



Assureds	Surname	Name	Date of Birth	Age	Premium
Principal Assured ( <i>not above 64 years</i> )					
Spouse ( <i>not above 64 years</i> )					
1 <sup>st</sup> Child ( <i>not above 23 years</i> )					
2 <sup>nd</sup> Child ( <i>not above 23 years</i> )					
3 <sup>rd</sup> Child ( <i>not above 23 years</i> )					
4 <sup>th</sup> Child ( <i>not above 23 years</i> )					
Mother ( <i>not above 74 years</i> )					
Father ( <i>not above 74 years</i> )					
Mother-in- law ( <i>not above 74 years</i> )					
Father-in- law ( <i>not above 74 years</i> )					
Extended Family Member: (Only 1 is allowed. Not above 74 years) (Specify Relationship) <input type="text"/>					

If at the time of claim it is discovered that the assured was more than the age limit at the inception of the policy, the company would only refund premiums.

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

### Beneficiaries

No.	Surname	First Name	Other Names	Date of Birth	Relationship	%	Contact No.
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

### Trustee (where a beneficiary is below 18 years of age)

Surname	First Name	Other Names	Date of Birth	Relationship	Address/Contact No.

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

If yes tick your 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%

### Optional Benefit for:

**Personal Accident (Cover ends at Age 60)**  
(Kindly denote [Y] or [N] in the preferred Option)

Personal Accident (Y/N)

	GH¢ Annual Benefit
Option 1 <input type="checkbox"/>	5,000
Option 2 <input type="checkbox"/>	10,000
Option 3 <input type="checkbox"/>	15,000
Option 4 <input type="checkbox"/>	20,000

**Hospitalisation Benefit (Cover ends at Age 60)**  
(Kindly denote [Y] or [N] in the preferred Option)

Hospitalisation Accident (Y/N)

	GH¢ Annual Benefit
Option 1 <input type="checkbox"/>	1,400
Option 2 <input type="checkbox"/>	2,500
Option 3 <input type="checkbox"/>	3,600
Option 4 <input type="checkbox"/>	5,000

**[E] STATEMENT OF HEALTH (please tick yes or no)**

1. Do you or any of the Proposed Life Assured suffer any disease, disorder, paralysis or health impairment? Yes  No
2. During the past 12 months did any Proposed Life Assured suffer from any of the following?
- 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 (e.g. Blood or albumin in the urine, chronic discharge, difficulty in passing urine, venereal diseases) Yes  No
3. Is any 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 Proposed Life Assured consult any medical doctor or other persons 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 is suffering from it? Yes  No
6. Do you or any of the 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 No.	Full Details

**[F] HOW DID YOU GET TO KNOW STARLIFE?**

Advertisement  Website  Referral  Agent  Broker  Others

If Others, Kindly specify

**[F] DECLARATION**

Declaration by Applicant

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 that I understand and I have been made to understand that this contract shall become operative until all of the following conditions have been met:

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

_____	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Proposer's Signature</i>	<i>Date</i>	<i>Branch Manager's Name</i>	<i>Zonal Manager's Name</i>
<input type="text"/>	<input type="text"/>	_____	<input type="text"/>
<i>Sales Executive's ID</i>	<i>Sales Executive's Name</i>	<i>Sales Executive's Signature</i>	<i>Date</i>
<input type="text"/>	_____	<input type="text"/>	_____
<i>Sales Managers Name</i>	<i>Sales Manager's Signature</i>	<i>Date</i>	

<b>FOR OFFICIAL USE ONLY</b>	Policy Number: _____	Approved By: _____
	Issue Date: _____	Signature: _____
	Issue Age: _____	Date: _____