



OLD MUTUAL INSURANCE LTD SERENICARE INDIVIDUAL HEALTH INSURANCE COVER APPLICATION FORM

OLD MUTUAL INSURANCE LIMITED

Nakawa Business Park, Plot 3-5 New Port Bell Road, P.O. Box 7185 Kampala, Uganda
Tel: +256414332700, 0200507200, Toll Free: 0800132700
Email: info-gi@oldmutual.co.ug, Website: www.oldmutual.co.ug

PLEASE COMPLETE THIS FORM USING BLOCK LETTERS. IT IS IMPORTANT THAT YOU PROVIDE ALL THE INFORMATION REQUESTED TO FACILITATE PROMPT PROCESSING OF YOUR APPLICATION. ANY BLANK SPACES WILL BE TAKEN TO MEAN THAT YOU HAVE NOTHING TO DISCLOSE.

APPLICANT DETAILS FOR BENEFICIARY

Section A: Principal Member

Option Chosen:

Title Mr. Mrs. Miss Other

Full name

ID/Passport number Date of birth

Gender Male Female Nationality

Tax identification number

Postal address

Physical address

Country of residence

Email address

Cellphone number Employer number

Occupation, Please state if student?

PARTICULARS OF DEPENDANTS

No.	Full name	Date of birth	Gender	Relationship	Option/Category Chosen
01		<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="checkbox"/> M <input type="checkbox"/> F		
02		<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="checkbox"/> M <input type="checkbox"/> F		
03		<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="checkbox"/> M <input type="checkbox"/> F		
04		<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="checkbox"/> M <input type="checkbox"/> F		
05		<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="checkbox"/> M <input type="checkbox"/> F		
06		<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="checkbox"/> M <input type="checkbox"/> F		
07		<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="checkbox"/> M <input type="checkbox"/> F		

Name of current/previous health insurer.

Expiry date

Name of next of kin	ID Number	Relationship
<input type="text"/>	<input type="text"/>	<input type="text"/>

LAST EXPENSE

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MEDICAL HISTORY OF APPLICANT AND DEPENDANTS

Have you had any of the following medical conditions? (Ask your doctor for any assistance if needed).

If there is a yes to any of the questions asked, kindly obtain a medical report from your attending doctor or discharge summary from hospital and forward together with your application form under confidential cover. This information is essential in processing your application. Please note that no liability will be accepted for any medical conditions which originated before the date of enrolment or which was foreseeable at the time of application unless such medical condition has been declared to and accepted by Old Mutual Insurance in writing. If in doubt you should still disclose the medical condition.

Questions	MEMBERS (Only "Yes" or "No" are acceptable answers for each)							
Department Code	Member 00	Dependant 01	Dependant 02	Dependant 03	Dependant 04	Dependant 05	Dependant 06	Dependant 07
A Cardiovascular Conditions								
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Cholesterol Levels	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B Respiratory								
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Obstructive Airway Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sinus Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C Endocrine								
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes Mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
D Neurological								
Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
E Blood Disorders								
Sickle Cell	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disease Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
F Musculoskeletal								
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic back pain/slipped disc	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
G Gastrointestinal								
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stomach and Duodenal Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
H Surgical Operations	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
I Hospitalised (within the last seven years)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
J On Regular Medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
K Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
L Genito-Urinary								
Pelvic Inflammatory disease (Female)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fibroids (Female)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Enlargement of the prostate (Male)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

M	Pregnancy (Female)									
	History of Caesorian	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Section Pregnant Member	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
N	Other Medical Conditions or Disabilities not mentioned above	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Details of positive (Yes answers to questions I,J,K,L,M and N or any other. If this space is insufficient append an additional sheet.

Question No.	Dependants No.	Details

FAMILY DOCTOR'S INFORMATION

Doctor's name

Email Address

Postal address

Clinic physical address

Speciality

Telephone number Cellphone number

Code

COVER PLAN AND PREMIUM (UGX)

Option Chosen	Premium	Comprehensive	Classic	Essential
INPATIENT PER FAMILY	100 000 000	60 000 000	30 000 000	15 000 000
Premium for all members proposed				
OUTPATIENT PER PERSON	5 000 000	3 000 000	2 000 000	1 500 000
Premium for all members proposed				
MATERNITY PER PERSON	4 000 000	3 000 000	2 500 000	1 500 000
Premium per family				

LEVIES

Training Levy	(0.5%)
Stamp Duty	(UGX 35 000)
Total premium payable (premium is payable upfront or through premium financing)	

DECLARATION

This membership application form is part of the contract with Old Mutual Group.

