

Additional insured life for Myriad

Complete additional forms as necessary for additional insured lives.

Quote ref number

Section 1: Insured life

Surname (as on ID)																					Title									
First name (as on ID)																														
Second name (as on ID)																														
Previous surname(s)																														
Home language	English				Afrikaans																									
Permanent ID/Passport number											Permanent ID number										Passport number									
Country of issue											Nationality																			
Residential address																									Postal code					
Postal address																									Postal code					
E-mail address																														
Telephone - cellphone													Telephone - alternative																	
Are you currently insolvent?																					Yes				No					
Are you a politically exposed person?																					Yes				No					

Section 2: Momentum Interactive

Please complete this section if you have applied for Momentum Interactive. All questions relate to the insured life.

- Have you had any motor vehicle accident insurance claims during the last three years? Yes No
- What distance have you travelled by road in the last year, either as a driver or passenger? km
- Are you the regular driver of a vehicle insured with Momentum Short Term Insurance? Yes No
- How should we apply any discount that you may qualify for? Reduce your premium Increase your cover

Section 3: Underwriting

All questions relate to the insured life.

A. Occupation

- Description of your main duties
- Percentage of working hours spent on

Travel	<input type="text"/>	Admin	<input type="text"/>	Supervision	<input type="text"/>	Manual work	<input type="text"/>
--------	----------------------	-------	----------------------	-------------	----------------------	-------------	----------------------
- Name of employer/Company name
- Industry in which you work
- How many years have you been performing your current occupation?
- How many years have you been employed by your current employer?
- Does your occupation require you to work underground, offshore, at heights or are you exposed to any danger while performing your occupational duties? Yes No

If Yes, please provide full details

A. Occupation (continued)

- ## B. Foreign travel

- ### C. Avocation

- #### D. Insurance history

1. Do you have any existing insurance? Yes ☐ No ☐
- Please complete the table below, giving the total for which your life will be insured. **In your calculation, please include all your existing cover plus the amounts on this application and any other simultaneous applications you are making and then deduct any amounts which you intend cancelling within the next four months.**

Insurance	Life cover	Dread disease/ Critical illness	Occupational disability	Monthly disability income
Business				
Personal				
Group cover				

- | | | | |
|----|---|-----|----|
| 2. | Has an insurer ever declined, postponed or withdrawn any of your benefit(s) applied for, or accepted it at an increased premium, or reduced the benefit(s) applied for, or issued a benefit subject to an exclusion clause? | Yes | No |
| | If Yes, please supply name of insurance company/ies. | | |

Replacement of insurance

3. Does this application replace the whole or any part of your existing insurance with any insurer (either immediately or to replace an insurance discontinued within the last four months or within the next four months)? Yes No
- If Yes, please complete the table below and (South Africa only) a *Replacement Policy Advice Record*.

Insurer																

Policy number								

If this policy will be replacing cover on the same insured life on an existing Myriad policy or a Myriad policy lapsed within the past 12 months, then this application will need to be accompanied by a replacement approval letter from the Myriad Replacement Panel. Please contact your marketing adviser or your local sales office should you require assistance in obtaining this letter.

Section 3: Underwriting (continued)

E. Habits, measurements and family history

1. Smoking habits within the past 6 months:

Have not smoked 1 - 10 per day 11 - 20 per day 21 - 30 per day > 30 per day

2. Do you consume any form of alcohol? If Yes, please indicate the average number of units per week (1 unit = 1 bottle beer or 1 glass of wine or 1 tot of spirits).

Yes No

1 - 10 per week 11 - 20 per week 21 - 30 per week > 30 per week

3. Have you ever received medical advice to stop/reduce alcohol intake and/or smoking?

Yes No

If Yes, please provide full details.

4. Height m Weight kg

5. Has your weight changed by more than 5 kg during the last year?

Yes No

If Yes, please indicate how much it has changed by kg

Why? Exercise Diet Pregnancy Illness/Medical condition Other

6. Has any of your father, mother or siblings suffered from any hereditary disorder or major illness under the age of 60, as listed below?

