Phobia HomeCall Plan Application Form

Kindly complete this form in **BLOCK LETTERS**
(All names should be in full; initials are not accepted)

Loan/Advance Number _____ (CAGD only)

a. Personal details of the Proposer

Surname

Middle Name(s)

First Name

Date of Birth

Nationality

(*If non-Ghanaian provide passport and residence permit issued by the Ghana Immigration Service)

Gender Male ☐ Female ☐

PEP STATUS: Are You a ☐ Politically Exposed or ☐ Family member or a known Close associate of a PEP

Marital Status Single ☐ Married ☐ Divorced ☐ Widowed ☐

Occupation

Work Place Address

Mobile 1 Mobile 2

Email

Permanent Address

ID Type: Voters ☐ Passport ☐ Drivers' ☐ National ID ☐ Biometric NHIS ☐
(*ID Type provided must be valid (not expired))

ID Number

Date of Issue Date of Expiry

b. Cover Details

Please select a product option Cover **Sum Assured**

Basic (2,500) ☐ Standard (5000) ☐ Prestige (10,000) ☐ Elite (15,000) ☐ Ultimate (30,000) ☐

Assureds	Name	Date of Birth	Age	Premium
Principal Assured ***(not above 64 years)***				
Spouse ***(not above 64 years) 100% of P.A***				
1st Child ***(not above 23 years) 30% of P.A***				
2nd Child ***(not above 23 years) 30% of P.A***				
3rd Child ***(not above 23 years) 30% of P.A***				
4th Child ***(not above 23 years) 30% of P.A***				
Mother ***(not above 74 years) 50% of P.A***				
Father ***(not above 74 years) 50% of P.A***				
Mother-in- law ***(not above 74 years) 50% of P.A***				
Father-in- law ***(not above 74 years) 50% of P.A***				
One extended family member: Specify _____ ***(not above 74 years) 50% of P.A***				

IF AT 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 ______ Total Premium ______

Extra Premium ______ Initial Sum assured ______

c. Beneficiary (ies) of the Proposer

Surname ______

Other Name(s) ______

Date of Birth ______ % ______ # ______

Relationship ______

Surname ______

Other Name(s) ______

Date of Birth ______ % ______ # ______

Relationship ______

Surname ______

Other Name(s) ______

Date of Birth ______ % ______ # ______

Relationship ______

Surname ______

Other Name(s) ______

Date of Birth ______ % ______ # ______

Relationship ______

Trustee
(Where a beneficiary is below 18 yrs of age) ______

Date of Birth ______ # ______

Relationship ______

d. Increment Option (Please tick applicable option)

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 the schedule below ? Yes ☐ No ☐

If yes, Kindly **tick** in the preferred option

If yes tick your preferred option		Annual Premium Increase	Annual Sum Assured Increase
Option 1	☐	10%	6%
Option 2	☐	15%	9%
Option 3	☐	20%	12%

e. Premium Payment

CAGD ☐ Corporate ☐ Bank Debit ☐

Staff ID Number

Bank and Branch

Account Number

Mobile Money Number **024 5287 497** ☐ Payment frequency; Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annually ☐

Source of income; Salary ☐ Business ☐ Other ☐

If Business or Other, Please specify nature of Business or other source of income

e. Medical History

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. Insurance History (Please tick Yes/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 ☐

How would you like to receive your policy certificate ? Soft Copy ☐ Hard copy ☐

If soft copy, provide e-mail address /whatsapp No.

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 by _____, which I understand, and 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.
2. The appropriate premium has been paid.
3. I satisfy all the conditions precedent to the policy especially those pertaining to my health and that of all the proposed lives assured.
4. All the persons proposed for cover are alive and in good health.

Proposer's Signature _____ Date

Sales Executive Name AGT No.

S.E Signature_____ Date S.E Contact No.

Sales Manager's Name Signature _____ Date

Branch Manager's Name Zonal Manager's Name

I hereby consent to the processing of personal data for the purposes of targeted and direct marketing. Yes ☐ No ☐

I hereby consent to the processing of my personal data for business relationship and further acknowledge and agree that my personal data may be disclosed to entities associated or affiliated to StarLife Assurance Company Limited to achieve the purpose of processing under this consent. Yes ☐ No ☐

Office Use

Approved by

Policy Number

Signature _____ Date Issue Date

Underwritten by:

StarLife
...your solid partner for life

* Terms and Conditions apply