any time. You should keep all correspondence and documents related to your Policy in a safe place for future reference.

Completing your Application Form
Your application forms part of the contract of insurance. Every question we ask is relevant and important. If any question or section is not applicable to you, please write "N/A" as your answer. If your application is incomplete or does not address each question, this will result in delays.

☐ Please tick here if additional sheets are attached.

Please complete the form in English. If you are completing it by hand, please use blue or black ink, and write clearly in BLOCK CAPITAL letters. If you make an error, please cross it out, write the new information clearly, and initial each corrected error. Do not use correcting fluid or other methods of removing incorrect information.

Full and Complete Disclosure
You must complete all sections accurately and completely to the best of your knowledge. We have the legal right to cancel any Policy issued, or not pay a claim, where the application form contains false or incomplete information.

Medical Evidence
We may need to request additional reports or tests following our assessment of your application and/or your medical evidence. We will pay for any test or assessment which we specifically request. We will not pay for any medical assessment or test which we have not requested, and we will not pay for any Personal Medical Attendant's Report which is requested to provide further details on a condition you have previously been treated for, or a procedure you have previously undergone.

Complaints
Our passion for Treating Clients Fairly governs everything we do and drives our mission to provide our corporate and individual customers world-class insurance solutions which are relevant, appropriate and fairly priced, supported by our first-class service.

There may, however, be occasions when you feel you have not received the service you expect from us. We want to hear about these experiences so we can continually improve our customer service.

For further details on how we deal with Complaints, please email **cc@ses-unisure.com**.

Part 2 - Start Date

PLEASE DO NOT WRITE A START DATE BELOW UNLESS YOU REQUIRE YOUR POLICY TO START ON A SPECIFIC DATE

A specific Start Date would normally be a future date and would only be required if you wish to align the start of your Policy with the start of a loan, a new job or the date you take up residence in a new country. Otherwise, the Start Date will be the date we receive your first premium after your application has been approved.

I require my Policy Start Date to be | D | D | M | M | Y | Y | Y | Y | **PLEASE LEAVE BLANK UNLESS YOU REQUIRE A SPECIFIC START DATE**

IMPORTANT - CHANGES IN HEALTH OR CIRCUMSTANCES BEFORE THE START DATE

You must inform us of any changes in your health or circumstances which occur between the date of this application and the Start Date of your Policy, which would have resulted in you providing different answers in this application.

Such changes would include developing a symptom of any type which is asked about in this application, or having or expecting to have doctor, hospital or clinic consultation, treatment as an in-patient or out-patient, or a blood test for any reason.

They would also include any changes to your family history; as well as planned changes to your lifestyle such as taking up any hazardous sport or pastime or intending to do so; in addition to any changes or planned changes to your occupation, country of residence, or travel obligations.

To inform us of any such changes, please email **life@ses-unisure.com** and we will confirm in writing whether any non-standard terms are proposed for your Policy.

Failure to inform us of any such change may result in non-payment of a claim, or cancellation of your Policy.

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 3 - Life Insured Details

A Life Insured is the person or persons on whose death the Death Benefit becomes payable.

Please complete each section in full, in BLOCK CAPITALS. If any section is Not Applicable, please mark "N/A".

	Life Insured 1	Life Insured 2
Title	☐ Mr ☐ Mrs ☐ Ms ☐ Dr	☐ Mr ☐ Mrs ☐ Ms ☐ Dr
	Other	Other
Given Name/s		
Family Name		
Gender	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth	D D M M Y Y Y Y	D D M M Y Y Y Y
Passport Number		
If 2 applicants, state relationship between the lives to be insured		
Residential Address		
INCLUDING HOUSE NUMBER OR APARTMENT NUMBER AND NAME		
Town or City		
Country		
Post Code		
Correspondence Address		
IF DIFFERENT		
Town or City		
Country		
Post Code		
	PLEASE PROVIDE THE BEST TELEPHONE NUMBER AND AN EMAIL ADDRESS FOR US TO CONTACT YOU	
Telephone Number		
	INCLUDING INTERNATIONAL COUNTRY CODE	**INCLUDING INTERNATIONAL COUNTRY CODE**
Email Address		

IF ANOTHER PERSON, A COMPANY OR A TRUST WILL OWN THIS POLICY, PART 4 MUST BE COMPLETED. OTHERWISE, PLEASE PROCEED TO PART 5.

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 4 - Policyholder Details

Every life insurance Policy has a Policyholder who owns the Policy. Every life insurance Policy also has a Life Insured who is/are the person/s on whose death the Death Benefit becomes payable. Often the Policyholder and the Life Insured are the same person, but occasionally the Policyholder is a third party who owns a Policy on the life of another. In these cases, the Policyholder may be a Trust, a Company, or another person such as a family member.

THIS SECTION SHOULD ONLY BE COMPLETED IF THE POLICYHOLDER IS DIFFERENT TO THE LIFE INSURED

Please select type of Policyholder. Please select **ONLY** one and then provide details requested.

☐ If Policyholder(s) is/are Individual(s) **PLEASE COMPLETE APPLICABLE SECTIONS BELOW**

☐ Policyholder(s) is/are a Company or an Existing Trust **PLEASE COMPLETE APPLICABLE SECTIONS BELOW**

	Policyholder 1	Policyholder 2
Title	☐ Mr ☐ Mrs ☐ Ms ☐ Dr	☐ Mr ☐ Mrs ☐ Ms ☐ Dr
	Other	Other
Given Name/s		
Family Name		
Date of Birth	D D M M Y Y Y Y	D D M M Y Y Y Y
Passport Number		
What is your relationship with or interest in the Life/Lives Insured?		
Company or Trust Name		
Contact Person Name		
Residential or Registered Address		
Town or City		
Country		
Post Code		
	PLEASE PROVIDE THE BEST TELEPHONE NUMBER AND AN EMAIL ADDRESS FOR US TO CONTACT YOU	
Telephone Number		
	INCLUDING INTERNATIONAL COUNTRY CODE	**INCLUDING INTERNATIONAL COUNTRY CODE**
Email Address		

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 5 - Policy Details

Please provide the reference number of the quotation you are applying for and the exact details of that quotation.