- a. I declare that all the persons named in the application form are members of my immediate family for whose membership I am responsible.
- b. I hereby apply to join the above mentioned health insurance plan.
- c. I understand that any mis-statement or non-disclosure of any material information in this form will jeopardize my membership.
- d. I warrant that the answers in this form are true, correct, and complete and I acknowledge that such answers are all material.
- e. I hereby authorize the hospital, medical or dental practioners who have treated me or any of mu dependents to disclose to Old Mutual Group the records relating to such current or previous hospitalizations/medical treatment and allow the company to receive extracts from such records and undertake to assist in obtain such information.
- f. I have read, understood and agree with the cover options, exclusions, terms and conditions as stipulated in the product brochure and benefit schedules.
- g. I have appointed as my Agent/Broker for this policy.
- h. Desired start date

Date

Signature of The Principal Member (Policy Holder)

AGENT/BROKER DECLARATION

I confirm that i have explained to the client the benefit structure, general conditions and exclusions of this cover.

Agent's/Broker's full name

Telephone number

Cellphone number

Email Address

Date

Authorized signature and stamp

PRIVACY NOTICE

Introduction

Thank you for choosing Old Mutual Insurance Uganda Limited. We, as data controller, respect your privacy and are committed to protecting your personal data and the personal data of third parties that you provide to us. This Privacy Notice is a summary of our Privacy Policy and describes how we collect, use, disclose, transfer, store or otherwise process your personal data and tells you about your privacy rights and how the law protects you. For the full version of the Privacy Policy, please visit www.oldmutual.co.ug or contact us for a copy.

Personal data means any information relating to you as an identified or identifiable natural person. In order for us to provide the services you have requested from us, it is necessary that we collect and process personal data from you.

The Types of Personal Data That We Collect

We may collect, use, store, transfer or otherwise process personal data about you or persons connected to you including identification information such as name and national identity card number or passport number, TIN, nationality, gender, contact information such as email address, telephone number and postal address and information relevant to your insurance policy or relevant to your claim such as your health data. If we require information about other people connected to you, we may request you to provide such information. If you are providing information about another person, please ensure that they know you are doing so and are content with their information being provided to us. It might be helpful to show them this Privacy Notice and our Privacy Policy and direct them to us if they have any concerns.

How Do We Collect Your Personal Data?

For most part, we will collect personal data directly from you and this may include personal data you provide when you apply for our products or services, make enquiries, register for our products offered through mobile and online platforms, request marketing information to be sent to you, give us feedback or contact us. In some instances, we may collect and receive your personal data from third parties or publicly available sources including medical professionals and hospitals; directly from an individual or employer (or your employer's service provider) who has a policy with us under which you are insured; directly from an employer which funds a cover that we administer where you are a beneficiary; directly from a person who is making a claim or application to us and they include information about you which is related to that claim or application; insurance brokers or agencies; National Identification and Registration Authority and any other Government platforms; or publicly available sources such as the Companies Registry.

How Do We Use Your Personal Data And What Legal Basis Do We Have For Processing Your Personal Data?

We use your personal data, including sensitive personal data in certain instances, for the following purposes:

- To consider your application for insurance and for initiating your insurance contract.
- To provide you with our group's insurance products and services and financial products and services.
- To meet our legal and regulatory obligations.
- To maintain consistent practices and procedures across the Company and the Company's group and affiliates.
- To use data analytics to improve our website, products/services, marketing, customer relationships and experiences.
- To provide you with optimized marketing analytics and information about our products and services that we consider may be of interest to you and/or your family.

In this regard, we rely on the following lawful basis for processing your personal data:

- **Performance of contract:** Including setting up and administering a contract of insurance by providing you with a quote for the insurance policy, underwriting the risks to be insured or processing any claims that might be submitted under the policy.
- **Legal and regulatory obligations:** Compliance with our legal and regulatory obligations such as KYC obligations under different statutes including the Anti-Money Laundering Act Cap 118 and the corresponding regulations and the Tax Procedures Act Cap 113.
- **Consent:** We will also rely on your consent as a lawful basis for processing your personal data in the instances where we (a) process personal data relating to a child; (b) process sensitive personal data outside Uganda; and (c) provide you with marketing information:
- **Legitimate interests:** for our legitimate business interests, including product and service improvement, prevention, and detection of fraud.

If you fail to provide us with your personal data when requested, we may not be able to perform the contract we have or that we wish to enter with you. In that case, we may have to cancel a product or service you have with us.

