



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

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

**StarLife WEALTH MASTER 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: 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**

Term of Policy (Tick preferred no. of years) 4  5  6  7  8  9  10

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

Total Premium (GH¢): \_\_\_\_\_ Initial Sum Assured (GH¢): \_\_\_\_\_

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"/>	5%	3%
Option 2 <input type="checkbox"/>	10%	6%
Option 3 <input type="checkbox"/>	15%	9%
Option 4 <input type="checkbox"/>	20%	12%

**[E] BENEFICIARY (IES)**

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

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

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

**[F] 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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rhematism, sciatica, or any disorder of the bones, joints or the spine? <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin disease, tumor or growth? <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disorder of the eyes, ears nose or throat? <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic test such as X-ray examinations, electrocardiogram? <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bilharzia?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<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

**[G] 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

**[H] 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	

<b>FOR OFFICIAL USE ONLY</b>	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"/>