Quotation Number

Currency of Quote ☐ USD

Type of Policy Required ☐ Single Life ☐ Joint Life First Death ☐ Joint Life Second Death

Sum Insured Value

Premium Payment Frequency ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

MONTHLY PREMIUMS CAN ONLY BE PAID BY DEBIT/CREDIT CARD OR DIRECT DEBIT

Premium Quoted for Selected Payment Frequency

Product Selected ☐ Term Insurance ☐ Decreasing Term Insurance

Selected Term Length in years

Have you selected any Optional Rider Benefits?

Accidental Death Benefit ☐ Yes ☐ No **ACCIDENTAL DEATH BENEFIT IS ONLY AVAILABLE ON SINGLE LIFE POLICIES**

Waiver of Premium Benefit ☐ Yes ☐ No **WAIVER OF PREMIUM BENEFIT IS ONLY AVAILABLE ON SINGLE LIFE POLICIES**

Part 6 - Nationality and Residence Details

Please answer each question in full, providing as much detail as is relevant. The more detailed the information you provide, the more likely we can avoid requesting clarification, or additional evidence, and the delays involved with such requests.

	Life Insured 1	Life Insured 2
1. Country of Birth		
2. What is your Nationality?		
3. Do you hold citizenship for any other country?	☐ Yes ☐ No	☐ Yes ☐ No
	IF YOU HAVE ANSWERED "YES", PLEASE LIST THE ADDITONAL COUNTRIES OF WHICH YOU ARE A CITIZEN	
4. What is the legal basis for stay in your country of residence? e.g. Citizen, work permit, etc.		
5. How long have you lived in your current country of residence?		
6. How long do you intend to continue living there?		

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 6 - Nationality and Residence Details (continued)

7. In which country do you intend to live next? If unknown, please state "Unknown".

8. Please list all the countries in which you have lived, and how long you lived in each country.

THE TOTAL NUMBER OF YEARS SHOULD EQUAL YOUR CURRENT AGE

Country Name --- Number of Years	Country Name --- Number of Years
Country Name --- Number of Years	Country Name --- Number of Years
Country Name --- Number of Years	Country Name --- Number of Years
Country Name --- Number of Years	Country Name --- Number of Years
Country Name --- Number of Years	Country Name --- Number of Years

IF THERE IS INSUFFICIENT SPACE, PLEASE CONTINUE ON A SEPARATE PIECE OF PAPER, ENSURING THAT YOU SIGN AND DATE ANY ADDITIONAL PAGES.

Part 7 - Occupation Details

	Life Insured 1	Life Insured 2
1. What is your occupation?		
2. How many years have you practiced your occupation?		
3. Nature of employer's business *(E.G. OIL & GAS, ENGINEERING, FINANCIAL SERVICES, ETC.)*		
4. How long have you worked for your current employer?		

	Life Insured 1	Life Insured 2
5. Name and Address of employer		
6. Do you work underground, underwater, at heights of more than 3 metres, offshore, and/or are there any hazardous aspects to your occupation?	☐ Yes ☐ No	☐ Yes ☐ No
7. Have you travelled outside your current country of residence for work in the last two years?	☐ Yes ☐ No	☐ Yes ☐ No

IF YOU HAVE ANSWERED "YES", USING THE SPACE PROVIDED BELOW, PLEASE PROVIDE FULL DETAILS, INCLUDING THE ESTIMATED PERCENTAGE OF YOUR WORKING TIME SPENT UNDERGROUND, UNDERWATER, AT HEIGHTS, OR ENGAGING IN HAZARDOUS ACTIVITIES.

IF YOU WORK AT HEIGHTS, PLEASE STATE AVERAGE AND MAXIMUM HEIGHTS AT WHICH YOU WORK.

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 7 - Occupation Details (continued)

8. Do you expect to travel outside your current country of residence for work in the future?

☐ Yes ☐ No ☐ Yes ☐ No

IF YOU HAVE ANSWERED "YES" TO QUESTIONS 7 AND/OR 8, USING THE SPACE PROVIDED BELOW, PLEASE PROVIDE DETAILS, INCLUDING SPECIFIC COUNTRIES VISITED, DATES OF VISITS, AND DURATION OF EACH STAY.

- **IF YOU TRAVEL EXTENSIVELY, PLEASE PROVIDE A LIST OF COUNTRIES VISITED EACH YEAR, HOW OFTEN YOU TYPICALLY VISIT EACH COUNTRY PER YEAR, AND THE AVERAGE LENGTH OF STAY IN EACH COUNTRY.**
- **FOR FUTURE TRAVEL, PLEASE PROVIDE DETAILS LISTING THOSE COUNTRIES YOU EXPECT TO VISIT, HOW MANY TIMES PER YEAR, AND HOW LONG YOU EXPECT EACH VISIT TO BE.**

9. Do you intend to change your occupation in the next year?

☐ Yes ☐ No ☐ Yes ☐ No

IF YOU HAVE ANSWERED "YES", PLEASE PROVIDE DETAILS OF YOUR NEW OCCUPATION, USING THE SPACE PROVIDED BELOW.

Question Reference Number	*If you have answered "Yes" to any of the questions in Part 7, please provide additional details here. Please note the Question Number for which you are providing additional information.*

IF THERE IS INSUFFICIENT SPACE, PLEASE CONTINUE ON A SEPARATE PIECE OF PAPER, ENSURING THAT YOU SIGN AND DATE ANY ADDITIONAL PAGES.

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 8A – Education Details

Our quotation engine requires information about a person's age, gender, nationality, residence and smoking status to produce a basic quotation. We also ask for information about education and income at the quotation stage as a means of determining the fairest pricing for every applicant, as higher levels of education and income may result in a discount to a person's nationality or residence pricing. (Note that this will never result in a higher premium)

If your education and income information has not been considered at the quotation stage, and your premium reduces by taking this into account, we will adjust the premium level accordingly before the Start Date and inform your financial adviser.

