MANDATE NO.: __________________ (CAGD only)

SALES ACTIVATION CODE: ____________________

StarLife CASHBUILDER PLUS POLICY

APPLICATION FORM

NB. EVERY QUESTION MUST BE ANSWERED. PLEASE COMPLETE THIS FORM IN BLOCK LETTERS

[A] PERSONAL DETAILS

Customer Classification: Individual ☐ Corporate ☐

Surname:

Middle Name(s):

First Name:

Date of Birth: **Nationality:**

Gender: (please tick) Male ☐ Female ☐

If female, are you pregnant? Yes ☐ No ☐

If yes, for how long:

Marital Status: (please tick) Single ☐ Married ☐ Divorced ☐ Widowed ☐

PEP STATUS:

a. Are you a politically exposed person? Yes ☐ No ☐

b. Is any family member or known close associate a PEP? Yes ☐ No ☐

Permanent Postal Address:

Residential Address:

Mobile: E-Mail:

ID Type: Passport ☐ Voters' ☐ Drivers' ☐ National ID ☐ NHIS ☐

ID type provided must be valid (not expired)

ID Number:

Date of Issue: Date of Expiry:

[B] EMPLOYER DETAILS

Occupation:

Name of Employer & Work Place Address:

Telephone:

Facsimile:

E-mail:

[C] PAYMENT DETAILS

Payment Mode:

CAGD ☐ Corporate ☐

Staff ID No.:

Debit Order ☐ Cash/Cheque ☐

Mobile Money ☐ 024 528 7497

State Bank & Branch

Bank A/C No.:

Payment Frequency: Monthly ☐ Quarterly ☐ Semi Annually ☐ Annually ☐

Source of Income:

Salary ☐ Business ☐ Other ☐

If Business or other, please specify nature of Business or other source of income:

[D] COVER DETAILS

Policy term (not below 10 yrs) :

Cover (10 times Annual Premium)

Rider

Do you require Dread Disease Insurance? Yes ☐ No ☐

Beneficiaries

No.	Surname	First Name	Other Names	Date of Birth	Relationship	%	Contact No.
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

Basic Premium (GH₵): Extra Premium (GH₵):

Total Premium (GH₵): Initial Sum Assured (GH₵):

Trustee *(where a beneficiary is below 18 years of age)*

Surname	Other Names	Date of Birth	Relationship	Contact No.

[E] MEDICAL HISTORY

Do you have or have you ever had any of the following If yes, provide details			Year	Clinic/Hospital	Results: Treated & Discharged	Results: Undergoing Treatment
Asthma, persistent cough, blood spitting, bronchitis, chest pains, tuberculosis, pneumonia, hypertension?	Yes ☐	No ☐			☐	☐
Fits, fit of dizziness, paralysis, stroke or any other nervous or mental disorder	Yes ☐	No ☐			☐	☐
Diabetes Mellitus?	Yes ☐	No ☐			☐	☐
Rheumatism, sciatica, or any disorder of the bones, joints or the spine?	Yes ☐	No ☐			☐	☐
Skin disease, tumour or growth?	Yes ☐	No ☐			☐	☐
Disorder of the eyes, ears nose or throat?	Yes ☐	No ☐			☐	☐
Diagnostic test such as X-ray examinations, electrocardiogram?	Yes ☐	No ☐			☐	☐
Bilharzia?	Yes ☐	No ☐			☐	☐
Any surgical operation, accident or severe injury, mutilation or amputation, any hospital treatment or medical attention not mentioned?	Yes ☐	No ☐			☐	☐
Are you currently taking any medication?	Yes ☐	No ☐	If yes give type of medication and dosage:			
Do you take in any alcoholic drink?	Yes ☐	No ☐	If yes, state weekly consumption			
Do you smoke cigarette?	Yes ☐	No ☐	If yes, how many sticks a day?			

I hereby consent to the processing of personal data for the purposes of targeted and direct marketing. Yes ☐ No ☐

I hereby consent to the processing of my personal data for business relationship and further acknowledge and agree that my personal data may be disclosed to entities associated or affiliated to StarLife Assurance Company Limited to achieve the purpose of processing under this consent. Yes ☐ No ☐

[F] INSURANCE HISTORY

Do you have any life assurance policy? Yes ☐ No ☐

If yes, list company(ies) and the sum(s) assured:

1. ______________ 2. ______________

Have you ever been refused life assurance, your application deferred or had special terms imposed on it? Yes ☐ No ☐

[G] DECLARATION

Declaration by Applicant

I ______________ do hereby declare to the best of my knowledge and belief that the above statements are true and complete and that this proposal will form the basis of contract.

Proposer's Signature	*Date*	*Branch Manager's Name*	*Zonal Manager's Name*
Sales Executive's ID	*Sales Executive's Name*	*Sales Executive's Signature*	*Date*
Unit Manager's Name	*Unit Manager's Signature*	*Date*	

FOR OFFICIAL USE ONLY		
	Policy Number:	Approved By:
	Issue Date:	Signature:
	Issue Age:	Date: