



HomeCall Plus 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

Please Select a Benefit Option

Cover Type Basic Standard Prestige Elite Ultimate

Sum Assured 2,500.00 5,000.00 10,000.00 15,000.00 30,000.00

Assured(s)	Name	Date of Birth	Age	Benefit/Sum Assured	Premium (GH¢)
Account Holder (<i>not above 64 years</i>) 100%					
Account Holder's Spouse (<i>not above 64 years</i>) 100%					
Mother (<i>not above 74 years</i>) 50%					
Father (<i>not above 74 years</i>) 50%					
First Child (<i>not above 23 years</i>) 30%					
Second Child (<i>not above 23 years</i>) 30%					
Father-in-law (<i>not above 74 years</i>) 50%					
Mother-in-law (<i>not above 74 years</i>) 50%					
One extended family member: Specify (<i>not above 74 years</i>) 50%					

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

d. Increment Options (Please tick applicable option)

Do you wish to have the benefit increase option? Yes No If yes, please tick your preferred option.

	Annual Premium Increase	Annual Benefit Increase
<input type="checkbox"/> Option 1	5%	3%
<input type="checkbox"/> Option 2	10%	6%
<input type="checkbox"/> Option 3	15%	9%
<input type="checkbox"/> Option 4	20%	12%

e. Premium Payment

GCB Selling Branch Account Number Account Holding Branch

Total Premium

Source of Income Salary Business Other If Business or Other, please specify the nature of Business

Other Source of Income

Frequency of Payment Monthly Quarterly Half Yearly Yearly

f. Statement of Health (Please Tick Yes or No)

1. Does any Proposed Life Assured suffer any disease, disorder, paralysis or health impairment? Yes No

2. During the past 12 months did any of the Proposed Life Assured suffer from any of the following? Yes No

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. (Blood or albumin in the urine, chronic discharge, difficulty in passing urine, venereal diseases) Yes No

3. Is any of the 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 of the Proposed Life Assured consult any medical doctor/alternative medical practitioner 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 suffering from it? Yes No

6. Do you or any 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 Number	Onset of Disease/Medical Condition	Full Details / State Any Complication

Account Holder's Signature _____ Date

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:

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

Account Holder's Signature _____ Date

Name of DSO & AGT Number & Contact Signature _____ Date

Bank Supervisor's Name Signature _____ Date

Relationship Manager's Name Signature _____ Date

Office Use

Approved by Policy Number

Signature _____ Issue Date

Date

*Terms and conditions apply

