TOGETHER
FUNERAL
ADMINISTRATORS

Together in Grief

Reg. No. 2002/040403/23

GROUP FUNERAL ASSISTANCE SCHEME AND MEMBERSHIP CERTIFICATE

N.B. The Membership willonly become valid and bindingwhen all premiums have been paid.

Inception date		Client No.	T F A	Persal No.	
Scheme Name	Plan A ☐	House Hold ☐	Prestigious Plan ☐	Special Scheme ☐	

1.BASIC PLAN SELECTED

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.

Basic Plan Selected _____

1.2 Applicant		1.1 Mode of Payment	Cash ☐ BDO ☐ Stop Order ☐
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 ☐ R3500 - R5000 ☐ R5000 - R7500 ☐ Above R7500 ☐

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:

ID Number:

5. Premuim Calculation

Basic Plan Selected : Plan			R
Total Premium		Joining Fee.....R	Monthly Premium R

DIRECT DEBIT ORDER DETAILS

Name of Bank		Branch		8 Digit branch code	
Account Name		Account Number		Town/City	

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.

Debit Date

Signed at :		On the		Day of	201

Declaration by applicant (please read carefully):

Premium Payer

AGENT No.

* 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.

NAME OF AGENT _____

SIGNATURE OF APPLICANT AND/OR PREMIUM PAYER _____

SIGNATURE OF AGENT _____

Together Funeral Administrat
Company Registration Number 2001

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**

☐ DELETION OF MEMBER	☐ ADDITION OF MEMBER	☐ CHANGE MODE OF
☐ CHANGE NAME & SURNAME	☐ CORRECTION OF DOB	☐ CANCELLATION OI
☐ CHANGE OF ADDRESS	☐ POLICY UPGRADE	☐ 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

VISSER PI

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: _____

VISSER PRINT (013) 712-6010