FUNDS PROTECT TRUST BUSINESS
APPLICATION FORM

insure through **Olive**

FUNDS PROTECT phishield

POLICY HOLDER DETAILS

Company Name…….

Type of entity: *select one of the following*

Private ☐   Close Corporation ☐   Sole Proprietor ☐   Public company ☐   Partnership ☐   Trust ☐

Registration number ……………………………………. Industry ………………………………………………………..

Physical address ……

……

Contact number ……………………………………………. Contact person………………………………………………

Email Address ……

Annual turnover ……………………………………………..Number of Employees………………………………………………

BROKERAGE DETAILS

Brokerage Name ……….

Broker Name ………

Broker Email Address ……………………………………….Broker contact number ………………………………………….

COVER LIMIT AND PREMIUM *select one option*

R 50 000 @ R 90.00 p/m	☐	R 100 000 @ R 165.00 p/m	☐	R 250 000 @ R 330.00 p/m	☐
R 500 000 @ R 580.00 p/m	☐	R 1 000 000 @ R 1045.00 p/m	☐	R 2 000 000 @ R 2 035.00 p/m	☐
R 3 000 000 @ R 3 245.00 p/m	☐	R 4 000 000 @ R 4 345.00 p/m	☐	R 5 000 000 @ R 5 450.00 p/m	☐

Inception date: ……… /……… / 20 ………   NOTE: Premiums are payable in advance

UNDERWRITING QUESTIONS *Please complete all questions*

Y | N

1   Does Your Business have an active, comprehensive, paid for internet security software installed on all computer systems?   Y N

2   Do you have documented procedures in place for the following:

2.1. Verifying the authenticity, trustworthiness and integrity of all payment instructions received to transfer Trust Account funds to a payee?   Y N

2.2. To verify requests to add and/or amend payee payment details for trust account payments?   Y N

3   Do you utilise account verification services offered by your bank or a third party?   Y N

4   If you have answered no to question 3, would you like to access Phishield's bank account verification services (for South African bank accounts only)?   Y N

5   Has your computer systems been breached in the last 24 months? If yes, please provide details   Y N
……….
……….

6   Have you previously experienced a loss for an event covered under the Funds Protect Trust Business Policy? If yes, please provide details of loss suffered……………………………………………………..   Y N
……….

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BANK ACCOUNT DETAILS

Bank name ....

Account name ....

Account number ....

Branch name .... Branch code ....

Account type .... Debit date .... /.......... / 20 ....

I, the undersigned, hereby authorise the appointed collection agent to deduct the premiums on behalf of the Insurer starting on the inception date or the next business day. Deductions from my account will be treated as though they have been signed by me personally. I acknowledge that premiums are collected in advance and not arrears and that cancellation of this debit order will not automatically cancel the policy. I understand that it is my responsibility to ensure that premiums are received by the Insurer. I acknowledge in the event of failed/ rejected debits I may incur additional charges as levied by my bank for which I will be responsible for.

I also understand that I cannot reclaim any amounts which have been withdrawn from my account in terms of this authority and mandate if such amounts are legally owed.

Signature of Account Holder... **Date** ....

PROTECTION OF PERSONAL INFORMATION

We at Phishield UMA (PTY) Ltd, respect your constitutional right to privacy. We are committed to and bound by the terms and provisions of the Protection of Personal Information Act 4 of 2013 ("POPIA") regarding the acquisition, usage, retention, transmission and deletion of your personal information. We will check and validate the information you provide through legal means. We have high level security measures in place to protect your personal information.

Your personal information herein collected is for the primary purpose of providing you with insurance cover and for all other activities and processes incidental to and relevant to this purpose. Your information shall be kept confidential, however, we shall disclose it to certain third parties as required and other insurers for the specific purpose of insurance and to reduce and prevent any form of fraudulent activity. Sharing of information includes, but is not limited to, information sharing as arranged via the South African Insurance Association.

You hereby give consent and fully understand the reason for Phishield UMA to process, use, share and retain your personal information for its designated purpose and you confirm the accuracy of the information. You may request Phishield to amend, update, change or correct your personal information processed by us by sending a request to our offices on the following email address lilian@phishield. com For a full version of the Consent to process Personal Information is available on this link www.phishield.com for download.

Should you decide to cancel this insurance contract you further consent to Phishield UMA retaining the information in line with the legally permitted retention period, for statistical and reporting purposes only. Should you decide not to accept the proposal, the information collected, will be de-identified and only used for statistical and research purposes.

POLICY HOLDER DECLARATION

I, the undersigned have made an informed decision to take out this policy without the benefit of a full financial needs analysis. Further, I warrant that I have taken note and understand the cover limits and the limitations of this policy.

I understand that this is an application for a binding insurance contract on the intermediary and myself and no further acceptance of terms and conditions or any other documents will be necessary for this contract to become binding. I further declare that all the information entered by me on my behalf is true and correct and should any further information be required, I will make this available to the Insurer as necessary for my policy or any query related to the policy. I am in no way entering this agreement with the knowledge of un-disclosed event or expected future event.

I understand that any misrepresentation, concealment of facts and/or non-disclosure in respect of information provided herein shall render my claim and policy null and void.

Signature of Policy Holder .... **Date** ....