Yes No

If Yes, please complete table below.

✓	Disorder/illness:	No. of family members
	Cancer of the breast (Indicate age at diagnosis. If more than one family member, provide youngest age.)	<input type="text"/> Age
	Cancer of the colon (Indicate age at diagnosis. If more than one family member, provide youngest age.)	<input type="text"/> Age
	Cancer other than the above (Indicate age at diagnosis. If more than one family member, provide youngest age.)	<input type="text"/> Age
	Heart disease, raised cholesterol, CAD, hypertension/blood pressure, heart attack/bypass or stroke, chest pain	
	Diabetes	
	Depression, mental disorders	
	Alzheimers disease	
	Polycystic kidneys	
	Huntington's disease	
	Retinitis Pigmentosa	
	Other (Please indicate below.)	

F. Doctors/specialists/healthcare provider(s)

1. Please complete the name, surname and practice name of your regular doctor/specialist/healthcare provider. If you don't have a regular doctor, then please provide the details of a doctor whom we may send confidential correspondence to (if required).

Name and surname of doctor

Practice name

Practice telephone number

2. Are you a member of a medical aid?

Yes No

If Yes, name of medical aid provider

Section 3: Underwriting (continued)

G. Medical history (continued)

Do you currently or have you ever suffered from any of the following?

