



# Child Education Plan Application Form

Kindly complete this form in BLOCK LETTERS  
(All names should be in full; initials are not accepted)

## a. Personal details of the Account Holder

**Surname:**

**Other Names:**

**Gender:** Male  Female  **Date of Birth:**  **Age Next birthday:**

**Nationality:**

**Marital Status:** Single  Married  Divorced  Widowed  Other

**Occupation:**

**Work Address:**

**Email:**  **Mobile:**  **Office Telephone:**

**Permanent Address:**

**ID Type:** Passport  Voters'  Drivers'  National ID  Biometric NHIS  ID type provided must be valid (*not expired*)

**ID Number:**  **Date of Issue:**  **Date of Expiry:**

## b. Beneficiary(ies) of the Account Holder

	Surname	Other Names	Date of Birth	Relationship	Percentage	Address/Contact Number
1						
2						
3						
4						
5						
6						
7						
8						

**Trustee (Provide one if any of the beneficiaries is below 18 years of age)**

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## c. Cover Details

**Policy Term** (minimum of 10years: maximum of 25years)

**Do you require the following riders?**

Total and permanent Disability Yes  No  Dread Disease Yes  No

Retrenchment (12 months waiver of premium) Yes  No  Personal Accident for child(Cover:GH¢1,000) Yes  No

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

Total Premium (GH¢):

Initial Sum Assured (GH¢):

Do you wish to have the benefits increase option which maintains the value of your benefit through an automatic increase in premium and benefit as per schedule below? Yes  No

If yes, please tick your preferred option.

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

MEDICAL LIMITS		
BENEFIT / SUM ASSURED		MEDICALS REQUIRED
AGES BETWEEN 18 & 45	AGES BETWEEN 46 & 52	
Up to GH¢150,000.00	Up to GH¢100,000.00	No Medicals
GH¢150,001 - GH¢200,000.00	GH¢100,001 - GH¢150,000.00	MER, ECG, LFT, Hepatitis B, Fasting Blood Sugar, Hypertension Screen
GH¢200,001+	GH¢150,001+	MER, ECG, LFT, Hepatitis B & C, Fasting Blood Sugar, Hypertension Screen, Urine RE, Full Blood Count, HIV Kidney Function Test, Lipid Profile

**d. Premium Payment**

<b>GCB Selling Branch</b>	<input style="width:95%;" type="text"/>	<b>Account Holding Branch</b>	<input style="width:95%;" type="text"/>
<b>Account Number</b>	<input style="width:95%;" type="text"/>		
<b>Total Premium</b>	<input style="width:95%;" type="text"/>		
<b>Source of Income</b>	Salary <input type="checkbox"/>	Business <input type="checkbox"/>	Other <input type="checkbox"/> If Business or Other, please specify the nature of Business <input style="width:80%;" type="text"/>
<b>Other Source of Income</b>	<input style="width:95%;" type="text"/>		
<b>Frequency of Payment</b>	Monthly <input type="checkbox"/>	Quarterly <input type="checkbox"/>	Half Yearly <input type="checkbox"/> Yearly <input type="checkbox"/>

**e. Medical History**

Do you have or have you ever had any of the following <b>If yes, provide details</b>					Year	Clinic/Hospital	Results	
							Treated & Discharged	Undergoing Treatment
Asthma, persistent cough, blood spitting, bronchitis, chest pains, tuberculosis, pneumonia, hypertension? <input style="width:80%;" 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 style="width:80%;" 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"/>
Rheumatism, sciatica, or any disorder of the bones, joints or the spine? <input style="width:80%;" 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 style="width:80%;" 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 style="width:80%;" 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 style="width:80%;" 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 style="width:80%;" 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 style="width:80%;" type="text"/>			
Do you take in any alcoholic drink?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	If yes, state weekly consumption <input style="width:80%;" type="text"/>			
Do you smoke cigarette?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	If yes, how many sticks a day? <input style="width:80%;" type="text"/>			

**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

Account Holder's Signature \_\_\_\_\_ Date

How would you Like to receive your policy certificate? Soft Copy  Hard Copy

If soft copy provide email address/WhatsApp number

**g. Declaration**

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 I understand by \_\_\_\_\_)

I have been made to understand that this contract shall not become operative until all the following conditions have been met:

1. This application has been approved by StarLife Assurance Company Limited, the underwriter of the policy.
2. The first premium has been paid.
3. I satisfy all the conditions precedent to the policy especially those pertaining to my health.

Account Holder's Signature _____	Date <input style="width:80%;" type="text"/>
Name of DSO & AGT Number & Contact <input style="width:80%;" type="text"/>	Signature _____ Date <input style="width:80%;" type="text"/>
Bank Supervisor's Name <input style="width:80%;" type="text"/>	Signature _____ Date <input style="width:80%;" type="text"/>
Relationship Manager's Name <input style="width:80%;" type="text"/>	Signature _____ Date <input style="width:80%;" type="text"/>

Office Use

Approved by

Policy Number

Signature

Issue Date

Date

\*Terms and conditions apply

