



The Hand-in-Hand Mutual Fire Insurance Company Ltd

Lots 1, 2, 3 and 4 Avenue of the Republic, Georgetown, Guyana

Tel: (592) 227-0663, 225-1865-7

Fax: (592) 225-7519

Email: info@hihgy.com

Website: www.hihgy.com

AML Customer Verification Form (Individual)

In accordance with the Anti- Money Laundering and Countering the Financing of Terrorism Act 2009 (As Amended)

PERSONAL INFORMATION		
SURNAME:		GIVEN NAME(S):
ALIASES:	GENDER: Male <input type="checkbox"/> Female <input type="checkbox"/>	
DATE OF BIRTH (dd/mm/yy):	MARITAL STATUS: Single: <input type="checkbox"/> Married: <input type="checkbox"/> Divorced: <input type="checkbox"/>	
NATIONALITY:	Separated: <input type="checkbox"/> Common Law: <input type="checkbox"/> Widow(er): <input type="checkbox"/>	
COUNTRY OF BIRTH:	AFFILIATION WITH SENIOR GOVERNMENT/JUDICIAL/MILITARY/STATE OFFICIALS/POLITICIAN(S):	
COUNTRY OF RESIDENCE:	Name:	Relationship:
FORMS OF IDENTIFICATION		
<input type="checkbox"/> NATIONAL IDENTIFICATION NUMBER:	ISSUE DATE:	
<input type="checkbox"/> PASSPORT NUMBER:	EXPIRY DATE:	
<input type="checkbox"/> OTHER (PLEASE SPECIFY):	TIN:	
CONTACT INFORMATION		
RESIDENTIAL ADDRESS:		
TELEPHONE: (Home)	(Work):	(Cell):
EMAIL ADDRESS:	FAX:	
EMERGENCY CONTACT: (Name)	EMERGENCY CONTACT: (Tel. No.)	
EMPLOYMENT INFORMATION		
OCCUPATION:		
EMPLOYER NAME:		
EMPLOYER ADDRESS:		
PERIOD OF EMPLOYMENT:		
PROOF OF INCOME (Job Letter/Pay Slip):		
PROOF OF ADDRESS (within 6 months)		
Utility Bill <input type="checkbox"/>	Bank Statement <input type="checkbox"/>	Other <input type="checkbox"/>
ORIGIN OF PROPERTY:		
SOURCE OF FUNDS (ORIGIN OF MONEY PAID TO THE POLICY):		EXPECTED LEVEL OF ACTIVITY (Average annual sum expected to be paid to policy):
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.		
CUSTOMER NAME: (Please print)		SIGNATURE:
HIHMF AUTHORISED OFFICER SIGNATURE:		DATE:
OFFICIAL USE ONLY		
POLICY NUMBER:		AML REQUIRED DOCUMENTS RECEIVED: <input type="checkbox"/>
Branch/Agent/Broker _____ Type of Transaction: Motor <input type="checkbox"/> Property <input type="checkbox"/> Other <input type="checkbox"/> Sum Insured.....Annual Premium..... Currency: Transaction Accepted: Yes <input type="checkbox"/> No <input type="checkbox"/>		Reason for Decline Transaction taken by: Position: Signature Date:



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AML Customer Verification Form (Business)

In accordance with the Anti- Money Laundering and Countering the Financing of Terrorism Act 2009 (As Amended)

COMPANY INFORMATION

REGISTERED NAME:	DATE OF INCORPORATION/REGISTRATION:
COUNTRY OF INCORPORATION/REGISTRATION:	TIN:

TYPE OF BUSINESS:
Company: Sole proprietor LLC Partnership Co-operative NGO Business Registration Non-Profit
 Other (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 (within 6 months)

Affiliation with Senior Government/Military/Judicial/State officials/Politicians or any person who provides an important public function for the state;

Name: _____ Relationship: _____

CONTACT INFORMATION

REGISTERED ADDRESS: _____

MAILING ADDRESS (if different): _____

EMAIL ADDRESS: _____ WEBSITE: _____

TELEPHONE NUMBER(S): _____ FAX: _____

PRINCIPAL PERSON OF BUSINESS:..... ID/PP #:

COUNTRY OF RESIDENCE: COUNTRY OF BIRTH: NATIONALITY:

CONTACT NUMBER (Work): (Cell):..... Email Address:

ORIGIN OF PROPERTY:

SOURCE OF FUNDS (money paid to the policy) is:

For new clients, where an annual premium exceeds \$2,000,000:- or multiple premium payments exceeding \$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.

SIGNATURE OF AUTHORIZED OFFICER OF COMPANY/BUSINESS:	SIGNATURE OF HIHMF AUTHORISED OFFICER:
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OFFICIAL USE ONLY

POLICY NUMBER(S):	AML REQUIRED DOCUMENTS RECEIVED: <input type="checkbox"/>
INCEPTION DATE:	EXPIRY DATE:

POLICY TYPE: Motor: Property: Accident: Marine: Public Liability: Other:

Branch/Agent/Broker _____ Sum Insured.....Annual Premium..... Currency:..... Transaction Accepted: Yes <input type="checkbox"/> No <input type="checkbox"/>	Reason for Decline Transaction taken by: Position: Signature: Date:
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