



MANDATE NO.: \_\_\_\_\_ ( CAGD only)

SALES ACTIVATION CODE: \_\_\_\_\_

**StarLife ESTEEM HOMECALL PLUS**

**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: Male  Female

If Female, are you Pregnant? Yes  No

If yes, for how long: \_\_\_\_\_

Marital Status: 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  Annually

**Source of Income:**  
Salary  Business  Other

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

**[D] COVER DETAILS**

Please select a product option:

Cover Type	Basic <input type="checkbox"/>	Standard <input type="checkbox"/>	Prestige <input type="checkbox"/>	Elite <input type="checkbox"/>	Ultimate <input type="checkbox"/>
Sum Assured	2,500	5,000	10,000	15,000	30,000

Assureds	Name	Date of Birth	Age	Premium
Principal Assured ( <i>not above 64 years</i> )				
Spouse ( <i>not above 64 years</i> ) 100% of P.A				
1 <sup>st</sup> Child ( <i>not above 23 years</i> ) 30% of P.A				
2 <sup>nd</sup> Child ( <i>not above 23 years</i> ) 30% of P.A				
3 <sup>rd</sup> Child ( <i>not above 23 years</i> ) 30% of P.A				
4 <sup>th</sup> Child ( <i>not above 23 years</i> ) 30% of P.A				
Mother ( <i>not above 74 years</i> ) 50% of P.A				
Father ( <i>not above 74 years</i> ) 50% of P.A				
Mother-in- law ( <i>not above 74 years</i> ) 50% of P.A				
Father-in- law ( <i>not above 74 years</i> ) 50% of P.A				
One extended family member: Specify _____ ( <i>not above 74 years</i> ) 50% of P.A				

*If at the time of claim it is discovered that the assured was more than the age limit at the inception of the policy, the company would only refund premiums.*

Basic Premium (GH¢): \_\_\_\_\_ Extra Premium (GH¢): \_\_\_\_\_ Total Premium (GH¢): \_\_\_\_\_

**Beneficiaries**

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

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

Surname	First Name	Other Names	Date of Birth	Relationship	Address/Contact No.

Do you wish to have the Benefits Increase option?      Yes            No     

**If yes tick your preferred option**

	Annual Premium Increase	Annual Sum Assured Increase
Option 1 <input type="checkbox"/>	10%	6%
Option 2 <input type="checkbox"/>	15%	9%
Option 3 <input type="checkbox"/>	20%	12%

**[E] STATEMENT OF HEALTH (please tick yes or no)**

1. Do you or any of the Proposed Life Assured suffer any disease, disorder, paralysis or health impairment?      Yes            No
2. During the past 12 months did any Proposed Life Assured suffer from any of the following?
  - i. Respiratory or lung disorder (e.g Persistent tuberculosis, spitting of blood, recurrent lung infection, difficulty in breathing)      Yes            No
  - ii. A disease or disorder of the bladder or reproductive organs (e.g. Blood or albumin in the urine, chronic discharge, difficulty in passing urine, venereal diseases)      Yes            No
3. Is any Proposed Life Assured at present receiving or has he/she during the past 12 months received any medication or treatment for longer than two weeks continuously?      Yes            No
4. Did any Proposed Life Assured consult any medical doctor or other persons providing healing services (e.g. Herbalist, traditional healer) during the past 3 months?      Yes            No
5. Has any Proposed Life Assured been informed that he/she has been infected with HIV or is suffering from it?      Yes            No
6. Do you or any of the Proposed Life Assured have any sickle cell condition?      Yes            No

**If the answer to any of the above is YES, please provide details below.**

Name	Question No.	Full Details

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] DECLARATION**

Declaration by Applicant

I \_\_\_\_\_ declare that every statement in response to questions asked in this application is true and correct to the best of my knowledge. I agree that this application shall serve as the basis and form part of the contract. All the questions have been explained to me in the language that I understand and I have been made to understand that this contract shall become operative until all of the following conditions have been met:

1. This application has been approved by StarLife Assurance Company Limited.
2. The appropriate premium has been paid.
4. I satisfy all the conditions precedent to the policy especially those pertaining to my health and that of all the proposed lives assured.
5. All the persons proposed for cover are alive and in good health.

_____	_____	_____	_____
<i>Proposer's Signature</i>	<i>Date</i>	<i>Branch Manager's Name</i>	<i>Zonal Manager's Name</i>
_____	_____	_____	_____
<i>Sales Executive's ID</i>	<i>Sales Executive's Name</i>	<i>Sales Executive's Signature</i>	<i>Date</i>
_____	_____	_____	_____

**FOR  
OFFICIAL  
USE ONLY**

Policy Number: \_\_\_\_\_ Approved By: \_\_\_\_\_

Issue Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Issue Age: \_\_\_\_\_ Date: \_\_\_\_\_