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

StarLife ULTIMATE PROTECTION 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

POLICY TERM (8 To 20 YRS):

Do you wish to have a rider? Yes ☐ No ☐

(OPTIONAL) DREAD DISEASE/CRITICAL ILLNESS ☐

Basic S.A (GH₵):

Dread Disease S.A (GH₵):

(Death) Basic Prem (GH₵):

Dread Dis Prem (GH₵):

Extra Premium (GH₵): Total Premium (GH₵):

Do you wish to have the Benefits Increase option? Yes ☐ No ☐

If yes please tick preferred option

	Annual Premium Increase	Annual Sum Assured Increase
Option 1 ☐	5%	3%
Option 2 ☐	10%	6%
Option 3 ☐	15%	9%
Option 4 ☐	20%	12%

Beneficiary(ies) ***Please provide details***

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	Other Names	Date of Birth	Relationship	Contact No.

[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, tumour 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?

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] INSURANCE HISTORY

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 ☐

[G] DECLARATION

Declaration by Applicant

I *do hereby declare to the best of my knowledge and belief that the above statements are true and complete and that this proposal will form the basis of contract.*

_____			
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*

FOR OFFICIAL USE ONLY

Policy Number: Approved By:

Issue Date: Signature:

Issue Age: Date: