CAPITAL ALLIANCE LIFE LIMITED
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CAPITAL ALLIANCE
Group Risk
A division of Liberty Corporate

Funeral Nomination Form

Scheme name UKZN BENEFIT ARRANGEMENT Scheme number RG308

1. Principal member's details

Surname ______________________ First names ______________________

Staff number ______________________ Date of birth D D M M Y Y Y Y

Identity number ☐☐☐☐☐☐☐☐☐☐☐☐☐ Premium GROUP - UKZN

College ______________________ Campus ______________________

Postal address ______________________ Code ________

Residential address ______________________

Telephone number (work) (c o d e) ______________________

Cellular number ______________________ E-mail address ______________________

(Please note that these benefits cover family members who are your financial dependents only)

2. Immediate Dependants covered under the Group Policy

	Surname	First Names	ID Number	University Medical Aid? Y/N	Other Medical Aid? Y/N
Principal Member					
Spouse	1.				
Spouse	2.				
Children (max 8)	1.				
	2.				
	3.				
	4.				
	5.				
	6.				
	7.				
	8.				

3. Extended Family Dependants covered at my request and at my cost (maximum of 8)

Relationship	Surname	First Names	ID Number	Age	Premium
			Total Premium		R

Declaration by Principal Member:

All the information set out in this form is true and complete.

I am aware that I must inform Capital Alliance Group Risk in writing should I wish to add additional family members under the extended family cover, and that extended family cover will only commence upon receipt of the first premium.

With regard to any cover applied for in respect of extended family dependants, I declare and agree to the following terms and conditions:

- All the information in this form that has been supplied in connection with my application for extended family benefits is true and complete, and will form the basis of this extended policy. I understand that any misrepresentation or false information can lead to the cancellation of these benefits, in which case all monies paid to Capital Alliance Group Risk will be forfeited.
- I understand that extended family policy will only be activated once the first premium is received, and that there is a six month waiting period for claims due to natural causes. I have signed a stop order form and provided it to the UKZN Payroll Department, in order for them to effect payment on my behalf monthly. I understand that payment for the extended family cover is my responsibility and that I must check that the stop order has been implemented, and remains in force.
- I agree to my premium being automatically adjusted after I have been advised of any annual premium adjustment that may apply, and undertake to alter the stop order myself when any of my family members covered under the extended family policy reach ages 65 or 75, at which ages I understand that the premium increases. I understand that in the event of my not doing this, my family member's cover may be cancelled.
- I confirm that I have read this declaration and understand the implications thereof.

Signature of Principal Member ______________________________ | D | D | M | M | Y | Y | Y | Y |

FOR OFFICE USE ONLY

	Date	Notes
Form Received by the Fund Office		
Forms checked, and any queries raised		
Stop Order Form forwarded to Payroll Department (in cases of Extended Family Cover)		
Funeral Nomination Form sent to Capital Alliance		