You have the right to withdraw your consent to our processing of your personal data at any time but please note, that your withdrawal will not affect the lawfulness of our processing of your personal data which was based on prior consent before your withdrawal, or which is based on other legal basis for processing of your personal data. Please further note we may not be able to provide you with our products and services if you withdraw your consent.

Who Do We Share Your Personal Data With?

In connection with the above purposes, we may share your personal data with third parties located within and outside Uganda such as our affiliates, public authorities or governments when required by law, our third-party service providers who help us manage our products and services including those service providers who maintain our IT and office systems, provide marketing and advertising services, provide application processing, fraud monitoring, call center and/or other customer services. In that connection, we will take adequate steps to protect your personal data including entering into agreements with third party recipients of your personal data (as applicable) governing protection of personal data.

Data Security

We have put in place appropriate security measures to prevent your personal data from being accidentally lost, used or accessed in an unauthorized way, altered or disclosed. In addition, we limit access to your personal data to those employees, agents, contractors and other third parties who have a business need to know. We have also put in place procedures to deal with any suspected personal data breach and will notify you and any applicable regulator of a breach where we are legally required to do so.

Retention and Storage of Your Personal Data

We will only retain your personal data for as long as may be necessary to fulfil the purpose we collected it for, including for the purposes of satisfying any legal, regulatory, tax, accounting or reporting obligations.

Your Legal Rights

You have the right to:

- Be informed of the use to which your personal data is to be put as we have endeavoured to outline in this Privacy Notice and our Privacy Policy.
- Request access to your personal data that we hold about you.
- Object to the processing of all or part of your personal data.
- Request correction of inaccurate, false or misleading data that we hold about you; and
- Request deletion of false or misleading data that we hold about you.

Contacting Us

If you have any concerns about the use of your personal data, questions about this Privacy Notice or our Privacy Policy including any requests to exercise your legal rights under the law, please contact us using the details set out below:

Email address: oldmutualuganda@Oldmutual.co.ug OR info-gi@oldmutual.co.ug
Postal address: P.O. Box 7185 Kampala
Physical address: 6th Floor, Block D Nakawa Business Park.
Telephone number: +256 414 332 700

We will respond to your questions or concerns in a timely manner and in compliance with the relevant laws.

CONSENT CLAUSES

CONSENT FOR PROCESSING PERSONAL DATA OUTSIDE UGANDA

Personal data refers to identifiable data of an individual relating nationality, age, marital status, occupation, identification numbers and any other information necessitating an individual's opinion. Special Personal data includes data revealing sexual life, financial information, health status or medical records of an individual.

It may be necessary that we process your personal data outside Uganda in connection of which we are required to obtain your consent. By signing below, you agree that you have read and understood the above Privacy Notice and our Privacy Policy, and you hereby authorize us to process your sensitive personal data outside Uganda.

Name

Signature

Date

CONSENT FOR PROCESSING PERSONAL DATA RELATING TO A CHILD

You may be required to provide personal data relating to a child; for instance, where providing details of your beneficiaries/next of kin. Please note that a child is a person under the age of 18 years. For us to process any personal data relating to a child, we require your consent as the child's parent or legal guardian and proof of the child's age.

By signing below, you confirm that you are the parent or legal guardian of the child whose personal data is being provided to us and that you have read and understood the Privacy Notice above and our Privacy Policy and you hereby consent to our processing of the child's personal data in or outside Uganda.

Name

Signature

Date

CONSENT FOR MARKETING PURPOSES/ COMMERCIAL USE OF DATA

We would like to use your details to carry out analytical and market research about our and our affiliates' products and services and to provide you with information about these insurance and financial products, services and special offers from us or our affiliates. Please note that if you do not want to receive our marketing information you may opt-out by contacting us at any time.

Please tick the relevant boxes below if you agree to receive marketing information from us:

Yes, I consent to receiving all marketing information and communications about all new products and services.

Yes, I consent to receiving marketing information and communications about products or service which relate to my current insurance policy only.

No, I do not consent to receiving any marketing information.

If you do not tick a box, we will assume that you do not wish to receive any marketing information.

DECLARATION

I confirm that I have read and understood the Privacy Notice and the Privacy Policy and that any queries/concerns I have regarding the nature and purpose of the processing of personal data have been adequately addressed.

DECLARATION FOR INTERMEDIARIES

I, the undersigned, acknowledge the advice given and indemnify Old Mutual Insurance Uganda Limited on any misrepresentation of such advice. I fully understand the terms, conditions and benefits of the Policy sold to the above applicant by me and I have addressed any queries or concerns regarding the processing of their personal data as set above.

Name

Signature

Date