



**LIBERTY**  
*In it with you*

# Stanbic Kuza Plan Application form

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NEW APPLICATION     AMENDMENT    POLICY NUMBER (For Amendments)

**Please note the following:**

1. Complete all the information on the form to ensure that there is no delay in processing your application.
2. Please read the Terms and Conditions to understand the rules of your policy.
3. You may be required to complete additional forms depending on the specifics of your application.
4. For amendments, only attach documents related to the amendment.

**SUPPORTING DOCUMENTS REQUIRED**

1. Completed application form (this form)
2. Certified copy of national identity document / valid passport
3. Proof of valid Bank Account Details in policyholder's name (for debit order payments)
4. Proof of residence (must not be older than three (3) months)
5. Proof of source of funds / income / wealth

**Declaration by the authorised representative**  
(Always complete this section)

By submitting an application, I declare that I have explained all material terms and conditions of the policy to the policyholder. I also confirm that I have verified the identity of the policyholder in accordance with the regulations set out in the related legislation, regulations or guidelines. I have loaded copies of all required documents on the Liberty system.

Brokerage / Agency name

City / Town

Intermediary full name and surname

Signatory's signature       Date

**Policyholder details**  
(Always complete this section. This individual is the Owner and the Principal Life Assured under the Policy terms and conditions. This individual is entitled to receive all benefits ascribed to this policy.)

Surname

First names       Gender  M  F

National ID / Passport number       Date of Birth

Country of Birth

Nationality

Resident

Citizenship

Income Tax Number       Not Applicable

Do you have a post - secondary school qualification?  YES  NO      Are you an U.S. Citizen?  YES  NO

Marital Status

Occupation

Occupation Industry

## Source of income

(Always complete this section for new applications, and complete for amendment if relevant. The Policyholder and Premium payer must be the same person.)

Please attach a copy of the latest salary slip - must not be older than 3 months, or confirmation of employment from the Policyholder's Employer on Employer's letterhead.

Source of Income

Are you employed?

YES

NO

Are you self-employed?

YES

NO

Name of employer

Employee salary reference

Work Telephone Number

**NB:** If client is self-employed, they must confirm this by submitting a sworn affidavit declaring the same.

## Contact details

(Always complete this section. These are the contact details of the Policyholder. It is important that this information is correct, as it will enable us to keep the policyholder up to date on what is happening on their policy and to notify them about our products that may be of value to them)

Telephone

Mobile Number

Email address

Postal address

Postal Code

Physical address

Postal Code

Correspondence preference

Email

SMS

Post

## Benefit selection

(Always complete this section)

Sum assured selected

Premium

**Optional Stanbic Kuza Plan benefits** (Please indicate the optional benefit(s) selected). Additional premium is payable for optional benefits.

Critical illness

Sum assured selected\*

Premium

Physical impairment

Sum assured selected\*

Premium

\* Sum assured amount cannot be higher than Stanbic Kuza Plan sum assured selected

Total premium payable for Stanbic Kuza Plan (incl. Optional benefits)\*\*\*\*

\*\*\*\* Please note that premiums indicated are inclusive of all charges applicable within the regulatory framework. For a detailed breakdown, please contact your financial advisor.

## Beneficiary / next of kin details

(In the event of the Policyholder becoming deceased, these are persons nominated by the Policyholder to receive payment of benefits. Please ensure that % share adds up to 100% across all beneficiaries)

First Name	Surname	Gender	Occupation	Date of Birth	Contact number	Relationship	% Share

## Payment details

(Always complete this section for new applications, and complete for amendment if relevant. The Policyholder and Premium payer must be the same person.)

### Payment Method

Debit Order

Stop Order

### Debit order payment details (Complete if Debit Order Payment is selected)

(Please attach a copy of the latest bank statement - must not be older than 3 months, or confirmation of account details from the Policyholder's Bank on the Bank's letterhead.)

Name of account holder

Name of bank

Account number

Branch name

Branch code

Debit order date

1st

5th

10th

20th

25th

Last day of the month

I, the undersigned authorise Liberty to, in terms of the agreement, deduct the premium for the amount as specified in this form, from this account, including any applicable premium increases I have selected or any increases that Liberty may apply as agreed with me, until the due premium on this policy is paid. If the bank account details are changed at any time, you undertake to notify us of such change and warrant that you will have the necessary authority to do so.

Account holder's full name and surname

Account holder's signature

Date

### Stop Order payment details (Complete if stop order details selected)

Please attach a copy of the latest salary slip - must not be older than 3 months, or confirmation of employment from the Policyholder's Employer on Employer's letterhead.

Name of employer

Employee salary reference

Current insurance deductions

I, the undersigned authorise the Employer to deduct the premium for the amount as specified in this form (including any applicable premium increases I have selected or any increases I have agreed to) from my salary and remit it to Liberty Life on a monthly basis, with effect from \_\_\_\_/\_\_\_\_/\_\_\_\_ until such time as I cancel this authority in writing or I substitute this with a new authority.

Policyholder's full name and surname

Policyholder's signature

Date

## Data Privacy and Marketing consent

You hereby expressly consent to the collecting and processing of your personal information by us as provided here by you, for the sole purposes of issuing a policy and sharing of this information within the Liberty Group and its affiliates and our third parties.

Where you give us Personal Information about or on behalf of another person (including, but not limited to, beneficiaries), you confirm that you are authorised:

- a. to give us the Personal Information; b to consent on their behalf to the Processing of their Personal Information; and c to receive any privacy notices on their behalf
- b. to consent on their behalf to the Processing of their Personal Information; and
- c. to receive any privacy notices on their behalf.

## Declaration by the policyholder

(Always complete this section)

This declaration contains guarantees and undertakings that I, as the Policyholder and the Principal Life Assured agree to.

### I confirm that I understand the product and policy:

I confirm that I understand the nature of the product and that the authorised representative has explained the product rules, Terms and Conditions, and relevant marketing material.

I confirm that Terms and Conditions have been explained and issued to me by the authorised representative.

### I guarantee that I am giving information correctly:

All information given to the Underwriter in respect of any transaction is true and accurate and can be relied on for contracting.

Where any material information is not fully disclosed, or is found to be untrue, the Insurer will declare the Policy invalid from the outset and will not pay any claim or benefits.

### I guarantee to keep my details up to date:

I undertake to keep the Insurer informed of any changes to the information supplied on this application, which includes but is not limited to my contact details to enable the Insurer to communicate with me.

### I authorise the Insurer and the authorised representative:

To collect, process and share certain personal and financial information from me if relevant to my policy.

### I authorise the Insurer to collect and share information:

I accept that with this authorisation I am limiting my right to privacy. However to assess the insurance risk, I irrevocably authorise the Insurer to:

- a. Obtain from any person, whom I hereby permit and request to give any information which the Insurer needs, and
- b. Share with other insurers that information and any information in this application or any related source at any time, in a form approved by the Insurer or the Regulator.

**Please note:** This authorisation is irrevocable and extends beyond your death. It applies only for the purposes above and therefore may partially limit your right to privacy. You are entitled at any time to request access to the information we have collected, processed or shared.

I, the undersigned, confirm that the information supplied on this form is to the best of my knowledge true and correct. I further acknowledge that the Insurer and the authorised representatives accept no responsibility or liability for the accuracy of the information provided by myself.

Policyholder's full name and surname

Policyholder's signature

Date