Please select ONE of the following education levels, and provide further details in the space below.

Life Insured 1	Life Insured 2	
☐	☐	INCOMPLETE PRIMARY AND SECONDARY SCHOOL EDUCATION
☐	☐	COMPLETED PRIMARY AND SECONDARY SCHOOL EDUCATION
☐	☐	COMPLETED ALL SCHOOL EDUCATION AND ATTENDED AT LEAST 2 YEARS' TERTIARY EDUCATION
☐	☐	COMPLETED ALL SCHOOL EDUCATION AND ATTENDED AT LEAST 4 YEARS' TERTIARY EDUCATION
☐	☐	COMPLETED ALL SCHOOL EDUCATION AND ATTENDED AT LEAST 6 YEARS' TERTIARY EDUCATION

If you have attended **2 or more years'** tertiary education at a college or university, please provide details of
- each college or university or other education institution attended,
- the name of the degree or course you studied, and
- the duration of the degree or course (please state year enrolled and year completed).

You may also use this space to provide any further details you may think are relevant.

IF THERE IS INSUFFICIENT SPACE, PLEASE CONTINUE ON A SEPARATE PIECE OF PAPER, ENSURING THAT YOU SIGN AND DATE ANY ADDITIONAL PAGES.

Part 8B – Income Details

To determine the fairest pricing for every applicant, we consider **annual average household income** from all sources. This means your employment income, your spouse's employment income as well as any other regular household income such as rent received or investment income, as long as these are received each year.

Please state **your own annual income** from employment (in the same currency as this application) for this year and last year.

	Life Insured 1			Life Insured 2	
This Year	Currency	Annualised Income	This Year	Currency	Annualised Income
Last Year	Currency	Annualised Income	Last Year	Currency	Annualised Income

Please state any additional **annual average household income** from other sources (in the same currency as this application) and provide further detail (such as the source) in the space provided on Page 9.

Other Income	Currency	Annualised Income	Other Income	Currency	Annualised Income

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 8B – Income Details (continued)

Sources of Other Income making up your **annual average household income** could include:

- your spouse's income from employment - rental income from property investments	- income from capital investments - other regular income earned each year

IF THERE IS INSUFFICIENT SPACE, PLEASE CONTINUE ON A SEPARATE PIECE OF PAPER, ENSURING THAT YOU SIGN AND DATE ANY ADDITIONAL PAGES.

Part 9A – Insurance Details

Please answer each question in full, providing as much detail as is relevant. The more detailed the information you provide, the more likely we can avoid requesting clarification, or additional evidence, and the delays involved with such requests.

1. Please provide full details of any existing insurance policies on your life, or tick 'None'.

Life Insured 1 ☐ None

Name of Insurer	Sum Insured (State Currency)	Start Date and Length of Term	Reason for Policy

Life Insured 2 ☐ None

Name of Insurer	Sum Insured (State Currency)	Start Date and Length of Term	Reason for Policy

2. Once this application has been issued, will you cancel any of the policies listed above?

Life Insured 1 ☐ Yes ☐ No ☐ N/A **Life Insured 2** ☐ Yes ☐ No ☐ N/A

Company and Policy Details	Company and Policy Details

3. With the exception of any policies listed above, have you applied to any other insurance company for life insurance in the last 12 months, or do you intend to do so?

Life Insured 1 ☐ Yes ☐ No **Life Insured 2** ☐ Yes ☐ No

Company		Company	
Date of Application	D D M M Y Y Y Y	Date of Application	D D M M Y Y Y Y
Sum Insured		Sum Insured	
Reason for Policy		Reason for Policy	

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 9A – Insurance Details (continued)

4. Have you ever applied for life, critical illness, income protection or disability insurance and been asked to pay a higher premium, had special terms imposed, or had your application declined?

Life Insured 1	☐ Yes	☐ No	Life Insured 2	☐ Yes	☐ No
Company			Company		
Date of Application	D D M M Y Y Y Y		Date of Application	D D M M Y Y Y Y	
Sum Insured			Sum Insured		
Reason for Adverse Decision			Reason for Adverse Decision		

Part 9B – Financial Details

What is the purpose of applying for this insurance?

From the options below, please select any of the Personal Protection options which apply OR select Business Protection, then complete the details requested for those section(s) you have selected.

☐ Personal - Family Protection
COMPLETE 9B 1 - FAMILY PROTECTION

☐ Personal - Loan Protection
COMPLETE 9B 2 – LOAN PROTECTION

☐ Personal - Estate Planning
COMPLETE 9B 3 - ESTATE PLANNING

☐ Business – Key Person Protection
COMPLETE 9B 4 - BUSINESS PROTECTION

☐ Business – Shareholder/Partnership Protection
COMPLETE 9B 4 - BUSINESS PROTECTION

☐ Business - Loan Protection
COMPLETE 9B 4 - BUSINESS PROTECTION

FOR SUMS INSURED EXCEEDING USD 3 MILLION (OR CURRENCY EQUIVALENT) A FINANCIAL QUESTIONNAIRE MUST BE COMPLETED AND ATTACHED TO THIS APPLICATION FORM. PLEASE NOTE, WE RESERVE THE RIGHT TO REQUEST EVIDENCE.

9B 1 – Family Protection

1. Please list your dependants, detailing their ages and their relationship to you.

Name	Age	Relationship

2. Please outline how the Sum Insured for this application was calculated.

AS A GUIDE, FOR FAMILY PROTECTION, THE TOTAL INSURANCE PROVIDED BY ANY EXISTING POLICIES AND THE SUM INSURED OF THIS APPLICATION SHOULD GENERALLY NOT EXCEED THESE LEVELS.

Age Next Birthday	18 – 30	31 – 50	51 – 60	61- 65	Over 65
Income Multiple	20 times	30 times	20 times	10 times	5 times

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

9B 2 - Loan Protection (You should only complete this section if you have ticked 'Loan Protection' above)

1. Who is the Lender?

2. What is the reason for the loan? If for a mortgage, is this for an investment property or your main residence?

3. What is the value of the loan?

FOR SUMS INSURED OVER USD 500 000 (OR EQUIVALENT) PLEASE ATTACH A COPY OF THE LOAN OFFER LETTER OR LOAN AGREEMENT

4. What is the duration of the loan?

5. Is the loan conditional on the issue of this Policy? ☐ Yes ☐ No

9B 3 - Estate Planning (You should only complete this section if you have ticked 'Estate Planning' above)

1. What is the value of your Estate Duty liability?

2. How was this calculated, and by whom?

9B 4 – Business Protection (You should only complete this section if you have ticked 'Business Protection' above)

1. What is the reason for the cover?

2. Please outline how the Sum Insured for this application was calculated.

Part 10 – Lifestyle Details

Please answer each question in full, providing as much detail as is relevant. The more detailed the information you provide, the more likely we can avoid requesting clarification, or additional evidence, and the delays involved with such requests.

	Life Insured 1	Life Insured 2
1. Do you smoke?	☐ Yes ☐ No	☐ Yes ☐ No

TO BE CONSIDERED A NON-SMOKER, YOU MUST NOT HAVE USED ANY FORM OF TOBACCO OR ANY NICOTINE-BASED PRODUCTS WITHIN THE LAST 12 MONTHS

If you have smoked, or used any form of tobacco or nicotine-based products in the last 12 months, please state in which form, and how frequently.

TOBACCO/NICOTINE-BASED PRODUCTS INCLUDE: CIGARETTES, CIGARS, PIPE TOBACCO, SHISHA, CHEWING TOBACCO, NICOTINE PATCHES, NICOTINE GUM, AND ELECTRONIC CIGARETTES

2. If you have stopped, please state when you last used tobacco, what form you used, and how frequently you used it.

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 10 – Lifestyle Details (continued)

	Life Insured 1	Life Insured 2
3. Do you drink alcohol?	☐ Yes ☐ No	☐ Yes ☐ No
If you drink alcohol, please state the average number of units of alcohol you drink per week.		

1 UNIT = 1 MEASURE OF SPIRITS,1 GLASS OF WINE OR ½ PINT OF BEER.

4. Have you ever been advised by a doctor, or any other medical practitioner, to reduce or stop your alcohol consumption on medical grounds; or have you ever taken part in counselling, therapy, or a programme with the aim of reducing or stopping your alcohol consumption?	☐ Yes ☐ No	☐ Yes ☐ No

IF YOU HAVE ANSWERED "YES", PLEASE PROVIDE FURTHER DETAILS USING THE SPACE PROVIDED BELOW.

5. In the last 7 years, have you used any non-prescription drugs?	☐ Yes ☐ No	☐ Yes ☐ No

EXAMPLES OF NON-PRESCRIPTION DRUGS INCLUDE, BUT ARE NOT LIMITED TO:
LSD, ECSTASY, COCAINE, HEROIN, CANNABIS AND ANABOLIC STEROIDS.
IF YOU HAVE ANSWERED "YES", PLEASE PROVIDE FURTHER DETAILS, USING THE SPACE PROVIDED BELOW.

6. Do you currently engage in any hazardous sport or pastime, or do you intend to start?	☐ Yes ☐ No	☐ Yes ☐ No

IF YOU HAVE ANSWERED "YES", PLEASE PROVIDE FURTHER DETAILS USING THE SPACE PROVIDED BELOW.

EXAMPLES INCLUDE MOUNTAIN CLIMBING; MOTOR SPORTS; UNDERWATER DIVING; OFF-PISTE SKIING; LIGHT AIRCRAFT OR HELICOPTER FLYING; SKYDIVING OR PARAGLIDING; WHITE RIVER CANOEING OR KAYAKING AND BIG GAME HUNTING.

YOU SHOULD INCLUDE ANY ACTIVITY CONSIDERED HAZARDOUS, BUT YOU DO NOT NEED TO INCLUDE DETAILS OF SPORTS SUCH AS HORSE RIDING, PISTE SKIING, FOOTBALL, RUGBY, HOCKEY, CRICKET, OR RACQUET SPORTS.

Question Reference Number	*If you have answered "Yes" to any of the questions in Part 10, please provide additional details here. Please note the Question Number for which you are providing additional information.*

IF THERE IS INSUFFICIENT SPACE, PLEASE CONTINUE ON A SEPARATE PIECE OF PAPER, ENSURING THAT YOU SIGN AND DATE ANY ADDITIONAL PAGES.

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 11 - Family History

All the questions we ask are relevant and important. You must complete all sections accurately and completely to the best of your knowledge. We have the legal right to cancel any Policy issued, or not pay a claim, where the application form contains false or incomplete information. If you answer "Yes" to any question in this section, please provide full details, including all facts, as they can influence the assessment and acceptance of your application.

Has any member of your immediate family (mother, father, siblings or children) died, or suffered from heart disease, cancer, multiple sclerosis, diabetes or from any other familial/hereditary disorder before the age of 60? If "Yes", please provide details of which family members have been affected, as well as the cause of death, or the conditions they suffer from.

