



CUSTOMER VERIFICATION FORM (Corporate)

PLEASE USE BLOCK CAPITALS AND TICK APPLICABLE

IDENTIFICATION DETAILS			
REGISTERED NAME:			
TRADING NAME (IF APPLICABLE):			
DATE OF INCORPORATION:		PLACE OF INCORPORATION:	
COMPANY REGISTRATION NUMBER:			
TYPE OF BUSINESS ENTITY:			
Company <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Charitable Entity <input type="checkbox"/> Other (please specify) <input type="checkbox"/> _____			
TYPE OF BUSINESS SECTOR:			
Private Sector Service	<input type="checkbox"/>	Professional (attorney/accountant)	<input type="checkbox"/>
Public Sector/Government Service	<input type="checkbox"/>	Real Estate	<input type="checkbox"/>
Financial Services	<input type="checkbox"/>	Broker Retail/Distribution	<input type="checkbox"/>
Medical (dentist/doctor)	<input type="checkbox"/>	Transport/Travel	<input type="checkbox"/>
Construction	<input type="checkbox"/>	Other (please specify) _____	<input type="checkbox"/>
ITEMS TO BE REQUESTED:			
<ul style="list-style-type: none"> • Certificate and Articles of Incorporation, Continuance (where applicable), Certificate of Registration of the entity • Information on the identity of the Directors, Beneficial owners, Substantial shareholders, Trustees (where applicable) inclusive of valid Government issued identification • Information on the identity of authorized signatories inclusive of valid Government issued identification • Registered and Mailing Address • Proof of Address in the form of a utility bill 			
POLITICAL AFFILIATION OR ASSOCIATION			
<ul style="list-style-type: none"> • Are any of the Directors, Executive Officers or Senior Managers have any affiliation to Government officials, Military officials or any person who provides an important public function/s for the state? YES <input type="checkbox"/> NO <input type="checkbox"/> 			
If Yes, provide details:			
CONTACT DETAILS			
REGISTERED ADDRESS:			
COUNTRY:		TELEPHONE NUMBER(S): <i>Please include area code</i>	
FAX:		EMAIL ADDRESS:	
MAILING ADDRESS:			
COUNTRY:		TELEPHONE NUMBER(S): <i>Please include area code</i>	
FAX:		EMAIL ADDRESS:	
SOURCE OF FUNDS			
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:	
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"/> _____			
FOR OFFICIAL USE ONLY			
POLICY #(S):		(ORIGINALS VERIFIED) CERTIFIED COPIES RECEIVED <input type="checkbox"/>	
REVIEWED BY:			
NAME: _____		NAME: _____	
TITLE: _____		TITLE: _____	
SIGNATURE: _____		SIGNATURE: _____	
DATE: _____		DATE: _____	