WealthMaster 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)					

c. 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 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
☐	Option 1	5%	3%
☐	Option 2	10%	6%
☐	Option 3	15%	9%
☐	Option 4	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

GCB Selling Branch		Account Holding Branch	
Account Number			
Total Premium			

Source of Income: Salary ☐ Business ☐ Other ☐ If Business or Other, please specify the naure 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	Results: Undergoing Treatment
Asthma, persistent cough, blood spitting, bronchitis, chest pains, tuberculosis, pneumonia, hypertension?	Yes ☐	No ☐			☐	☐
Fits, fit of dizziness, paralysis, stroke or any other nervous or mental disorder?	Yes ☐	No ☐			☐	☐
Diabetes Mellitus?	Yes ☐	No ☐			☐	☐
Rhematism, sciatica, or any disorder of the bones, joints or the spine?	Yes ☐	No ☐			☐	☐
Skin disease, tumor or growth?	Yes ☐	No ☐			☐	☐
Disorder of the eyes, ears nose or throat?	Yes ☐	No ☐			☐	☐
Diagnostic test such as X-ray examinations, electrocardiogram?	Yes ☐	No ☐			☐	☐
Bilharzia?	Yes ☐	No ☐			☐	☐
Any surgical operation, accident or severe injury, mutilation or amputation, any hospital treatment or medical attention not mentioned?	Yes ☐	No ☐			☐	☐

Are you currently taking any medication? Yes ☐ No ☐ If yes give type of medication and dosage: ____

Do you take in any alcoholic drink? Yes ☐ No ☐ If yes, state weekly consumption ____

Do you smoke cigarette? Yes ☐ No ☐ If yes, how many sticks a day? ____

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