



MANDATE NO.: _____ (CAGD only)

SALES ACTIVATION CODE: _____

StarLife ULTIMATE PROTECTION 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

POLICY TERM (8 To 20 YRS): _____ Do you wish to have the Benefits Increase option? Yes No

Do you wish to have a rider? Yes No *If yes please tick preferred option*

(OPTIONAL) DREAD DISEASE/CRITICAL ILLNESS		Annual Premium Increase	Annual Sum Assured Increase
Basic S.A (GH¢): _____	Option 1 <input type="checkbox"/>	5%	3%
Dread Disease S.A (GH¢): _____	Option 2 <input type="checkbox"/>	10%	6%
(Death) Basic Prem (GH¢): _____	Option 3 <input type="checkbox"/>	15%	9%
Dread Dis Prem (GH¢): _____	Option 4 <input type="checkbox"/>	20%	12%

Extra Premium (GH¢): _____ Total Premium (GH¢): _____

Beneficiary(ies) Please provide details

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

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.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Proposer's Signature	Date	Branch Manager's Name	Zonal Manager's Name
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sales Executive's ID	Sales Executive's Name	Sales Executive's Signature	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Unit Manager's Name	Unit Manager's Signature	Date	

FOR OFFICIAL USE ONLY	Policy Number: <input type="text"/>	Approved By: <input type="text"/>
	Issue Date: <input type="text"/>	Signature: <input type="text"/>
	Issue Age: <input type="text"/>	Date: <input type="text"/>