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

c. Cover Details

Policy Term (Minimum of 8yrs: Maximum of 25 yrs)

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

	Annual Premium Increase	Annual Benefit Increase
Option 1 ☐	10%	6%
Option 2 ☐	15%	9%
Option 3 ☐	20%	12%

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

Extra Premium

Total Premium

Initial Sum Assured

MEDICAL LIMITS

BENEFIT/ SUM ASSURED		
AGES BETWEEN 18 & 45	AGES BETWEEN 46 & 52	MEDICAL REQUIRED
Up to Gh¢150,000.00	Up to Gh¢100,000.00	No Medicals
Gh¢150,001-GH¢200,000	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

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

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 ☐			☐	☐
Rheumatism, 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/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, 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

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