CANCELLATION REQUEST FORM

(To be completed by the policyholder)

Please note it is essential to complete this form to prevent necessary delays as a result of missing information.

The following must be included:

a. Copy of identity document for the policyholder.

b. Copy of identity document for the premium payer. (if different.)

Kindly return the completed form and the supporting document to lifeclientservice@hollard.co.za or fax to 011 547 7777.

Please allow 10 – 14 working days from receipt of documentation for the cancellation to be completed.

Policyholder details

All Fields are Mandatory

If the policyholder is a company or trust, please ignore this section and complete applicable addendum.

Policy no. _____

Tel. no. _____ Cell no. _____

Email address _____

Identity no. _____ Title _____

Full name _____

Residential address _____ Postal code _____

Postal address _____ Postal code _____

Employer _____

Occupation _____

Source of wealth _____

Source of income _____

Country of residence _____

Premium Payer (if different to the Policyholder)

All Fields are Mandatory

If the premium payer is a company or trust, please ignore this section and complete applicable addendum.

Tel. no. _____ Cell no. _____

Email address _____

Identity no. _____ Title _____

Full name _____

Residential address _____ Postal code _____

Postal address _____ Postal code _____

Employer _____

Occupation _____

Source of wealth _____

Source of income _____

Country of residence _____

Hollard.

To be completed by the policyholder **All Fields are Mandatory**

I, _____ (full names)

hereby wish to cancel my policy with the effect from | Y | Y | Y | Y | M | M | D | D |

The reason for the cancellation is (please tick one of the options below):

Reason for cancellation	**Tick if relevant**
I cannot afford the cover	☐
I have no need for the cover	☐
I am unhappy with the service from my broker	☐
I am unhappy with the service from Hollard Life	☐

The policy is being replaced with another insurer. Please provide details below:

Name of insurer _____

Policy no. _____

Reasons for the replacement _____

Signature (policyholder) _____ Date | Y | Y | Y | Y | M | M | D | D |

Please take note of the following Hollard disclosures

Protection of Personal Information Act (POPIA)

Hollard cares about your privacy. In order to provide you with our service, we and our service providers have to process the personal information you provide us with by completing this form. We will treat this information with caution and we have put reasonable security measures in place to protect it.

Financial Intelligence Centre Amendment Act (FICAA)

In accordance with applicable anti-money laundering laws in South Africa, we are required to obtain specific information and evidence to verify your identity (and in many cases the identities of related persons, such as, but not limited to, directors, beneficial owners and persons instructing us on your behalf (where applicable)) when applying for cover and on an on-going basis. If we ask you for information or documents (including originals or certified copies) you must provide them to us as soon as possible. If we do not receive adequate information and evidence within a reasonable time of our request we may be unable to provide you with cover or may cancel the policy in accordance with applicable law.