LIBERTY

Member/ Policy number

HEALTH COVER

Sworn Affidavit Confirming Dependency

Please complete the following information in full using block capitals

1. PERSONAL DETAILS | PRINCIPAL MEMBER OR POLICYHOLDER

Last name

First name(s) Title

Other names Initials

Date of birth Y Y Y Y M M D D

ID/ Passport No.

I,_____ the undersigned, hereby declare the following:
(Member/policyholder's name)

Please select the relevant item

☐ **Regarding my living-in partner/customary spouse**
We have been in a committed and permanent relationship since Y Y Y Y M M D D and share a common household.

☐ **Regarding my parent/parent-in-law**
He or she is financially dependent on me for care and support.

☐ **Regarding a special beneficiary/dependant (e.g., a niece, nephew or other relative)**
He or she is financially dependent on me for care and support.

2. BENEFICIARY/DEPENDANT DETAILS

Beneficiary / Dependant 1

Last name

First name(s) Initials

Relationship to member/ policyholder

Date of birth Y Y Y Y M M D D

ID/ Passport No.

Beneficiary / Dependant 2

Last name

First name(s) Initials

Relationship to member/ policyholder

Date of birth Y Y Y Y M M D D

ID/ Passport No.

Beneficiary / Dependant 3

Last name

First name(s) Initials

Relationship to member/ policyholder

Date of birth Y Y Y Y M M D D

ID/ Passport No.

Beneficiary / Dependant 4

Last name

First name(s) Initials

Relationship to member/ policyholder

Date of birth Y Y Y Y M M D D

ID/ Passport No.

Beneficiary / Dependant 5

Last name

First name(s) Initials

Relationship to member/ policyholder

Date of birth Y Y Y Y M M D D

ID/ Passport No.

Beneficiary / Dependant 6

Last name

First name(s) Initials

Relationship to member/ policyholder

Date of birth Y Y Y Y M M D D

ID/ Passport No.

Member / Policyholder's signature

Date Y Y Y Y M M D D

Please ensure this form is signed and stamped by a Commissioner of Oaths in the block provided below.