We Can
(Singakhona)

# LUBANE DEVICE LOAN APPLICATION FORM

**Full Name & Surname:** _____
**(Print Name)**

**Membership No.: LUB**_____**Branch/Depot:** _____ **Application Date:** _____

**Requested Amount: E**_____**(in words)** _____

**Basic Salary: E**_____ **Recent Net Pay Amount: E**_____

**Employer:** _____**Occupation:** _____

**Contact No: (MTN)**_____**(Eswatini Mobile)** _____

**ID Number:** _____**(*Attach Certified Copy of ID*)**

**Purpose of Loan:**_____

Applicants Signature: * _____ Date: _____

**A) POST-PAID DEVICE AND NETWORK VALUE (DATA + VOICE BUNDLES):**
Device Chosen: Brand - _____ Model - _____
MTN Network Value (Data + Voice Bundle): _____

Applicants Signature: * _____ Date: _____

**B) POST-PAID NETWORK VALUE (DATA + VOICE BUNDLES) ONLY:**
Data & Voice Package: _____ Number of Months: _____

Applicants Signature: * _____ Date: _____

**Please ensure that you have attached a copy of your recent pay slip and Certified Copy of National Identity*

---

***OFFICE USE:***

**At a meeting held on** _____**it was resolved that this application form be**

**Rejected/ Deferred /Approved.** _____

**If rejected give reasons** _____

_____

**Amount Approved E** _____

**CEO:** _____ **DATE** _____

**Loans Officer:** _____ **DATE** _____

**Accountant:** _____ **DATE** _____

**Telephone Numbers:** (+268) 2416 1836 (+268) 2417 1802 **Mobile Number:** (+268) 7865 1899 **Email Address:**
loans@lubane.co.sz / admin@lubane.co.sz **Postal Address:** PO Box A213, Swazi Plaza, Mbabane
**Physical address:** Portion 22 of Farm 706, Ezulwini, Hhohho District, Eswatini

# LUBANE SAVINGS & CREDIT CO-OPERATIVE SOCIETY

## DEBT ACKNOWLEDGEMENT FORM

I, the undersigned,

_____

In my personal capacity of_____which address I choose as *domicillium citandi et executandi* for purposes hereof do hereby admit that I am liable, and hold myself bond to Lubane Savings and Credit Co-operative Society Ltd or its successor or assigns for the due and proper payment of the amount of E_____in words(_____ _____ Emalangeni) being monies loaned and advanced to me at my own special instance and request on the _____day of_____20_____.

I agree that this debt is payable in monthly instalments of E _____ (_____Emalangeni) on the last day of each month, the first payment being due on_____and thereafter on the last day of each succeeding month.

I agree that the amount owing bears interest at the rate of _____% per month on a reducing balance calculated monthly.

I hereby specifically renounce the benefits of the non *causa debiti*, the *errore calculi*, the revision of accounts and no value recorded.

I agree and bind myself to provide any security that may be demanded by the said Lubane Savings and Credit Co-operative Society Ltd or its successors in title costs for the registration of which I shallbare.

Should I default to make payment within seven (7) days of a demand having been made and should the said creditor institute action against me, then I agree that the full sum owing shall become due and I agree to pay, in addition to the principal debt, a sum equivalent to 10% thereof as collection commission and in addition pay such costs on an attorney and own client scale.

I hereby consent to my personal and credit information being shared with a registered credit bureau or third-party service provider for the purposes of credit assessment, verification, and related services

**THUS DONE AND SIGNED AT_____ON THE_____DAY OF _____, 20_____IN THE PRESENCE OF THE UNDERSIGNED WITNESSES.**

**AS WITNESSES:**

**1.** * _____
**WITNESS SIGNATURE**

* _____
**LOAN APPLICANT SIGNATURE**

**2.** * _____
**WITNESS SIGNATURE**

| | |
|---|---|
| Entity Name: Lubane Savings & Credit Co-operatives | |
| Reference/Member Number: | |

| **Life Assured** | | |
|---|---|---|
| Surname: | Title: | Gender: |
| First Names: | | |
| Marital Status: | Date of Birth: _____/_____/_____ | |
| Identity No.: | Cell No.: | |

| **Cover Option** | |
|---|---|
| Product Name: | |
| Initial sum assured: E | |
| Term of loan (months): | |
| ✓ **Option 1 – initial monthly premium** | ❑ **Option 2 – Once off premium** |
| | |

**Declaration by Life Assured**

I, the Life Assured, understand, agree, and where applicable, declare that:

1. Apart from minor ailments, I/we have not received treatment from any Medical Practitioner during the past 3 months or been hospitalized or undergone hospital treatment or specialist investigation during the past 12 months and have never suffered any form of disability or heart attack or heart disease, stroke, cancer, kidney disease, impaired vision or any AIDS related condition.
2. I further understand that this declaration will be made and is also applicable to any adjustment in the sum assured of the policy.
3. An application for insurance on my life has never been declined or accepted on special terms by any insurance company.
4. I understand that the sum assured will be determined by the Institution in line with facility granted to me and I therefore authorize Orchard Insurance Limited to adjust the cover and amounts due to it in terms of the policy from time to time and effect payment.
5. All the information supplied or to be supplied in connection with this proposal, whether in my/our handwriting or not, is true and complete and forms the basis of the policy.
6. I understand that this proposal, the master policy and any endorsements duly authorized by the Insurer, set out the full provisions under which this policy is underwritten. In an event of any discrepancy between the master policy will apply in all cases.
7. Any doctor, other person or institution is authorized at any time to disclose any information concerning my/our health including the results of any blood test, to Orchard Insurance Limited should any amount exceed the Free Cover Limit applicable to the Master Policy.
8. I have been given prior written notice regarding my freedom of choice:
   - To enter a new policy, as to the insurer and intermediary as to the value of policy benefits under the new policy, and
   - I have not been subjected to any coercion or inducement in applying for this policy.
9. I hereby cede, transfer, assign, and make over unto the Institution all my/our rights, titles and interest in this policy as collateral security for the credit/loan agreement or facility with the institution.

**I agree that if the above particulars are not correct then the assurance shall be null and void and all premiums paid by me will be forfeited.**

Signed at * .....on this ..... day of ..... 20 .....

.....
Signature of First Life Assured

Cell No. .....

Name of Doctor:.....

Address: .....

Tel. No.: .....