

RANDMORE
SINGLE & PENSIONER FUNERAL PLAN

MAIN MEMBER

NAME:										SURNAME:										TITLE:									
ID:										GENDER:										CELL:									
										Male ☐										Female ☐									
Current address used for correspondence:																													
Street:																													
City:										Province:										Postal Code:									
Marital Status:										Tel W:										Email:									

BENEFICIARY DETAILS (MUST BE 18 YEARS or OLDER)

Name:										Surname:										Relationship:									
ID:										Gender:										CELL:									
										Male ☐										Female ☐									

Please SELECT your cover premium option

AGE GROUP	BENEFIT	PREMIUM	
Single 18-64	R5 000	R90,00	☐
	R10 000	R110,00	☐
	R15 000	R180,00	☐
Single 65-74	R5 000	R110,00	☐
	R10 000	R180,00	☐
	R15 000	R299,00	☐
Single 75-85	R5 000	R150,00	☐
	R10 000	R299,00	☐
	R15 000	R399,00	☐
Single 86-99	R5 000	R250,00	☐
	R8 000	R350,00	☐
	R9 000	R380,00	☐

COVER AMOUNT CHOSEN	R	My signature below warrants that I have read the terms and conditions of this contract, that I have completed the information on the application form personally and that I fully understand and agree to abide by the terms and conditions. I authorize the verification of the information provided on this form as to my credit and employment. I have received a copy of this application.
TOTAL PREMIUM CHOSEN	R	
MAIN MEMBER SIGNATURE		I HEREBY CHOOSE TO PAY MY MONTHLY PREMIUM ON THIS DATE

RANDMORE FUNERAL PLAN (PTY) LTD – FSP 50088 - DISCLOSURE DOCUMENT/RECORD OF ADVICE



P.O. Box 12081
Centrahil
PORT ELIZABETH
6006

Tel: 041 582 2066
Fax: 086 416 3427
WhatsApp: 082 659 4445
E-mail: admin@randmore.co.za

1ST Floor University Chambers
26 Bird Street, Central
PORT ELIZABETH
6001

I, _____, ID/Passport number _____, am a Representative / Representative Working Under Supervision of the above authorised financial services provider. I have been in financial services since _____. I am authorised to render financial services in Category I sub-categories LONG-TERM A. I am trained and authorised to market and sell the **Randmore FUNERAL PLAN (Pty) Ltd, underwritten by African Unity Life Ltd.**, a licensed life insurer and authorised financial services provider, FSP 8447.

Client Name & Surname		ID																		
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SINGLE NEED IDENTIFIED AND FULL ANALYSIS WAS NOT UNDERTAKEN

You have identified the financial need for a funeral product to cover your family members at the cheapest possible rate. Therefore, **a financial analysis was not conducted.** Please take into account the following important considerations:

1. a full analysis of your financial objectives, financial situation and particular needs was not undertaken;
2. there may be limitations on the appropriateness of the product accepted by you;
3. that you must take particular care to consider on its own whether the advice is appropriate considering your own objectives, financial situation and particular needs.

Product Provider / Insurer Underwritten by African Unity Life Ltd.

Kindly refer to the quote, annexure or policy document for information on Product Supplier and Administrator: name, physical and postal address, telephone details, name and contact details of their compliance department. No product provider holds 10% or more shareholding in this FSP and none are associated companies of this FSP.

Policy No:	RM	Monthly Premium:		Deduction Date:	
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The FSP did earn more than 30% of its total commission during the last financial year from _____. We earn and income from commission that the Product Provider pays over to us on the products purchased by our clients. Fees and commissions will be disclosed in the marketing material or application form. We always strive to **Treat our Customers Fairly (TCF)**. We have implemented a TCF policy and the policy is available on request.

