



**CUSTOMER VERIFICATION FORM
(Individuals)**

PLEASE USE BLOCK CAPITALS AND TICK AS APPLICABLE

IDENTIFICATION DETAILS		
SURNAME:		FIRST NAME:
OTHER NAMES:		TITLE: Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms <input type="checkbox"/> Other <input type="checkbox"/>
ALIAS (if any)		DATE OF BIRTH (dd/mm/yy):
MARITAL STATUS: Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widow(er) <input type="checkbox"/>		
NATIONALITY:	COUNTRY OF RESIDENCE:	PLACE OF BIRTH:
NATIONAL IDENTIFICATION NUMBER:		PASSPORT NUMBER:
DRIVER'S LICENCE NUMBER:		OTHER (PLEASE SPECIFY):
AFFILIATION WITH GOVERNMENT/MILITARY/STATE OFFICIALS:		
PROOF OF IDENTITY : <i>At least one(1) of the following forms of identification must be provided, please tick <input checked="" type="checkbox"/> as applicable</i>		
National Identification Card <input type="checkbox"/> Driver's Licence <input type="checkbox"/> Passport <input type="checkbox"/> Other (please specify) <input type="checkbox"/> _____		
CONTACT DETAILS		
PERMANENT RESIDENTIAL ADDRESS:		
TELEPHONE: [home] () <i>Please include area code</i>	[work] ()	[cell] ()
EMAIL ADDRESS:		Fax:
PROOF OF ADDRESS : <i>Please indicate which of the following documents has been attached</i>		
Fixed Line Phone Bill <input type="checkbox"/> Electricity Bill <input type="checkbox"/> Water &/Sewage Bill <input type="checkbox"/> Mobile Phone Bill <input type="checkbox"/>		
EMPLOYMENT DETAILS		
OCCUPATION:		
EMPLOYER NAME :		
ADDRESS:		
DATE:	PLACE:	
CUSTOMER NAME (PLEASE PRINT):	SIGNATURE:	
SOURCE OF FUNDS (Required for premiums \$25,000.00 and above)		
ORIGIN OF MONEY PAID TO POLICY:		
EXPECTED LEVEL OF ACTIVITY(Average annual sum expected to be paid to policy):		
DATE:	PLACE:	
CUSTOMER NAME: (PLEASE PRINT)	SIGNATURE:	
FOR OFFICIAL USE ONLY		
POLICY DETAILS		
POLICY NUMBER (S):	INCEPTION DATE:	EXPIRATION DATE:
POLICY TYPE: Motor <input type="checkbox"/> Accident <input type="checkbox"/> Marine <input type="checkbox"/> Property <input type="checkbox"/> Public Liability <input type="checkbox"/> Other (Please Specify) <input type="checkbox"/>		
REVIEWED BY :	(ORIGINALS VERIFIED) CERTIFIED COPIES RECEIVED <input type="checkbox"/>	
NAME: _____	NAME: _____	
TITLE: _____	TITLE: _____	
SIGNATURE: _____	SIGNATURE: _____	
DATE: _____	DATE: _____	