	Life Insured 1 ☐ Yes ☐ No	Life Insured 2 ☐ Yes ☐ No
Relationship 1		
Condition		
	Age at onset ☐ Age now ☐ **OR** Age at death ☐	Age at onset ☐ Age now ☐ **OR** Age at death ☐
Relationship 2		
Condition		
	Age at onset ☐ Age now ☐ **OR** Age at death ☐	Age at onset ☐ Age now ☐ **OR** Age at death ☐

Part 12 - Medical History

1. Body Mass Index	Life Insured 1		Life Insured 2	
a. What is your height?	☐ CM (OR)	☐ IN	☐ CM (OR)	☐ IN
b. What is your weight?	☐ KG (OR)	☐ LBS	☐ KG (OR)	☐ LBS
c. Other than as a result of diet, exercise or pregnancy, has your weight changed by more than 5 kilograms in the last six months?	☐ Yes	☐ No	☐ Yes	☐ No

2. Do you currently have, or have you ever had, any of the following:	Life Insured 1 Yes	Life Insured 1 No	Life Insured 2 Yes	Life Insured 2 No
a. Chest pain, heart attack, heart disease, heart abnormality or defect, heart murmur, irregular heartbeat, rheumatic fever, or any cardiac procedure?	☐	☐	☐	☐
b. A stroke, mini-stroke, transient ischaemic attack (TIA) or brain haemorrhage?	☐	☐	☐	☐
c. Raised blood pressure or cholesterol for which treatment or a change in diet were advised?	☐	☐	☐	☐
d. Any form of malignant cancer, growth, or tumour, whether removed or not?	☐	☐	☐	☐
e. Any lump which has appeared or grown in size, any mole which has bled, caused pain or changed in appearance?	☐	☐	☐	☐
f. Adult asthma, bronchitis, tuberculosis, persistent coughing, coughing with blood or any chest, lung or breathing disorder?	☐	☐	☐	☐
g. Hepatitis A (Jaundice) B, C or E?	☐	☐	☐	☐

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 12 - Medical History (continued)

2. Do you currently have, or have you ever had, any of the following:	Life Insured 1 Yes	Life Insured 1 No	Life Insured 2 Yes	Life Insured 2 No
h. Crohn's disease, colitis, other disorder of the digestive system, gall bladder, pancreas or liver, such as gallstones, pancreatitis, rectal bleeding or gastric ulcers?	☐	☐	☐	☐
i. Any disorder of the kidneys, bladder or reproductive organs, such as kidney stones, bladder infection, blood or protein in urine, or prostate problems?	☐	☐	☐	☐
j. Diabetes, raised blood sugar, thyroid problems, anaemia or other bleeding disorders?	☐	☐	☐	☐
k. Multiple sclerosis, Parkinson's disease, Alzheimer's disease, paralysis or paraplegia?	☐	☐	☐	☐
l. Tingling, pins and needles, numbness, a tremor or any loss of feeling, balance or coordination?	☐	☐	☐	☐
m. Epilepsy, blackout, persistent or recurrent headache?	☐	☐	☐	☐
n. Visual disturbance, blurred or double vision, optic or retrobulbar neuritis?	☐	☐	☐	☐
o. Any mental illness or eating disorder or have you attempted self-harm or taken an overdose?	☐	☐	☐	☐
p. Any feelings of depression, anxiety, stress or fatigue that you have reported to a doctor, hospital, nurse, psychologist or psychiatrist or any other type of medical practitioner?	☐	☐	☐	☐
q. Skin problems such as psoriasis, eczema, dermatitis or sun damaged skin?	☐	☐	☐	☐
r. Disorders of the spine, joints, bones or muscles, such as arthritis, gout, rheumatism, fibromyalgia, back pain or back surgery, slipped disc, fractured bones or joint problems?	☐	☐	☐	☐
s. Any disorder of the eyes, ears, nose or throat?	☐	☐	☐	☐
t. Have you ever been exposed to the risk of HIV infection, tested positive or received treatment for HIV, AIDS or any sexually transmitted disease?	☐	☐	☐	☐

HIV CAN BE TRANSMITTED THROUGH UNSAFE SEX, INTRAVENOUS DRUG USE, AND BLOOD TRANSFUSIONS.
IF THE RESULT WAS NEGATIVE, A PREVIOUS HIV TEST WILL NOT EFFECT THE ASSESSMENT OF THIS APPLICATION.

3. In the last 5 years, have you	Life Insured 1 Yes	Life Insured 1 No	Life Insured 2 Yes	Life Insured 2 No
a. had any operation or received treatment from any medical facility as an inpatient or outpatient?	☐	☐	☐	☐
b. sought any medical advice, including from any specialist, or undergone any medical examination for any condition not already mentioned?	☐	☐	☐	☐
c. had, or been advised to have, any medical investigation, x-ray, scan or test?	☐	☐	☐	☐

YOU DO NOT NEED TO GIVE DETAILS OF OCCASIONAL CONSULTATIONS WITH YOUR REGULAR DOCTOR FOR COLDS, FLU, OR CONSULTATIONS FOR ORAL CONTRACEPTIVE PILLS, SMEAR TESTS, OR FOR WELL MAN/WOMAN CHECK-UPS WHERE THE RESULTS ARE KNOWN AND WERE NORMAL.

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 12 - Medical History (continued)

	Life Insured 1		Life Insured 2	
	Yes	No	Yes	No
4. In the last twelve months, have you been prescribed any drug or medicine, or had any other form of medical treatment? e.g. physiotherapy, psychotherapy.	☐	☐	☐	☐
5. In the last six months, have you had any medical symptom, change in your physical or mental health or change in your physical or mental ability for which you have not consulted a doctor, hospital or medical practitioner?	☐	☐	☐	☐

YOU DO NOT NEED TO GIVE DETAILS OF COLDS AND FLU WHICH HAVE LASTED LESS THAN 2 WEEKS IN TOTAL.

	Yes	No	Yes	No
6. In the next twelve months, are you due to have any consultation or check-up in connection with any medical symptom or condition, or are you waiting for the result of any medical investigation?	☐	☐	☐	☐
7. Do you have, or have you had, any illness, disorder, disability or accident not already disclosed in this application?	☐	☐	☐	☐
8. Have you ever claimed for disability, critical illness or third-party insurance benefits or are you planning to?	☐	☐	☐	☐
9. Have you ever been laid off work on medical grounds?	☐	☐	☐	☐

If you answered "Yes" to any of the questions in Part 12, please provide as much additional information as you can remember in the space provided below for each condition noted.

