"TEGANYA" INSURANCE PROPOSAL FORM (v2025) N°.....

Products: [ ] WORKERS LIFE COVER (3 in 1) [ ] FUNERAL AND SAVING

1. IDENTIFICATION OF THE LIFE ASSURED

Names: Mr/Mrs/Miss.....Sex: [ ] Male [ ] Female

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Widowed [ ] Divorced

Nationality.....Date of Birth:...../...../.....

Place of Birth: Village.....Cell: .....

Sector:..... District.....Province.....

If not in Rwanda, state the country:.....

Place of Residence: Village.....Cell: .....

Sector:..... District.....Province.....

If not in Rwanda, state the country:.....

Residence type: [ ]Owner [ ]Tenant Number of dependents: .....

Occupation: .....Id/Passport N° .....

Employer: .....

Economic sub-sector:.....

Related Party: [ ]Director [ ]Management/Senior Officer [ ] Non Related Party [ ]Shareholder/Principal owner/Promoter [ ] Staff [ ]Direct or indirect qualifying holding in your institution [ ]Direct or indirect control by your institution [ ]Spouse, partner, or family member up to the second degree of the related persons in your institution

Relationship type: .....

Tel(1): .....Tel(2):.....Email.....

Education: [ ]Below Primary [ ]Primary School [ ]High School

[ ]School Attendance Below A2 level [ ]Diploma (A2 & A1) [ ]Bachelors Degree

[ ]Masters [ ]PHD

Strategic Business Unit (Vision_SBU)

[ ]Micro Enterprises (Less than 1million FRW) [ ]Small Enterprises (1 to 20 million FRW)

[ ]Medium Enterprises (20 to 500 million FRW)

[ ]Large Enterprises (More than 500 million FRW) [ ]Retail or Individuals

[ ]NGOs, Charity/Welfare organisations [ ]BusinessGroups/Community [ ]Others

Does your employer contribute to the payment of premiums? [ ]Yes [ ]No

If Yes, provide the following information:

Employer's name: ……PO. BOX (if any……
Telephone……Email ……

Registration number……Registration Date……/……/……..

Business location……Nature of business ……

Legal representative (Mr/Mrs/Ms.)……..Position……

Date of birth ……/……/……. Residence address……Nationality……

Email address …… Tel: ……..

Employer's contribution percentage ……%.

2. PREMIUMS AND BENEFITS PAYMENT (in FRW): ……..

Amount of the premium: ……..

2.1. SAFE FAMILY

If the Safe Family with cash back rider is applicable, an additional 15% in premium will be added to the already-existing Safe Family premium.

Monthly income:……N.B: If Saving or funeral insurance only, salary is not necessary.

2.2. FUNERAL

Option and premium

[ ]Option 1	3,000	[ ]Option 2	3,800	[ ]Option 3	4,500	[ ]Option 4	5,000

2.3. Periodicity: [ ]Single Premium [ ]Yearly [ ]Half-yearly [ ]Quarterly [ ]Monthly

2.4. Premiums Pay Period (in years):

2.5. Modalities of payment of premiums: [ ]MoMo [ ]Cheque [ ]Salary Deduction [ ]Bank Deduction Standing Order

2.6. Source of income: [ ] Salary [ ] Business [ ] Will (Testament) [ ] Donation
[ ]Succession [ ] Other source (precise)……

3. BENEFITS

3.1. SEFE FAMILY	**Sum assured**	**Capital (in Frw)**
Death/TPP	15 X Monthly salary	
Partial Permanent Disability	15 X Monthly salary X Percentage of invalidity rate approved by a Medical Doctor	
Loss of income due to accident or illness	75% X 15 X Monthly salary	
Do you need to share the death guarantee (benefit) with your spouse in case of death?		[ ] Yes [ ] No
If Yes	Spouse names:	Date of Birth:	Share Percentage […….%]
Do you need Safe Family with Cash Back benefits?		[ ] Yes [ ] No
If Yes, the following benefits will be paid:		
Benefit amount payable		20% of total paid premiums
Benefit payments frequency		Every 5 years
3.2. SAVING		Interest rate 5%
3.3. FUNERAL		
Option 1		
Funeral fees (Extendable to family members: insured, spouse and not above 4 children)		1,000,000
Accidental death of the policyholder		2,00,000
Option 2		
Funeral fees (Extendable to family members: insured, spouse and not above 4 children)		1,500,000
Accidental death of the policyholder		3,000,000
Option 3		
Funeral fees (Extendable to family members: insured, spouse and not above 4 children)		2,000,000
Accidental death of the policyholder		4,000,000
Option 4		
Funeral fees (Extendable to family members: insured, spouse and not above 4 children)		3,000,000
Accidental death of the policyholder		6,000,000

