



Together in Grief

# TOGETHER FUNERAL ADMINISTRATORS

Reg. No. 2002/040403/23

## GROUP FUNERAL ASSISTANCE SCHEME AND MEMBERSHIP CERTIFICATE

*N.B. The Membership will only become valid and binding when all premiums have been paid.*

Inception date	<input type="text"/>	Client No.	T	F	A	<input type="text"/>	Persal No.	<input type="text"/>
Scheme Name	Plan A <input type="checkbox"/>	House Hold <input type="checkbox"/>	Prestigious Plan <input type="checkbox"/>		Special Scheme <input type="checkbox"/>			

*Please note that the particulars of ALL participants as mentioned in this application form must correspond with that in their identity document. Only persons under the age of 65 are accepted for the basic plan.*

1. BASIC PLAN SELECTED	Basic Plan Selected _____		
	1.2 Applicant	<input type="text"/>	1.1 Mode of Payment
	Surname		I.D. Number
	Names		Date of Birth
	Address (Home)		Age next birthday
	Address (Postal)		Occupation
	Telephone No.(H)		Telephone No.(W)
			E-mail:
	INCOME BRACKET: Under R3500 <input type="checkbox"/>		
	R3500 - R5000 <input type="checkbox"/>		
R5000 - R7500 <input type="checkbox"/>			
Above R7500 <input type="checkbox"/>			

2. Direct Family (First Spouse and children only.)	SURNAME	FIRST NAMES	ID Number	
	Spouse			
	Child 1			
	Child 2			
	Child 3			
	Child 4			
	Child 5			
	Child 6			

3. Parents & Extended Family members	SURNAME	FIRST NAMES	RELATIONSHIP	COVER	ID Number	

4. Beneficiary	Beneficiary:	<input type="text"/>
	ID Number:	<input type="text"/>

5. Premium Calculation	Basic Plan Selected : Plan	<input type="text"/>	R
	Total Premium	<input type="text"/>	
	Joining Fec.....R	<input type="text"/>	Monthly Premium R

DIRECT DEBIT ORDER DETAILS			
Name of Bank	<input type="text"/>	Branch	<input type="text"/>
Account Name	<input type="text"/>	Account Number	<input type="text"/>
		8 Digit branch code	<input type="text"/>
		Town/City	<input type="text"/>

I the undersigned, request Together Funeral Administrators, to arrange with my bank to collect the premium payable in the terms of the scheme against my bank account in the terms of a debit order.

Signed at :	<input type="text"/>	On the	<input type="text"/>	Day of	<input type="text"/>	201
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**Declaration by applicant (please read carefully):**

- \* Member, Spouse and Own Children - (six) 6 months
- \* Parents and Extended Family - (nine) 9 months of natural causes
- \* Death following an accident (suicide excluded) is covered after 1 month with an effect of the first premium.
- \* A 12 month waiting period is applicable to all members in the Classic Scheme, due to natural death.
- \* Individuals 3 months waiting period.
- \* 24 months waiting period for suicide.
- \* Company reserves the right to adjust premiums according to the ages of parents and extended family members.
- \* Premiums are payable promptly on or before the 7th of every month.
- \* Should you fail to pay your policy within the specified period the policy will lapse and no claims will be payable.
- \* Transportation of deceased will be made available for the first free 70 kilometers radius, there-after kilometers will be charged per distance traveled.

Premium Payer

AGENT No.

NAME OF AGENT \_\_\_\_\_

SIGNATURE OF APPLICANT AND/OR PREMIUM PAYER \_\_\_\_\_

SIGNATURE OF AGENT \_\_\_\_\_



Head Office  
57 Bester Street  
PO Box 4189, Nelspruit 1200

Telephone (013) 755-1435 / 752-7317  
Facsimile: (013)755-3477 / 752-7315  
Email: togetherfa@telkomsa.net

## AMENDMENT TO EXISTING POLICY

POLICY HOLDER: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_

IDENTITY NO: \_\_\_\_\_

PLAN OF ASSURANCE: \_\_\_\_\_

OLD PREMIUM: \_\_\_\_\_

NEW PREMIUM: \_\_\_\_\_

MODE OF PAYMENT AND DATE: \_\_\_\_\_

ACTION DATE: \_\_\_\_\_

### PLEASE TICK THE APPROPRIATE BLOCK

### ATTACH DOCUMENTS

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> DELETION OF MEMBER    | <input type="checkbox"/> ADDITION OF MEMBER | <input type="checkbox"/> CHANGE MODE OF  |
| <input type="checkbox"/> CHANGE NAME & SURNAME | <input type="checkbox"/> CORRECTION OF DOB  | <input type="checkbox"/> CANCELLATION OF |
| <input type="checkbox"/> CHANGE OF ADDRESS     | <input type="checkbox"/> POLICY UPGRADE     | <input type="checkbox"/> OTHER           |

PART ONE: \_\_\_\_\_

\_\_\_\_\_

PART TWO: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PART THREE: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DATE SUBMITTED AT BRANCH OFFICE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

DATE SUBMITTED AT HEAD OFFICE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

DATE FINALISED: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

**POST AND FAXED DOCUMENTS ARE ACCEPTED**



# Together Funeral Administrators cc.

2002/040403/23

*Together in Grief*

## DEDUCTION AND PAY-OVER AUTHORITY GROUP SHORT-TERM INSURANCE

57 BESTER STREET, NELSPRUIT 1200  
P.O. BOX 4189, NELSPRUIT 1200

TEL: (013) 755 1435      FAX: (013) 755 3477  
752 7317                      752 7315

### **STOP ORDER**

I, the undersigned: \_\_\_\_\_ Policy Reference No: \_\_\_\_\_

(a) Full Name and Surname: \_\_\_\_\_

(b) Occupation: \_\_\_\_\_ (c) Salary No: \_\_\_\_\_

(d) Department: \_\_\_\_\_

(e) Name of School/Institution: \_\_\_\_\_ (f) Pay point: \_\_\_\_\_

(g) Identity No: \_\_\_\_\_

hereby authorize the Accountant of my Department to deduct from my salary as follows:

1. The first deduction to be made at the end of \_\_\_\_\_  
amount to R \_\_\_\_\_ plus R \_\_\_\_\_ = R \_\_\_\_\_ which includes the stamp duty as well as the initial premium.

2. Monthly deductions thereafter should be R \_\_\_\_\_  
Kindly deduct the premiums and remit to Together Funeral Administrators from whom I have obtained a short-term funeral policy.

Should the relevant premium be adjusted by the company as a result of general decrease/increase in premium or should I request the company to decrease/increase the premium for certain reasons, I agree that the adjusted premium (including stamp duty) may be deducted from my salary, until such time as I cancel this authority in writing or until I substitute it with a new authority.

#### **EMPLOYEE'S CONSENT**

I hereby understand that should deduction not be made for some reason or another from my salary/wages, my monthly premium shall not be paid over to Together Funeral Administrators by my employer and further that I shall be responsible for payment. Should my payment as stated and agreed upon on the stop-order not be received by the 7th of every month, my benefits shall be immediately withdrawn.

Signed at: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of proposer: \_\_\_\_\_

#### **PARTICULARS OF AGENT**

Debit No: \_\_\_\_\_ Branch office: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone No: \_\_\_\_\_

Signature:  \_\_\_\_\_