

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)

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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
<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%

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 nature 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? <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fits, fit of dizziness, paralysis, stroke or any other nervous or mental disorder? <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism, sciatica, or any disorder of the bones, joints or the spine? <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin disease, tumor or growth? <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disorder of the eyes, ears nose or throat? <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic test such as X-ray examinations, electrocardiogram? <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bilharzia?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<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 type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<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 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 (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:

- 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.

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