Question Reference Number | *Date of Diagnosis* | *Condition diagnosed*

Duration of condition | *Date of last symptoms*

Name, address and contact details of attending physician or medical centre you attended

Name, address and contact details of attending physician or medical centre you attended

Any additional Notes you think might be relevant or important

Any additional Notes you think might be relevant or important

Question Reference Number | *Date of Diagnosis* | *Condition diagnosed*

Duration of condition | *Date of last symptoms*

Name, address and contact details of attending physician or medical centre you attended

Name, address and contact details of attending physician or medical centre you attended

Any additional Notes you think might be relevant or important

Any additional Notes you think might be relevant or important

IF THERE IS INSUFFICIENT SPACE, PLEASE CONTINUE ON A SEPARATE PIECE OF PAPER, ENSURING THAT YOU SIGN AND DATE ANY ADDITIONAL PAGES.

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 12 - Medical History (continued)

If you answered "Yes" to any of the questions in Part 12, please provide as much additional information as you can remember in the space provided below for **each condition noted**.

Question Reference Number	*Date of Diagnosis*	*Condition diagnosed*
Duration of condition	*Date of last symptoms*	
Name, address and contact details of attending physician or medical centre you attended		
Name, address and contact details of attending physician or medical centre you attended		
Any additional Notes you think might be relevant or important		
Any additional Notes you think might be relevant or important		

Question Reference Number	*Date of Diagnosis*	*Condition diagnosed*
Duration of condition	*Date of last symptoms*	
Name, address and contact details of attending physician or medical centre you attended		
Name, address and contact details of attending physician or medical centre you attended		
Any additional Notes you think might be relevant or important		
Any additional Notes you think might be relevant or important		

Question Reference Number	*Date of Diagnosis*	*Condition diagnosed*
Duration of condition	*Date of last symptoms*	
Name, address and contact details of attending physician or medical centre you attended		
Name, address and contact details of attending physician or medical centre you attended		
Any additional Notes you think might be relevant or important		
Any additional Notes you think might be relevant or important		

Question Reference Number	*Date of Diagnosis*	*Condition diagnosed*
Duration of condition	*Date of last symptoms*	
Name, address and contact details of attending physician or medical centre you attended		
Name, address and contact details of attending physician or medical centre you attended		
Any additional Notes you think might be relevant or important		
Any additional Notes you think might be relevant or important		

IF THERE IS INSUFFICIENT SPACE, PLEASE CONTINUE ON A SEPARATE PIECE OF PAPER, ENSURING THAT YOU SIGN AND DATE ANY ADDITIONAL PAGES.

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 12 - Medical History (continued)

Please provide Name, Address and Telephone Numbers of the Doctor, Clinic or Hospital **most familiar** with your Medical History.

We understand that some people, especially younger people or those living as Expatriates may not have a GP or a regular Doctor. We do still need the name and contact details of whichever Doctor or Medical Centre which is **most familiar** with your medical history.

	Life Insured 1	Life Insured 2
Name of Doctor		
Name of Medical Practice		
Address		
Telephone Number		
	INCLUDING INTERNATIONAL COUNTRY CODE	INCLUDING INTERNATIONAL COUNTRY CODE

WE WILL NOT PROCESS YOUR APPLICATION IF THIS SECTION HAS NOT BEEN COMPLETED

Part 13 - Access to Existing Medical Records

We might not contact your Doctor. Even if we do, you must still disclose all facts and information when completing this application form.

We may need medical reports to support your application. Before we can ask any doctor you have consulted to fill in a report, we need your permission. Before you give permission, you should read the Medical Report the doctor will complete to understand which questions are asked. You do not need to give your permission, but if you do not, we may not be able to proceed. This will not prevent you from applying to other companies for insurance.

You can ask to see the report before the doctor returns it to us; in which case, you must instruct the doctor not to release the report until you have arranged to see it, and given them permission to send it, but this will delay your application. If you choose not to see the report at this stage, you may ask the doctor or us for a copy at any time.

If you think that any part of the report is not factually correct or is misleading, you may ask the doctor to amend it. If the doctor refuses to make the amendments, you may ask them to attach a statement outlining your views, which will then accompany the report. Your doctor can withhold access to the report from you if they feel it would cause physical or mental harm to you or others.

We do not ask your doctor to reveal information about negative tests for HIV, Hepatitis B or C, or any sexually transmitted diseases unless there could be long-term effects on your health; or predictive genetic tests unless there is a favourable test result showing you have not inherited a genetic disorder your family suffers from.

The information you and your doctor provide about your health may result in us refusing to provide insurance; offering you cover at a higher than standard premium; applying an exclusion to the cover; or accepting your application at standard rates.

	Life Insured 1	Life Insured 2
As Life Insured, **I DO** want to see the medical report before it is released.	☐	☐
As Life Insured, **I DO NOT** want to see the medical report before it is released.	☐	☐

WE WILL NOT PROCESS YOUR APPLICATION IF YOU HAVE NOT SELECTED ONE OF THESE OPTIONS.

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 14 – Declaration

In this Declaration, references to the singular include the plural, and vice versa.

This declaration must be signed by the Life Insured and (if applicable) the Policyholder.

1. This application is my formal request to enter into a contract with Specialty Emergency Services Limited (SES Limited). I understand and accept that the contract will be on SES Limited's standard Terms and Conditions for the SES Life Insurance policies.

   I understand and accept that SES Limited is subject to the supervisory arrangements and laws of Zambia; and that this SES Policy is governed by the laws of Zambia; and that all disputes relating to this Policy shall be subject to the jurisdiction of the courts of Zambia; except as otherwise expressly agreed by the parties in writing.

   I understand and accept that this application can only be accepted by duly authorised employees of SES Limited and that no other parties have the necessary authority to create a binding contract.

2. I acknowledge that, in the event of any premium tax or withholding tax being levied on this contract in my country of residence, it will be my responsibility to settle such tax liabilities directly with the relevant tax authorities; or where there are any statutory reporting requirements by any authority in my country of residence related to any premiums paid or insurance contracts owned, it will be my responsibility to make such reports as may be required for this contract directly to the relevant authorities.

