

Phobia Child Education 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 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 <input type="checkbox"/> | 10% | 6% |
| Option 2 <input type="checkbox"/> | 15% | 9% |
| Option 3 <input type="checkbox"/> | 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 | | MEDICAL REQUIRED |
| AGES BETWEEN 18 & 45 | AGES BETWEEN 46 & 52 | |
| 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? <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