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 (Must be above 18years)					

c. Cover Details

Policy Term (minimum of 8years: maximum of 25years)

Do you require the following riders?

Total and permanent Disability Yes ☐ No ☐

Retrenchment (12 months waiver of premium) Yes ☐ No ☐

Dread Disease 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
☐	Option 1	10%	6%
☐	Option 2	15%	9%
☐	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

Access Bank 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 (Please Tick Yes or No)

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?	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 (Please Tick Yes or No)

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

Underwritten by:
StarLife
...your solid partner for life