

REQUEST FOR REINSTATEMENT FORM

Medical questionnaire application to be completed (this is dependent on your policy's terms and conditions)

A. POLICYHOLDER'S DETAILS

Policy Number

Surname Title and Initials

Full Names Contact Number

Passport / ID Number.....Date of Birth (yyyy / mm / dd).....

Email Address Postal Address.....

..... Postal Code

B. PREMIUM PAYMENT DETAILS (only choose one)

Option A – Debit my Bank Account

Account Holder

Bank Name and Branch

Account Number Branch Code

Type of Account Deduction Date

Expiry Details (only applicable to credit card deduction requests).....

Option B – Stop Order Deduction

Employee Number Facility Code

Employer's Name

I, hereby request that my policy premium be deducted from the above account/salary. I understand this premium will automatically increase in terms of the policy conditions on each anniversary unless such increase is cancelled or deferred by me in writing.

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SIGNATURE OF PREMIUM PAYER

DATE

C. DECLARATION BY POLICYHOLDER

I, the undersigned hereby acknowledge that I understand the content contained herein and confirm that the above information is true and correct in every detail and that Sanlam Developing Markets Ltd is hereby authorised to update and amend my personal details.

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SIGNATURE OF POLICYHOLDER

DATE

CONTACT US

Client Contact Centre: 0861 235 433
 Fax: 011 388 5084
 Postal address: PO Box 1941, Houghton 2041, South Africa
 Physical address: Sanlam Business Park, 13 West Street, Houghton, 2198
 E-mail address: info@sanlamsky.co.za

THIS POLICY IS UNDERWRITTEN AND ADMINISTERED BY SANLAM DEVELOPING MARKETS LIMITED, AUTHORISED FINANCIAL SERVICES PROVIDER, FSP NUMBER 11230/1