1. Heart or blood circulation

Yes

No

1.1 High blood pressure ☐

1.4 Heart attack ☐

1.7 Stroke ☐

1.10 Ischaemic heart disease ☐

1.2 Raised cholesterol ☐

1.5 Heart murmur ☐

1.8 Any cardiac procedure ☐

1.11 Other ☐

1.3 Palpitations ☐

1.6 Rheumatic fever ☐

1.9 Chest pain ☐

2. Respiratory and/or lung complaints

Yes

No

2.1 Asthma ☐

2.4 Persistent coughing ☐

2.2 Bronchitis ☐

2.5 Other ☐

2.3 Tuberculosis ☐

3. Disorders of the digestive system, gall bladder, pancreas or liver

Yes

No

3.1 Hepatitis A or Jaundice ☐

3.4 Hepatitis B, C or E ☐

3.7 Rectal bleeding ☐

3.2 Hiatus hernia ☐

3.5 Gastric ulcers ☐

3.8 Other ☐

3.3 Gall stones ☐

3.6 Pancreatitis ☐

4. Disorders of the kidneys, bladder or reproductive organs

Yes

No

4.1 Kidney stones ☐

4.4 Protein in the urine ☐

4.2 Bladder infection ☐

4.5 Prostate problems ☐

4.3 Blood in the urine ☐

4.6 Other ☐

5. Disorders of the central nervous system or mental disorders

Yes

No

5.1 Brain disorders ☐

5.4 Persistent migraine or headache ☐

5.7 Parasthesia ☐

5.9 Depression, stress or anxiety ☐

5.2 Epilepsy ☐

5.5 Multiple sclerosis ☐

5.8 Consultation with psychiatrist or psychologist ☐

5.10 Other ☐

5.3 Blackouts ☐

5.6 Neuralgia ☐

6. Problems with your spine, joints, bones, muscles, limbs or skin

Yes

No

6.1 Gout ☐

6.4 Psoriasis ☐

6.7 Back problems ☐

6.10 Fibromyalgia ☐

6.2 Arthritis ☐

6.5 Dermatitis ☐

6.8 Neck problems ☐

6.11 Arthroscopy ☐

6.3 Rheumatism ☐

6.6 Fractured/broken bones ☐

6.9 Slipped disc ☐

6.12 Other ☐

7. Disorders of the ear, nose, throat or eye, excluding conditions corrected by lenses or keratotomy

Yes

No

7.1 Defective vision ☐

7.4 Other ☐

7.2 Hearing loss ☐

7.3 Hoarseness ☐

8. Diabetes, raised blood sugar, other endocrine, glandular, blood or hormonal disorders

Yes

No

8.1 Bleeding disorders ☐

8.4 Diabetes/sugar in urine ☐

8.2 Anaemia ☐

8.5 Raised blood sugar ☐

8.3 Thyroid problems ☐

8.6 Other ☐

9. Any form of malignant cancer, growth or tumour, whether removed or existing

Yes

No

9.1 Skin ☐

9.4 Liver ☐

9.7 Prostate ☐

9.2 Breast ☐

9.5 Lung ☐

9.8 Other ☐

9.3 Bowel ☐

9.6 Brain ☐

Details of medical condition/problem

If you ticked Yes to any of the conditions above, please provide us with more detail in the table below.

Q no	Condition/impairment detail	Doctor initial and surname	On treatment?		Last symptoms							Fully recovered?	
			Yes	No	M	M	Y	Y	Y	Y	Y	Yes	No
			Yes	No	M	M	Y	Y	Y	Y	Y	Yes	No
			Yes	No	M	M	Y	Y	Y	Y	Y	Yes	No
			Yes	No	M	M	Y	Y	Y	Y	Y	Yes	No
			Yes	No	M	M	Y	Y	Y	Y	Y	Yes	No

G. Medical history (continued)

10. Any form of benign cancer, growth or tumour, whether removed or existing

Any form of benign cancer, growth or tumour, whether removed or existing						Yes	No	
10.1	Moles or lumps		10.2	Fibroadenoma		10.3	Sun spots/solar keratosis	
10.4	Sebaceous cysts		10.5	Lumps/cysts in breast		10.6	Other	

Yes No

11.1	ECG		11.2	Scans		11.3	X-rays		
11.4	Specialised laboratory tests		11.5	Tumour markers		11.6	Genetic testing		
11.7	Had an operation or been a patient at any medical facility						11.8	Angiogram	
11.9	Other								

Yes No

12.1	HIV test - negative result		12.2	HIV test - positive result		12.4	Sexually transmitted disease	
12.4	Other							

Yes No

13.1	For conditions that you have already specified in the preceding questions	
13.2	For any other condition or symptoms that you have not told us about	

Yes No

14.1	Antidepressants	14.2	Homeopathic medicines	14.3	Anabolic steroids
14.4	Cannabis	14.5	Cocaine	14.6	Any other substance

Yes No

If Yes, please provide full details:	
--------------------------------------	--

Yes No

If Yes, please provide full details.	
--------------------------------------	--

If you ticked Yes to any of the conditions above, please provide us with more detail in the table below.

[illegible]

1. Please indicate your preference for obtaining medical information for underwriting.

Please get medicals from other insurer**

**** This option is only available if those medicals were performed within the past 12 months.**

[illegible]

Section 4: Additional questions for income benefits

Complete this section only if you are applying for one or more of the following benefits: Income protector; Temporary income protector; Business protector; Business overheads expenses benefit or Retrenchment waiver benefit.

You only need to complete the applicable parts:

- If you are self-employed, a business owner or a self-employed/fee earning professional, complete part A.
- If you are an employee of a company, complete part B.
- If you are applying for a business overheads expenses benefit, complete part A and part C.

When completing the income questions below, please use the following definitions to calculate the income amount you should declare.

- **Gross taxable income (taxable income)**
This is the taxed income or benefits that you receive on account of your employment, or any services that you deliver.
- **Cost to company income (gross taxable income plus drawings)**
This is the gross taxable income plus drawings in the form of dividends. It includes the value of the use of a motor vehicle, as well as your employer's contributions to a medical scheme and/or a pension fund, and the cost of any other benefits paid for by your employer.
- **Gross professional income (for professionals that charge a fee for service)**
This is the sum of the professional fees that you charge and the net income from trading activities after deducting your business overhead expenses.