NB: 1. If the policyholder has more than four (4) children, he or she must pay the following additional premium of per child on a regular basis for funeral insurance:

[ ]Option 1	300	[ ]Option 2	450	[ ]Option 3	600	[ ]Option 4	900

2. When the insured child turns 25, his or her funeral coverage terminates immediately.

3. A policyholder whose parent (s) are under the age of 65 is eligible for funeral benefit

Coverage with the following additional premium:

[ ]Option 1	2,500	[ ]Option 2	3,750	[ ]Option 3	5,000	[ ]Option 4	7,500

3.4. FAMILY MEMBERS COVERED UNDER FUNERAL FEES

NO	Names	Date of Birth	Relationship
1			
2			
3			
4			
5			
6			

4. BENEFICIARIES

	Names	Date of Birth	Relationship	Percentage
In case of life				
In case of death	1			
	2			
	3			
	4			
	5			
	6			

Only the designated beneficiaries will be allowed to collect the sum assured in the proportions defined above in the event of death of the life assured. In case of disappearance, absence or death of the beneficiaries, the succession will take place in accordance with Rwandan laws.

Ultimate beneficial ownership information declaration

[ ] **In case of life assured benefits**

I, ..., hereby declare that I subscribed for this policy for myself and that I do not stand for or represent any other person, be it premium payment or benefits arising from this policy.

[ ] **In case of another beneficial owner**

I, ..., declare that the payment of the annuity/installments assured under this contract will benefit another person other than me. Here below are his/her identifications:

……
……
……..

Regarding the protection of processing of personal data and information

I authorize SanlamAllianz Life Insurance Plc the right to process, in a manner prescribed by the law, my personal data, as well as that of the insured persons or beneficiaries (both minors and those of legal age) as outlined in this insurance proposal. The insurer has also explained to me that further information regarding the rights and processing of personal data and the privacy notice is available in a document accessible on the website www.rw.sanlamallianz.com.

Names **Date** **Signature**

QUESTIONNAIRE ON THE HEALTH STATUS OF THE LIFE ASSURED UNDER SAFE FAMILY INSURANCE AND FUNERAL INSURANCE

The insured person must answer each question personally, clearly, and without omissions or additions. A simple pen stroke will not suffice. Tick the appropriate blank box that corresponds to the correct answer. In the case of an affirmative response, provide the necessary precisions on a separate attached separate sheet.

QUESTIONNAIRE FOR THE PRINCIPAL INSURED

1. Height (in cm) ……Weight (in kg)……

2. Are you currently under medical treatment? [ ] No [ ] Yes If Yes, which one? ……
When did you start?……

3. Have you recently done these tests:

Test	No	Yes	Date (Day/Month/Year)	Results	
				Positive (+)	Negative (-)
Hepatitis (B or C)					
AIDS					
Kidney failure					
Heart diseases					
Diabetes					
Cancer					

4. Have you been operated or will you be operated? [ ] No [ ]Yes Date and reason……

5. Is there any illness you know you suffer from? [ ] No [ ] Yes Which one?……

6. Is there any of the persons you want us to ensure who suffers from an illness? [ ] No [ ] Yes

If Yes, give more details ……

QUESTIONNAIRE FOR THE SPOUSE OF THE INSURED (in case the principal insured wants the spouse to be covered)

1. Height (in cm) ……Weight (in kg)……
2. Are you currently under medical treatment ? [ ] No [ ] Yes If Yes, which one? When did you start? ……
3. Have you recently done these tests:

Test	No	Yes	Date (Day/Month/Year)	Results	
				Positive (+)	Negative (-)
Hepatitis (B or C)					
AIDS					
Kidney failure					
Heart diseases					
Diabetes					
Cancer					

4. Have you been operated, or will you be operated? [ ] No [ ] Yes Date and reason……
5. Is there any illness you know you suffer from? [ ] No [ ] Yes Which one?……

If it is discovered that the policyholder made a false declaration about his or her health status, the contract is declared null and void, and the premium paid is refunded.

I----------I hereby certify to have answered sincerely, without reluctance and having hidden nothing about my past and current health, and hereby acknowledge that any reluctance and or false declaration shall lead to the nullity of the contract. I expressly authorize the company to get all information deemed useful and necessary from medical doctors who treated me. I authorize those medical to communicate to the company all information requested. I hereby declare to have received and read the information notice regarding the contract.

Done at ……On……

Life assured names: ……Signature: ……

For SanlamAllianz Life Plc use only

Agent ……Code……Signature……

Supervisor:…… ……

Particular remarks: ……