



Ultimate Protection 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. Cover Details

POLICY TERM (8 To 20 YRS):

Do you wish to have a rider? Yes No

(OPTIONAL) DREAD DISEASE/CRITICAL ILLNESS

Basic S.A (GH¢):

Dread Disease S.A (GH¢):

(Death) Basic Prem (GH¢):

Dread Dis Prem (GH¢):

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

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

If yes please tick 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%

c. 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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d. Premium Payment

GCB Selling Branch: Account Holding Branch:

Account Number:

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

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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fits, fit of dizziness, paralysis, stroke or any other nervous or mental disorder? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism, sciatica, or any disorder of the bones, joints or the spine? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin disease, tumor or growth? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disorder of the eyes, ears nose or throat? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic test such as X-ray examinations, electrocardiogram? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bilharzia?	<input type="checkbox"/>	<input type="checkbox"/>	<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="checkbox"/>	<input type="checkbox"/>	<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"/>	

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

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