A. Self-employed, business owner or self-employed/fee earning professional

- How many years has your business been trading?
- How many years have you owned the business?
- Is this a family business? Yes No
- Is the business based at your home? Yes No
If Yes, do you have business rights to operate from your home? Yes No
- How many partners/business associates do you have?
- How many of your employees/partners/business associates are capable of performing your job?
- What is your percentage share in this business?
- How many permanent employees do you have (excluding temps, contractors or seasonal workers)?
- Are you aware of any processes pending against your business for liquidation/administration or debt review? Yes No
If Yes, please provide full details.
- What was your gross taxable income or cost to company income or gross professional income during the past 12 months?
(Refer to definitions of income above, before answering.)
- 10.1 Was any of this income based on commission? Yes No
If Yes, how much commission did you earn during the past 12 months?
- 10.2 Will you continue to receive income from other sources if you are unable to work (such as rent, investments, shareholdings in other companies, etc.)? Yes No
If Yes, how much income did you earn from this source(s) during the past 12 months?
- 10.3 Do you anticipate/expect your income to decrease in the next 12 months? Yes No
If Yes, please provide full details.
11. Please complete the table indicating the amount of income protection benefit already in force:

Benefit	Monthly amount	Waiting period (days)	Payment period (months)
Income Protector			
Temporary Income Protector			
Business Cover/Business Protector/Business Overheads Expenses			

Section 4: Additional questions for income benefits (continued)

B. Employee

1. What type of employment contract do you have with your employer? (Please choose one.)

Full time, permanent employee

Contractor/Seasonal/Part time/Casual

Other

Are you entitled to paid sick leave?

Yes

No

If Yes, please provide full details.

--

2. Are you aware of any retrenchments being planned by your employer?

Yes

No

If Yes, are you likely to be affected by this?

Yes

No

3. What was your gross taxable income or cost to company income or gross professional income during the past 12 months?

(Refer to definitions of income above, before answering)

--	--	--	--	--	--	--	--

- 3.1 Was any of this income based on commission?

Yes

No

If Yes, how much commission did you earn during the past 12 months?

--	--	--	--	--	--	--	--

- 3.2 Will you continue to receive income from other sources if you are unable to work (such as rent, investments, share-holdings in other companies, etc.)?

Yes

No

If Yes, how much income did you earn from this source(s) during the past 12 months?

--	--	--	--	--	--	--	--

- 3.3 Do you anticipate/expect your income to decrease in the next 12 months?

Yes

No

If Yes, please provide full details.

--

4. Please complete the table indicating the amount of income protection benefit already in force:

Benefit	Monthly amount	Waiting period (days)	Payment period (months)
Income Protector			
Temporary Income Protector			
Business Cover/Business Protector/Business Overheads Expenses			

C. Business overhead expenses

1. Please complete the table below indicating how much the business pays towards the following expenses per month:

Expense	Amount
Rent or mortgage bond repayment	
Property taxes	
Electricity	
Water	
Telephone(s)	
Regular maintenance services	
Equipment leasing costs	
Insurance premiums	
Accounting fees	
Staff salaries	
Other (please specify)	

2. What percentage of the business turnover is generated from the sale of goods?

--	--	--

3. What is your percentage share of these overheads?

--	--	--

Momentum 268 West Avenue Centurion 0157 PO Box 7400 Centurion 0046 South Africa
ShareCall 0860 66 23 45 Fax +27 12 675 3911 myriad@momentum.co.za www.momentum.co.za

Momentum, a division of MMI Group Limited, an authorised financial services and credit provider. Reg. No. 1904/002186/06

Momentum Namibia Limited Metropolitan Place 5th Floor Cnr Dr Frans Indongo & Werner List Street Windhoek PO Box 79 Windhoek Namibia
Tel +264 (0)61 297 3631 Fax +264 (0)61 297 3573 service@momentum.com.na

Reg. No. 91/369