3. I confirm that I have not been subject to a sequestration order, declared bankrupt, or unfit to enter into contracts. I also confirm that I have contracting capacity in respect of this Policy.

4. I confirm that any premiums I pay will not contravene any trade or economic sanctions or any applicable exchange controls.

5. I confirm that any premiums paid have not originated directly or indirectly from any actual or attempted money laundering, tax evasion or any other criminal activities.

6. I understand that the Policy Terms and Conditions and a copy of this completed application are available on request.

7. I understand and accept that I am applying via an Intermediary, and that they are acting on my behalf and not as an agent of SES Limited.

   I understand and accept that the Intermediary and its authorised employees shall have access to and knowledge of the personal data in this application, and any medical information provided, which is necessary for them to act in an administrative capacity on my behalf to assist in the processing of this application.

8. I have read all the important information contained at the start of this application, and checked my answers to the questions in this application and declare that, to the best of my knowledge and belief, all the information I have given is true and that no fact has been withheld.

   I understand and accept that failure to disclose a material fact or the giving of false information may give SES Limited the right to cancel from inception any Policy issued as a result of this application and may invalidate any future claim.

   I understand that I must inform SES Limited without delay of any changes in my health or circumstances which occur between the date of this application and the Start Date of the Policy, which would have resulted in me providing different answers to the questions in this application.

9. I accept that if I am required to undergo a medical examination, the replies to the medical examiner's questions will form part of this application. I understand and agree that SES Limited will use the information I give (as well as information about me relating to any existing Policy I may have with SES Limited) for administration, underwriting, claims, research and statistical purposes.

   I authorise SES Limited to pass personal data, including medical information, to medical examiners and practitioners, underwriters, claims investigation companies, life insurance or reinsurance companies, data processors, and to any company or agency appointed for these purposes.

   I understand that SES Limited may be legally required to share certain personal data, which might include mine, if they are involved in legal proceedings or complying with legal obligations, a court order, or the instructions of a government authority.

10. I have read the GDPR Policy and Website Privacy Policy and understand that personal data given to SES Limited in connection with this application may be used by them to allow for the proper administration of my application and my policy and in their consideration of any claim in future. I understand that personal data may be shared with a third party, e.g. a medical examiner, to help in the assessment of a claim against this Policy.

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 14 – Declaration (continued)

11. I understand and accept SES Limited may require sight of my medical records to review my application or consider a claim. I authorise any doctor, physician, practitioner, hospital, clinic, insurance or reinsurance company, employer, other individual organisation or government office that has any records or knowledge of me or my health to disclose to SES Limited any information for the purpose of reviewing my application or considering a claim. This authorisation shall irrevocably bind my successors and remain valid, notwithstanding my death or incapacity, and a copy of this authorisation shall be as effective and valid as the original.

12. I consent to SES Limited asking any doctor I have consulted about my physical or mental health to provide medical information so they may assess this application. I agree they may gather relevant personal data from other insurers about any other applications for life, critical illness, sickness, disability, accident or private medical insurance on my life for which I have applied. I authorise those asked to provide medical and Policy information when presented with a copy of this consent. This authorisation shall irrevocably bind my successors and remain valid, notwithstanding my death or incapacity, and a copy of this authorisation shall be as effective and valid as the original.

13. I have read and understood **Part 13 relating to Access to Existing Medical Reports.** I understand this does not apply to any medical examination and tests I may be required to undergo in respect of this application.

14. I have read, understood, and accept the Terms and Conditions for this Policy.

Life Insured 1
WHO WILL ALSO BE POLICYHOLDER 1 IF SECTION 4 IS NOT COMPLETED

Signature

Date D D M M Y Y Y Y

Life Insured 2
WHO WILL ALSO BE POLICYHOLDER 2 IF SECTION 4 IS NOT COMPLETED

Signature

Date D D M M Y Y Y Y

Policyholder 1
ONLY TO BE SIGNED IF POLICYHOLDER 1 IS DIFFERENT TO LIFE INSURED 1

Signature

Date D D M M Y Y Y Y

Policyholder 2
ONLY TO BE SIGNED IF POLICYHOLDER 2 IS DIFFERENT TO LIFE INSURED 2

Signature

Date D D M M Y Y Y Y

If signing on behalf of a company or trust, please state in what capacity you are signing (e.g. Company Secretary or Trustee)

Capacity

Capacity

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 15 - Beneficiary Appointment

USING THIS FORM MAY NOT BE AN EFFECTIVE SOLUTION IF YOUR OBJECTIVE IS TO REDUCE THE INHERITANCE TAX/ESTATE DUTIES PAYABLE BY YOUR ESTATE FOLLOWING YOUR DEATH.

THIS APPOINTMENT DOES NOT APPLY TO ANY PAYMENT OF BENEFITS MADE UNDER THE TERMS OF THE TERMINAL ILLNESS BENEFIT.

Complete this section to appoint a beneficiary, or beneficiaries, to receive the amount payable on death. You may only elect a primary class of beneficiary or beneficiaries. We advise you make use of a family trust or establish a will if you wish to make provision for contingent beneficiaries or a second class of beneficiaries.

Subject to any future revocation or appointment of beneficiaries, I/we* hereby appoint the following person/persons* as beneficiary in the share/ shares* indicated below.

YOU SHOULD OBTAIN LEGAL ADVICE BEFORE COMPLETING THIS SECTION.

☐ I/We* confirm that I/we* have taken legal advice before signing this beneficiary appointment instruction.

☐ I/We* have elected not to take legal advice before signing this beneficiary appointment instruction.

*** DELETE AS APPLICABLE**

If you need to appoint more beneficiaries, please print a copy of this page.

IF THIS IS A JOINT LIFE APPLICATION AND YOU ARE NOMINATING EACH OTHER AS PRIMARY BENEFICIARY, THE PERCENTAGE SHARE MUST BE 100% EACH.

YOU MAY ONLY ELECT A PRIMARY CLASS OF BENEFICIARY OR BENEFICIARIES.

