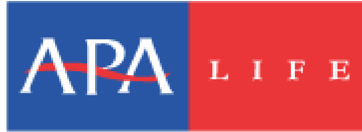

GROUP LAST EXPENSE APPLICATION FORM

All questions must be answered in full and in BLOCK letters

Proof of identity of Self and dependants is required. Provide copies of National Identity Card, Passport or Birth Certificate together with this application.

Scheme Name: **DFSL**

Full Name: .... Gender ....

ID No.. Date of birth: ....

Tel No .... Email: ....

SECTION A. DEPENDANTS

I hereby declare the following dependants to be considered for cover

Full Names	ID No	Date of birth	Tel No

I hereby declare the following Beneficiaries to be considered to receive my insured benefit in the event of my death

Full Names	ID No	Date of birth	Tel No	%

Are the dependants listed above currently in good health?

YES ☐ NO ☐ If no give details

SECTION B. To be completed by Chairperson / Authorized Official

As Chairperson / Authorized official, I confirm that the information given above is correct.

This Member is to be included in the Scheme with effect from: ………./………..2024 (Date)

Signature of Chairperson/Authorised official ……………………………………………..…………………

Signature of Principal Member ……………………………………….………………………

Date of signing…………………………

Benefit Option selected

Tick Option Chosen							
BENEFIT	**500,000**	**300,000**	**250,000**	**200,000**	**150,000**	**100,000**	**50,000**
M	5,000	3,000	2,500	2,000	1,500	1,000	500
M+1	6,000	3,600	3,000	2,400	1,800	1,200	600
M+2	6,900	4,200	3,500	2,800	2,100	1,400	700
M+3	8,000	4,800	4,000	3,200	2,400	1,600	800
M+4	9,200	5,500	4,600	3,700	2,800	1,900	1,000
M+5	10,500	6,300	5,300	4,200	3,200	2,100	1,100
Extra Child	1,500	1,250	1,000	750	500	500	500
Cover Per Parent < 75	2,500	1,500	1,250	1,000	750	500	500

Parents/ Parents - In - Law Rates (Cover Per Person)

Tick Option Chosen					
Cover Limits	250,000	200,000	150,000	100,000	50,000
76 - 84 Years	5,000	4,000	3,000	2,000	1,000
85 - Unlimited Years	No Cover	No Cover	No Cover	No Cover	2,500

- Parents & Parents in law benefit should be less or equal to the principal member benefit

Declaration (please tick if in agreement):

☐ I have understood the benefits covered under the scheme.

☐ I understand that the statements and all information provided in this application form are complete and true to the best of my knowledge and that it will form part of the policy.

☐ It is also agreed that APA Life will incur no liability under this application until:
- the application has been received and approved;
- the premium has been paid and accepted by APA Life

☐ I understand that no intermediary has the authority to waive the answers to any of the questions in this application or to make or alter any contract for APA Life Assurance Limited.

☐ I understand that claims resulting from illness will not be paid during the first 3 months of the commencement date of the policy.

Signed By(Your Name)--**On**------------**Day** ------------**Of** -------------- 2024

I --, hereby accept and agree to the terms and conditions outlined in this document, and acknowledge my consent by entering my name below as my electronic signature.