

# Life Policy Proposal Form

Please answer every part of each question. Note an insurance agent who assists an applicant to complete an application or proposal for insurance shall be deemed to have done so as the agent of the applicant.

Please use block letters

Life to be assured:

Surname:  Other names

Sex: male  female

Marital status:  Married  Single

Date of birth:  Place of birth:

Occupation:

(in order that the age may be admitted, evidence of birth (and marriage for a married lady) should be produced before commencement of assurance)

Please use block letters

Postal address

Residential address

Telephone number  e-mail

If the person proposing the assurance is not the life to be assured please state

Full name of proposer:   
(if married woman or a widow please state maiden name also)

Address:

Occupation:

The nature and amount of pecuniary interest dependent on the life to be assured.

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1. PARTICULARS OF ASSURANCE REQUIRED :

SUM ASSURED: N

TERM OF POLICY:

TYPE OF POLICY

<p>1. Term Assurance                  2. Endowment Assurance                  3. Educational Assurance                  4. Mortgage Assurance                  5. Multi- Payment Plan                  6. Hi Yield</p>	<p>....Without Profit                  .....With Profit                  ..... With Profit ...Spread</p>
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Number of times per annum that premiums are to be payable  
 (for yearly insert 1. half yearly 2. Quarterly 4. Monthly 12 or by single premium SP)

4. If you wish to include any ADDITIONAL BENEFIT in the Policy please complete details below

- Only for benefit(s) required:
- A) Waiver of premium benefit N
- b) Double accident benefit required N
- C) Accidental death benefit N

QUESTIONS TO BE ANSWERED BY PERSON WHOSE LIFE IS TO BE ASSURED

5. (a) Are you now in all respects in good health?
- (b) Do you usually enjoy good health?

6. Have you in the past 2 years been absent from work because of sickness or accident for a period longer than 6 weeks in the aggregate?

7. Have you ever had:
- (a) Recurrent or persistent fever or skin disorder (a)
- (b) Persistent night sweats? (b)
- (c) Weight loss? (c)
- (d) Infections of swollen glands? (d)
- (e) Chronic or frequent diarrhoea? (e)
- (f) Persistent cough? (F)
- (g) Hepatitis B or any sexually transmitted diseases including genital sores or discharge? (G)

8. What are your height and weight in indoor clothes and shoes Height  (metres) Weight  (kg)

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9. Any previous life policy? Yes  No  Policy No:

Assurer:  Dated:

10. If female, are you now pregnant? Yes  No   
 If "YES" Please state the expected date of delivery

11. (a) Name and address of your doctor   
 (b) How long has he known you?   
 (c) When and for what ailment have you consulted him or her?

(d) Name and address of any other doctor you have consulted within the last five years

12. Name and address of your employers (if any)

13. State the beneficiary and the address if not same as 1 above (in block letters please)

NAME	RELATIONSHIP	ADDRESS	PERCENTAGE (%)
<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="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"/>

**DECLARATION:**

I/We the life to be assured named overleaf, do hereby state that I/We are at present in good health and that the statements in this proposal are true and complete. I/We consent to the company seeking medical evidence from any doctor who at any time has attended to me and/or seeking information from the employer named above and from any insurance company to which I/We have at any time made a proposal for life assurance, and I/We authorize the giving of such information.

I/We the undersigned proposing to effect the policy declare that to the best of my /our knowledge the statements in this proposal are true and complete in every particular and together with any statement which may be made to the company's Medical Examiner by the person whose life is to be assured shall be the basis of the contract between me/us and the company.

I/We understand that if the policy is discontinued or surrendered before the maturity date, the amount payable (if any) will be substantially less than the premium paid.

Dated this .....day of .....

Signature of the life to be Assured.....

Signature(s) of the person(s) proposing to effect the Assurance.....

Signature of Witness.....

The Assurance will not commence until the proposer is in possession of the formal letter of acceptance issued from the Head Office of the Company and of the valid official receipt for payment of the first premium on the company's printed form.