	Beneficiary 1 %	**Beneficiary 2** %
Full Name (as per passport)		
Relationship to Life Insured		
Date of Birth	D D M M Y Y Y Y	D D M M Y Y Y Y
Telephone Number		
	INCLUDING INTERNATIONAL COUNTRY CODE	**INCLUDING INTERNATIONAL COUNTRY CODE**
Email address		

	Beneficiary 3 %	**Beneficiary 4** %
Full Name (as per passport)		
Relationship to Life Insured		
Date of Birth	D D M M Y Y Y Y	D D M M Y Y Y Y
Telephone Number		
	INCLUDING INTERNATIONAL COUNTRY CODE	**INCLUDING INTERNATIONAL COUNTRY CODE**
Email address		

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 15 - Beneficiary Appointment (continued)

	Beneficiary 5 %	Beneficiary 6 %
Full Name (as per passport)		
Relationship to Life Insured		
Date of Birth	D D M M Y Y Y Y	D D M M Y Y Y Y
Telephone Number		
	INCLUDING INTERNATIONAL COUNTRY CODE	INCLUDING INTERNATIONAL COUNTRY CODE
Email address		

CERTIFIED IDENTIFICATION AND VERIFICATION OF RESIDENTIAL ADDRESS WILL BE REQUIRED FOR EACH BENEFICIARY AT THE TIME OF A CLAIM.

If at the time of any payment, you are unable to contact a beneficiary, you should make enquiries with the following person/persons* for the purposes of locating the beneficiary. If no contact name is provided, this will not affect the validity of this appointment. Names and details of other contact persons can be provided on separate sheets, which you should sign and date.

Full Name		
Address		
INCLUDING HOUSE NUMBER OR APARTMENT NUMBER AND NAME		
Post Code		
Telephone Number		
	INCLUDING INTERNATIONAL COUNTRY CODE	INCLUDING INTERNATIONAL COUNTRY CODE
Email address		

I understand that this beneficiary appointment shall be revoked by any assignment or disposal of the Policy. I also understand that it shall be revoked by my death if, at my death, I am survived by other persons named as Life Insured on the Policy. This instruction shall form part of the Policy and any appointments made, are made in accordance with the relevant provision of the Policy Terms and Conditions.

ALL SIGNATORIES TO PART 14 MUST SIGN HERE IN THE SAME CAPACITY.

Life Insured 1
WHO WILL ALSO BE POLICYHOLDER 1 IF SECTION 4 IS NOT COMPLETED

Signature

Date D D M M Y Y Y Y

Life Insured 2
WHO WILL ALSO BE POLICYHOLDER 2 IF SECTION 4 IS NOT COMPLETED

Signature

Date D D M M Y Y Y Y

Policyholder 1
ONLY TO BE SIGNED IF POLICYHOLDER 1 IS DIFFERENT TO LIFE INSURED 1

Signature

Date D D M M Y Y Y Y

Policyholder 2
ONLY TO BE SIGNED IF POLICYHOLDER 2 IS DIFFERENT TO LIFE INSURED 2

Signature

Date D D M M Y Y Y Y

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Part 16 - Payment Details

Premiums can be paid Monthly, Quarterly, Semi-Annually or Annually, by Banker's Standing Order, Telegraphic Transfer, or Credit Card. Please note that monthly premium payments must be made by Credit Card.

Please select your preferred method of premium payment.

☐ Credit Card ☐ Standing Order ☐ Bank Transfer

Credit Card Payments

If your premium frequency is monthly, you must pay by Credit Card.

Our Card payments are managed by Cybersource and we can accept payments by Visa and Mastercard.

If you have elected to pay by Credit Card, once we have confirmed your application is approved, and the premium amount, we will send you a secure link for your Policy to the Payments section of our website. You will need to enter your Credit Card details and approve the ongoing Credit Card authority. Once you have completed this, and your first payment is approved, your Policy will be issued.

Banker's Standing Order

Most banks insist on completion of their own standing order form or provide a facility for their customers to set up standing orders online. After we have confirmed that your application has been approved, and confirmed the premium amount, please make arrangements with your bank to set up your standing order using the bank details below.

When setting up your standing order, please ensure you stipulate that all premiums will be paid net of charges to ensure the full premium amount is received by us. As payment reference, please state your Family Name and the Quote Number (e.g. SESxxxxxx) entered on your application form.

If you set up the standing order at your bank, please forward us a copy of the standing order form with the official bank stamp. If you set up your standing order online, please print the confirmation page once complete, and forward us a copy.

Bank Transfer/Online Payment

If you elect to make payment by Telegraphic Transfer, please ensure that all premiums are paid net of charges to ensure the full premium amount is received by us. As payment reference, please use your Family Name and the Quote Number (e.g. UNIxxxxxx) entered on your application form.

Currency	**USD**
Account Name	Specialty Emergency Services
Bank	Standard Chartered Bank Lusaka Main Branch Cairo Road Lusaka 10101 Zambia
BIC/SWIFT	**SCBLZMLX**
IBAN	
Account No.	**8700 2114 33501**
Sort Code	**06 00 17**

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM

Service and **Administration** Contact Details

If we can help you with more information about our product offerings, or if you would like to meet with one of our product experts, please contact us:

Local

P.O. Box Address
Specialty Emergency Services
P. O. Box 30337
Lusaka

Physical Address
Plot 335
Cnr Kafue & Mahogany Dr.
Lilayi, Lusaka

Contact Numbers
+260 977 770 302
+260 962 740 300

Global

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139 Greenway
Greenside, Randburg
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South Africa

Tel: +27 10 592 1752

United Kingdom
40 Gracechurch Street
London
EC3V 0BT
United Kingdom

Tel: +44 207 118 1455

Asia
D4-6-9 Solaris Dutamas
Jalan Dutamas 1
50480, Kuala Lumpur
Malaysia

Tel: +60 3 6206 1616

Central email enquiries: info@ses-unisure.com
Please specify within your query which country or area your enquiry relates to

ses-unisure.com