The FSP does hold professional Indemnity Cover. The FSP compliance is outsourced to an external compliance practice, Key Consulting represented by Leanne Morgan who can be contacted on 083 654 1777; fax 086 633 0647 or leanne@keycompliance.co.za. If you feel that your rights have been prejudiced, or you have been aggrieved in any way by a financial loss or you have been treated unfairly by the FSP, **you have the right to lodge a complaint.** Our complaints procedure is available on request and will be provided to you if you ever lodge a formal written complaint.

As a client, no provider may request or induce you in any manner to waiver any right or benefit conferred on you by, or in terms of, any provision of the FAIS Act and Code of Conduct.

The **Protection of Personal Information (POPI) Act** requires us to inform you how we use, disclose and destroy personal information we obtain from you. During the course of rendering services to you we will come into possession of confidential information. It is our undertaking that we will not impart this information to any third parties, unless required to provide you with appropriate advice and intermediary services, or with your specific permission or if required to do so by law.

REPLACEMENT

Have you cancelled any policies in the last 4 months' or will you cancel an existing policy as a result of this advice? If yes, the advisor MUST complete and request you to sign a replacement policy advice record.	YES	NO
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ANNUAL REVIEW

Do you require an annual review of this product or is this a once off transaction? If you require a review, this will be annually and you must contact the representative if you require any assistance during the year.	YES	NO
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I confirm that I have been properly advised of the full implications of my actions and have considered the same. The advisor gave me the relevant product disclosures which included the benefits, exclusions, contributions AND waiting periods.	I declare that the record of advice is an accurate reflection of the single need identified by the client for themselves. I confirm that all documents were completed and signed by the client and that the client did not sign any blank documentation.
CLIENT SIGNATURE	REP SIGNATURE
DATE	DATE

A copy of this document is for you, THE CLIENT, to keep for future reference.

HOW YOUR PREMIUM WILL BE PAID

I the premium payer, will pay the premium of R_____

The day I prefer payment to be made is (for example: on the 25th of every month): _____

OPTION 1: BANK DEDUCTION METHOD

I wish to pay my monthly premium by means of bank debit order and I hereby authorise Randmore to draw my premiums from my bank account. If the premiums change for any reason in terms of the policy or by agreement between Randmore and the policy holder, Randmore likewise may draw the premium from my account. If the payment cannot be done on the preferred day of the month filled in below, it must be done on a day close enough to the date provided, determined by Randmore. Should the policy end, the authorisation also ends. I may cancel, amend or replace this authorization by written notice to Randmore. I accept that Randmore must receive the notice not later than 30 days before the month from which the cancellation, amendment or replacement is to apply. I shall not be entitled to any refund of amounts which you have withdrawn while this Authority was in force, if such amounts were legally owing to you.

NAME OF BANK:		BRANCH NAME:	
BRANCH CODE:		ACCOUNT NUMBER:	
TYPE OF ACCOUNT:	CURRENT ☐	SAVINGS ☐	TRANSMISSION ☐
ACCOUNT HOLDER INITIALS and SURNAME:			
ACCOUNT HOLDER ID NUMBER:		ACCOUNT HOLDER CELLULAR NUMBER:	
ACCOUNT HOLDER SIGNATURE:		DATE SIGNED:	

OPTION 2: NU PAY METHOD

This method allows you to make use of the swipe method. Where you only need to swipe your bank card once and the payment will be set for the months following. Please ask your representative or contact the office help line to explain how you can make use of this paying method.

YOUR DECLARATION AS THE CLIENT

I declare that all information given in this form is complete and correct and that I have received a signed copy. I am satisfied that I understand everything I need to know about the policy and that I will be able to pay my premiums. I am not replacing any existing policies with this policy. I understand and accept the waiting period of six (6) months which applies to any natural cause of death.

MY SIGNATURE

MY DECLARATION AS THE INTERMEDIARY

NAME:		SURNAME:		ID:	
MY COMMISSION IS:	R			DATE:	

INTERMEDIARY
SIGNATURE: