

## VAPS Insurance Underwriters – Intermediary Application Form 2020

Inception date of facility requested:

### Company Details

Name in full, including current trading title:

Previous trading names, agencies or brokers:

Form of business - tick as appropriate:

- |  |   |
|--|---|
| <input type="checkbox"/> Proprietary Limited Company (Pty Ltd) | Registration Number: <input type="text"/> |
| <input type="checkbox"/> Limited Liability Company             | Registration Number: <input type="text"/> |
| <input type="checkbox"/> Close Corporation                     | Registration Number: <input type="text"/> |
| <input type="checkbox"/> Partnership                           |   |
| <input type="checkbox"/> Sole Proprietor                       |   |
| <input type="checkbox"/> Other                                 | Details: <input type="text"/>             |

Please list the names, I.D. numbers and occupations of all directors

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Please list the names, I.D. numbers or registration numbers, and occupations of all share holders

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Please list the names, I.D. numbers and occupations of all members (CC's) and/or Partners (Partnerships)

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Have any of the persons listed above, or has any organisation in which they have held a managerial position been placed in provisional or final liquidation, or been placed under provisional or final judicial management, or been provisionally or finally sequestrated or entered into arrangements with creditors or are any such matters still pending? If yes, please provide full details:

  

Have any of these persons been convicted of any criminal offence during the past 10 years? If yes, please provide full details:

Is there any civil or criminal litigation pending against any of the persons mentioned above or against the applicant?  
If yes, please provide full details:

Have any of these persons ever had any agency or an agency application declined, terminated or granted on special terms?  
If yes, please provide full details:


1. Is awareness of TCF outcomes created in business?

2. Is TCF outcomes applied in business? If so, please provide details?

3. Are there any areas for concern?

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## Contact Details

Physical address from which business is conducted:

Telephone No:  Mobile:  Fax:

Postal address  Email Address:

Website Address:

Postal Code:

Date business was established or incorporated:

Date of inception of present management:

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## Membership Details

State any insurance / broker / underwriting association related membership

Association:  Membership no:

Association:  Membership no:

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## Banking Details

Name of Bank:

Branch Name:

Branch Number:

Account Name:

Type of Account:

Account Number:

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## Facility/Contract Details

Below, list the details of the three Insurance Companies and / or Underwriting Agencies with whom most of your business is placed:

Company Name:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Branch:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Contact Person:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Contact Number:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Period of Agreement:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Monthly Premium:	<input type="text"/>	<input type="text"/>	<input type="text"/>
12 Month Loss ratio	<input type="text"/>	<input type="text"/>	<input type="text"/>

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## Tax Status

Is the Company a registered taxpayer? Yes  No

Income tax number:

VAT registration number:

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## FAIS

Are you licensed in terms of the Financial Advisory and Intermediary Services Act (FAIS)? Yes  No

FSP Number:

Name of Compliance Officer:

Contact details: Business:  Mobile:

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## Cover Details

Professional Indemnity Cover: Yes  No  (Please attach a copy as proof)

Excess Structure:

Underwriter:

Limit of Indemnity:

Policy Nr:

IGF Cover: Yes  No  (Please attach a copy as proof)

Excess Structure:

Underwriter:

Limit of Indemnity:

Policy Nr:

Who is covered under the PI policy, e.g. only Directors, all staff? Please specify

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## Technical Details of Employees

Number of employees:

Employee	Short term insurance experience	Short term insurance related qualifications
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

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## Declaration

The information contained herein is true and correct and shall form part of the agreement to be concluded between VAPS Insurance Underwriters (Pty) Ltd, the Underwriting Manager and the independent intermediary

Important notice: The acceptance of this proposal is subject to the final approval of VAPS Insurance Underwriters (Pty) Ltd. VAPS Insurance Underwriters (Pty) Ltd will not accept responsibility for cover until written confirmation has been issued.

Name of Authorised Signature:

Signature:  Date:   
Place: