REF NO:

Contact: **086 177 7100**
Fax to: **086 218 1490** | EMAIL: **amendments@dignitygroup.co.za** |

Dignity Group
FUNERAL INSURANCE

Registration Number 2017/085106/07
Authorised (FSP NO 44875)

AMENDMENT FORM

Policy Holder Details

Policy Number:		ID no:	
First Name:		Email Address:	
Surname:		WhatsApp no:	
Cell no. (compulsory):			

COMMENTS: *(Please tick the appropriate box below)*

- [ ] Nomination/change of a beneficiary
- [ ] Changing payment Method - payslip / stop order form required
- [ ] Removing dependants from policy
- [ ] Amending Capturing Errors
- [ ] Change/Amending of Banking Details
- [ ] Double Deduction (Please indicate on the month)
- [ ] Change of Address or Contact Numbers
- [ ] Reduce / increase cover amount
- [ ] Adding dependants
- [ ] Change debit date

Postal Address: (compulsory and correct)
Street _____
Suburb _____
Town
Postal Code:

How do you prefer your policy schedule to be sent after amendment?
Branch[ ] Email[ ] WhatsApp[ ] [WhatsApp no:]

BENEFICIARY CHANGE: *Please enter the details of the beneficiary:*

First Name(s):		Surname:	
Identity No:		Contact No:	

Relation to principal member:

DEPENDANTS CHANGE: Please indicate: **C- Correction**; **D -Deletion** or **A - Addition** in the last column:

Name & Surname	Expected Inception date	Full ID Number (attached copy of ID)	Relationship to main member	Cover	C, D or A

BANK ACCOUNT CHANGE:

Account Holder's Name:		Bank Name:	
Premium Payer ID No:		Branch Code:	
Premium Payer Cell No:		Account Type:	
Account Number:		Account Holder's Signature:	
Debit Date:			

COVER AMOUNT CHANGE:

Required Cover:	
Correct Premium:	

[Jan] [Feb] [Mar] [Apr] [May] [Jun] [Jul] [Aug] [Sep] [Oct] [Nov] [Dec]

OFFICE USE:

Representative Name:	
Date Received:	
Receiving Admin:	

REASON FOR AMENDMENT:

DECLARATION:

Policy Holder ☐ Premium Payer ☐

I, _____ declare that the information I have provided on this amendment form is true and accurate. I fully understand the terms and conditions and waiting benefits related to this amendment. I hereby confirm that I have received a copy of this document and aware that **inception of my dependant/s may change depending on when their premium is received, if applicable.**

Client Signature: _____ Date: _____

Representative Signature: _____ Date: _____

Should you not receive confirmation of your amendment request within 7 working days, please contact your nearest office.