MANDATE NO.: _____ (CAGD only) SALES ACTIVATION CODE:. _____

StarLife ESTEEM HOMECALL PLUS

APPLICATION FORM

NB. EVERY QUESTION MUST BE ANSWERED. PLEASE COMPLETE THIS FORM IN BLOCK LETTERS

[A] PERSONAL DETAILS

Customer Classification: Individual ☐ Corporate ☐

Surname:

Middle Name(s):

First Name:

Date of Birth: **Nationality:**

Gender: Male ☐ Female ☐

If Female, are you Pregnant? Yes ☐ No ☐

If yes, for how long:

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

PEP STATUS:

a. Are you a politically exposed Person? Yes ☐ No ☐

b. Is any family member or known close associate a PEP? Yes ☐ No ☐

Permanent Postal Address:

Residential Address:

Mobile: E-Mail:

ID Type: Passport ☐ Voters' ☐ Drivers' ☐ National ID ☐ NHIS ☐

ID type provided must be valid (not expired)

ID Number:

Date of Issue: Date of Expiry:

[B] EMPLOYER DETAILS

Occupation:

Name of Employer & Work Place Address:

Telephone:

E-mail1:

E-mail2:

[C] PAYMENT DETAILS

Payment Mode:

CAGD ☐ Corporate ☐

Staff ID No.:

Debit Order ☐ Cash/Cheque ☐

Mobile Money ☐ 024 528 7497

State Bank & Branch

Bank A/C No.:

Payment Frequency:

Monthly ☐ Annually ☐

Source of Income:

Salary ☐ Business ☐ Other ☐

If Business or other, please specify nature of Business or other source of income:

[D] COVER DETAILS

Please select a product option:

Cover Type	Basic ☐	Standard ☐	Prestige ☐	Elite ☐	Ultimate ☐
Sum Assured	2,500	5,000	10,000	15,000	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 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	☐	10%	6%
Option 2	☐	15%	9%
Option 3	☐	20%	12%

[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**

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 ☐

[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.

_____			
Proposer's Signature	*Date*	*Branch Manager's Name*	*Zonal Manager's Name*
		_____	
Sales Executive's ID	*Sales Executive's Name*	*Sales Executive's Signature*	*Date*
	_____		
Unit Manager's Name	*Unit Manager's Signature*		*Date*

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Policy Number: _____ Approved By: _____

Issue Date: _____ Signature: _____

Issue Age: _____ Date: _____

Plot No. Z 20B, Airport Residential Area, Accra
on the Mankata Avenue P. O. Box AN 5783, Accra-North
Tel: +233 302-258943-6 Fax: +233 302-258947 **Email:**info @starlife.com.gh
Website: www.starlife.com.gh

DEBIT MANDATE

PAYMENT MODE: (Please tick preferred option) Bank Debit ☐ Direct Debit ☐

POLICY HOLDER'S NAME _____

BANK NAME:

BRANCH _____

ACCOUNT NO: _____

DEDUCTION AMOUNT GH¢ : _____

DATE OF FIRST DEDUCTION: _____

FREQUENCY OF PAYMENT: MONTHLY ☐ ANNUAL ☐

ANNUAL BENEFITS INCREASE OPTIONS? YES ☐ NO ☐

STATE RATE OF INCREASE (%) N/A

DECLARATION

I have applied to StarLife Assurance Company Limited for a life policy and authorise you to deduct from my account the amount stated above and credit same to StarLife Assurance Company Limited on the date stated and every month after.

This authorisation shall be effective, until a written notice by me to cancel this authorisat--ion has been issued, stating when such cancellation shall be effective or until termination of this premium payment by StarLife Assurance Company Ltd.

Bank Customer's Signature Date _____

Contact No. _____

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Policy No. _____ Date _____