

PROPOSAL FORM

Medical Scheme Trustees Liability

1. General Information

1. Details of entities to be insured (the "Proposer") _____

2. Proposer's name _____
3. Postal address _____
_____ Post code _____
4. Registration number of the Scheme _____
5. Date Fund was established

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|---|---|---|---|---|---|---|---|

6. Name of Employer Company (if applicable) _____
7. Name of Employee Benefit Consultant/Broker _____
8. Name of Scheme Administrator/Insurer _____
9. Current value of Scheme assets _____ R
10. Current annual contributions to Scheme _____ R
11. Is there any instances of non-compliance issues/matters stated in the schemes latest audited financial statements? Yes No
If Yes, please specify on a separate piece of paper corrective measures/Remedial actions put in place.
12. Does the scheme comply with the statutory solvency margin as defined in the medical scheme act? Yes No
If Yes, what is the solvency percentage? _____ %
13. Please Identify the type of Scheme Open Closed/Restricted

2. Officers of the Scheme

1. How many persons are employed directly by the Scheme? _____
2. Details of Trustees:

| Name | Occupation | Age | Date appointed | Employer nominated/ Member Elected/ Independent |
|------|------------|-----|----------------|---|
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3. Details of the Principal Officer:
 - Name _____
 - Employed by _____
 - Qualifications _____
4. Details of training (if any) provided for Trustees _____

5. Has a Trustee ever been dismissed or asked to resign? Yes No

If Yes, please specify

3. Accounting System

1. Do any of the Trustees have direct access via computer systems to information regarding salary deductions and Employer contributions? Yes No

2. Are Trustees able to input data into computer systems? Yes No

3. Do the Trustees receive regular reports of salary deductions and contributions by the Employer and of monies transferred to the scheme Managers? Yes No

If Yes, at what intervals? _____

4. How often do Trustees receive reports from the Fund Managers on investment performance and accumulated reserves and liabilities? _____

4. Audits

1. How often do internal auditors report to Trustees regarding salary deductions and Employer contributions? _____

2. Name of external auditor _____

Date appointed _____

3. When was the last external audit carried out? _____

4. Were there any recommendations made by the auditor? Yes No

If Yes, please specify

5. Who is the actuary to the Scheme? _____

Date appointed _____

6. How often are actuarial reports submitted? _____

5. Insurance History

Limit of Indemnity R _____

Excess R _____

Premium R _____

Date of expiry of coverage _____

Retro Active date _____

6. Required Coverage

| | Option 1 | Option 2 | Option 3 | Option 4 |
|------------|----------|----------|----------|----------|
| Quote | _____ | _____ | _____ | _____ |
| Deductible | _____ | _____ | _____ | _____ |

7. Insurance and Loss Details

1. Has there OR are there any pending claims or legal proceeding against any Trustee, Director, Officer, Partner or Employee, or against the Employer Company or Corporate Trustee Company or any subsidiary arising out of any fund/scheme. Yes No

If Yes, please provide full details

2. Is the proposer aware, after enquiry, of any circumstances, incident or investigation which may give rise to a claim? Yes No

If Yes, please provide full details

3. Has any similar trustee insurance or fidelity insurance ever been refused, cancelled or non-renewed? Yes No

If Yes, please provide full details

8. Extensions

Please state which extensions are required:

Description

| | | | | |
|--|-----|--------------------------|----|--------------------------|
| Estates, Heirs and Legal Representatives | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Joint Property/Spousal Liability | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Extended Reporting Period | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Reinstatement | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Claims Preparation Costs | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Costs of Recovery | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Costs of Reinstating Office Records | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Emergency Legal Costs | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Investigation Costs | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Third Party Service Provider Legal Costs | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Legal Defence Costs for Bodily Injury | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

Privacy

In order to provide you with insurance, we have to process your personal information. We will share your personal information with other insurers, industry bodies, credit agencies and service providers. This includes information about your insurance, claims and premium payments. We do this to provide insurance services, prevent fraud, assess claims and conduct surveys. We will treat your personal information with caution and have put reasonable security measures in place to protect it. By signing this application for insurance, you agree to the processing and sharing of your personal information.

Declaration

I/We, the undersigned, declare that the statements set forth in this proposal form together with any other information supplied are true and correct and that I/we have not misstated or suppressed any material facts.

I/We agree that this proposal form together with any other information supplied by me/us shall form the basis upon which the contract of insurance is concluded and shall be incorporated therein.

I/We further undertake that in the event that the information provided changes between the date of this application and inception of cover, I/We will notify ITOO of such changes as soon as reasonably possible.

Name (duly authorised)

Designation

Signature

Date

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