The Hand-in-Hand Mutual Life Assurance Company Ltd

Lots 1, 2, 3 and 4 Avenue of the Republic, Georgetown, Guyana
Tel: (592) 227-00663, 225-1865-7
Fax: (592) 225-7519 Email: info@hihgy.com; Website: www.hihgy.com

AML Customer Verification Form (Business)

COMPANY INFORMATION

REGISTERED NAME: DATE OF INCORPORATION:

PLACE OF INCORPORATION: TIN:

TYPE OF BUSINESS:

Company ☐ Sole proprietor ☐ Partnership ☐ Co-operative ☐ Non-Profit Other ☐ (Please specify) ……..…

ITEMS TO BE REQUESTED:

- ☐ 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(no older than six months)
- ☐ Indicate any affiliation to Government officials, Military officials or any person who provides an important public function/s for the state;

Name: Relationship:

CONTACT INFORMATION

REGISTERED ADDRESS:

MAILING ADDRESS:

EMAIL ADDRESS:

TELEPHONE NUMBER(S): FAX:

PRINCIPAL PERSON OF BUSINESS:…….. ID #: ……...

CONTACT NUMBER (Work):……(Cell):……

SOURCE OF FUND:

Origin of the money paid to the policy is: ……

For new clients, where an annual premium exceeds $2,000,000:- or multiple premium payments exceeds $2,000,000 please attach one (1) of the following:

☐ Management Accounts ☐ Other Form of Proof _____ ☐ Not Applicable (specify) _____

NATURE OF SHAREHOLDER'S HOLDING ≥ 10% PAID UP SHARE CAPITAL

NAME	RESIDENTIAL ADDRESS	ID/PP #(attach copy)	Exp. Date	Country of issue	# SHARES

DECLARATION: I do hereby declare that I have read the above/the above has been read and explained to me. I further declare that the above information given by me is true and any misrepresentation or material non-disclosure whatsoever on my part shall render the insurance policy issued herein of no legal effect.

AUTHORISED OFFICER OF COMPANY/BUSINESS: (Please print) SIGNATURE:

SIGNATURE OF HIHMF AUTHORISED OFFICER: DATE:

OFFICIAL USE ONLY

POLICY NUMBER(S): AML REQUIRED DOCUMENTS RECEIVED: ☐

INCEPTION DATE: EXPIRY DATE:

POLICY TYPE: Life ☐ Medical: ☐ Pension: ☐ Other: ☐

Branch/Agent/Broker _____

Sum Insured……Annual Premium……

Currency:……

Transaction Accepted: Yes ☐ No ☐

Reason for Decline ……

Transaction taken by:……

Position: ……

Signature ……

Date:……