MHA
Authorised Financial Services Provider
FSP#10134

POLICY AMENDMENT FORM

One form per policy

Call Centre 0861 001 788

NHB
Authorised Financial Services Provider
FSP#11314

1. POLICYHOLDER DETAILS (PERSONAL DETAILS COMPLETED ON THIS FORM WILL BE USED TO UPDATE EXISTING DETAILS ON YOUR POLICY)

Name | Surname

ID Number | Date of Birth (D D / M M / Y Y Y Y)

Tel No (H) | Tel No (W) | Cell No

Fax No | Email Address

Physical Address

Policy Number | SADTU [X] | NEHAWU [X] | OTHER [X] | Code

2. SELECTION

- [ ] Adding / removing / updating particulars of Dependants (Section A)
- [ ] Updating particulars of Nominated Beneficiary (Section B)
- [ ] Updating particulars of Plan selection and / or change in premium (Section C)
- [ ] Changing / updating payment method (Section D)

SECTION A. ADDING / REMOVING OR UPDATING PARTICULARS OF DEPENDANTS

Select the plan you wish to update:

- [X] SADTU Prosperity Funeral Plan
- [X] Top Up / Xtra Cover for Immediate Dependants
- [X] Immediate Dependants Funeral Plan
- [X] Extended Dependants Funeral Options / Bundles / Plan

RELATIONSHIP	NAME & SURNAME	ID NUMBER	PERSONAL INFORMATION ADD	PERSONAL INFORMATION UPDATE	PERSONAL INFORMATION REMOVE	IS THERE A PLAN / PREMIUM CHANGE NEEDED? EXPLAIN IN SECTION C
			X	X	X	X
			X	X	X	X
			X	X	X	X
			X	X	X	X

SECTION B. UPDATING PARTICULARS OF NOMINATED BENEFICIARY

RELATIONSHIP	NAME & SURNAME	CONTACT NUMBER	ID NUMBER

SECTION C. UPDATING PARTICULARS OF PLAN SELECTION

Explain your request in detail. Points to note:

1. Identify the Dependant, the Dependant's ID Number / Date of Birth and the Policyholder's relationship with the Dependant for option / plan changes.
2. Using the rate card, identify the Dependant's current plan and what new plan / option / bundle / Extended Dependant option the Policyholder would like to change to.
3. Identify the new premium to be paid.

	NEW MONTHLY PREMIUM
e.g. Please change Thembisa Pako's plan. She is my grandmother. Her date of birth is 01/07/1959. I would like her current option of R59 changed to option R121.50	R 121.50
eg. Please can you change my current plan of R82 to R93.50.	R 93.50
	PREMIUM
CONFIRMATION OF TOTAL NEW PREMIUM	R

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ASSUPOL

SECTION D. CHANGING / UPDATING PAYMENT METHOD - THE BELOW DEBIT ORDER AUTHORISATION MUST ALSO BE COMPLETED

CURRENT PAYMENT METHOD | NEW PAYMENT METHOD: PERSAL [X] DEBIT ORDER [X] OTHER [X]

Name & Surname | ID Number

Amount to be deducted R | Preferred date of 1st deduction D D M M Y Y Y Y

STOP ORDER / PERSAL AUTHORISATION

Occupation | Persal or other? Other [ ] SASSA [ ] Persal [ ] SANDF [ ]

If Persal, Persal Number [ ][ ][ ][ ][ ][ ][ ][ ] [ ][ ] (SANDF) | If SANDF, Department Code

I hereby authorise the Accounting Officer of the Department of _____ to deduct the premium indicated above from my salary on a monthly basis and remit it to Assupol, from which I have obtained an insurance policy, until such time as I cancel this authorisation in writing or until I substitute it with a new authorisation. Should the relevant premium be adjusted by Assupol as a result of a general contractual increase / decrease in the premium, or should I request Assupol to increase / decrease the premium for certain reasons, I hereby grant permission that the adjusted premium may be deducted from my salary until such time as I cancel this authorisation in writing or substitute it with a new authorisation. No pro-rata (proportional) payments are applicable. Only full payment in respect of the premium is accepted.

X		
Full name of Policyholder / Premium Payer	Signature of Policyholder / Premium Payer	Date

If payment by Persal is not possible I authorise that my method of payment be changed to bank debit order [X]

DEBIT ORDER AUTHORISATION

Name of Account Holder

Name of Bank: FNB | ABSA | NEDBANK | STD BANK | BIDVEST | CAPITEC | OTHER

Account Number

Branch Name | Branch Code

Type of Account: Cheque [X] Savings [X] Transmission [X]

Day of debit order

SELECT THE CORRECT DEBIT ORDER DESCRIPTION

Debit Order Description in respect of MHA Funeral / MHA Value Plan: MHAPROSPER [X] OR MHAVALUEPL [X]

Debit Order Description in respect of NHB Funeral / NHB Value Plan: NHBPROSPER [X] OR NHBVALUEPL [X]

I hereby authorise Assupol (Pty) Ltd ("Assupol") and / or MHA Management Holdings (Pty) Ltd ("MHA") and / or NHB Administrators (Pty) Ltd ("NHB") to draw against my account (or any other bank or branch to which I may transfer my account), the premium payable under the above plan, and I request my bank to debit my account in terms of this order. This request will remain in force until cancelled by me in writing. I understand that I shall not be entitled to any refund of amounts which have been withdrawn while this authority was in force if such amounts were legally owing to Assupol and / or MHA and / or NHB. I hereby irrevocably authorise Assupol and / or MHA and / or NHB to obtain at any time verification of my account details from my bank. Further, if there are insufficient funds in the nominated account to meet the obligation, you are entitled to track my account and re-present the instruction for payment as soon as sufficient funds are available in my account. All such withdrawals from my bank account by you shall be treated as though they have been signed by me personally.

X		
Full name of Premium Payer	Signature of Premium Payer	Date

PROTECTION OF PERSONAL INFORMATION

MHA / NHB may use personal information about you, as defined in the Protection of Personal Information Act, that MHA / NHB lawfully obtained in the past or may obtain in the future, including the information provided to MHA / NHB for this form, for the following reasons:

- To consider applications for policies of which you are the Policyholder of Life Assured; and
- For all purposes of such policies, issued in the past or in the future, particularly to consider claims for benefits and to trace persons who could receive benefits (tracing fees may be deducted from the benefits)
- To market MHA / NHB and its associates' products and services

PLEASE STATE PREFERRED METHOD OF CONTACT	Post	Email	SMS

DO YOU GIVE MHA / NHB PERMISSION TO CONTACT YOU REGARDING ADDITIONAL BENEFITS?	YES	NO
DO YOU GIVE MHA ASSOCIATES PERMISSION TO CONTACT YOU REGARDING ADDITIONAL PRODUCTS?	YES	NO

X		
Full name of Policyholder	Signature of Policyholder	Date

Representative Name | Representative ID Number

Representative code | Representative Signature