

# FABU Ultimate Protection 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	<input type="text"/>									
Middle Name(s)	<input type="text"/>									
First Name	<input type="text"/>									
Date of Birth	<input type="text"/>									
Nationality	<input type="text"/>									
(*If non-Ghanaian provide passport and residence permit issued by the Ghana Immigration Service)										
Gender	Male	<input type="checkbox"/>	PEP STATUS: Are You a Politically exposed person?		Yes	No				
	Female	<input type="checkbox"/>	Is any family member or known close associate a PEP?		Yes	No				
Marital Status	Single	<input type="checkbox"/>	Married	<input type="checkbox"/>	Divorced	<input type="checkbox"/>	Widowed	<input type="checkbox"/>		
Occupation	<input type="text"/>									
Work Place Address	<input type="text"/>									
	<input type="text"/>									
Mobile 1	<input type="text"/>		Mobile 2	<input type="text"/>						
Email	<input type="text"/>									
	<input type="text"/>									
Permanent Address	<input type="text"/>									
	<input type="text"/>									
ID Type :	Voters	<input type="checkbox"/>	Passport	<input type="checkbox"/>	Drivers'	<input type="checkbox"/>	National ID	<input type="checkbox"/>	Biometric NHIS	<input type="checkbox"/>
(*ID Type provided must be valid(not expired))										
ID Number	<input type="text"/>									
Date of Issue	<input type="text"/>			Date of Expiry	<input type="text"/>					

## b. Beneficiary (ies) of the Proposer

Surname	<input type="text"/>				
Other Name(s)	<input type="text"/>				
Date of Birth	<input type="text"/>	%	<input type="text"/>	#	<input type="text"/>
Relationship	<input type="text"/>				

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 20 yrs)  Total Premium (GH¢)

Do you wish to have a Rider? Yes  No

Dread Disease / Critical illness (Optional) Yes  No

Basic Sum Assured (GH¢)  Basic Premium(GH¢)

Dread Disease Sum Assured (GH¢)  Dread Disease Premium (GH¢)

Extra Premium (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 the schedule below ? Yes  No

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

	Annual Premium Increase		Annual Benefit Increase	
Option 1	<input type="checkbox"/>	5%	<input type="checkbox"/>	3%
Option 2	<input type="checkbox"/>	10%	<input type="checkbox"/>	6%
Option 3	<input type="checkbox"/>	15%	<input type="checkbox"/>	9%
Option 4	<input type="checkbox"/>	20%	<input type="checkbox"/>	12%

#### 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? <input type="text"/>	<input type="text"/>	<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"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus?	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism, sciatica, or any disorder of the bones, joints or the spine? <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin disease, tumor or growth? <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disorder of the eyes, ears nose or throat? <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic test such as X-ray examinations, electrocardiogram? <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bilharzia?	<input type="text"/>	<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"/>	<input type="text"/>	<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/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	<input type="text"/>
Sales Executive Name <input type="text"/>	AGT No.	<input type="text"/>
S.E Signature _____	Date <input type="text"/>	S.E Contact No. <input type="text"/>

Sales Manager's Name <input type="text"/>	Signature _____	Date <input type="text"/>
Branch Manager's Name <input type="text"/>	Zonal Manager's Name <input type="text"/>	

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 <input type="text"/>	
<input type="text"/>	
Policy Number <input type="text"/>	
Signature _____	Date <input type="text"/> Issue Date <input type="text"/>



\* Terms and Conditions apply