



GPCC HomeCall 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

Middle Name(s)

First Name

Date of Birth

Nationality
(*If non-Ghanaian provide passport and residence permit issued by the Ghana Immigration Service)

Gender Male Female

Marital Status Single Married Divorced Widowed

Occupation

Work Place Address

Mobile 1 Mobile 2

Email

Permanent Address

ID Type : Voters Passport Drivers' National ID Biometric NHIS
(*ID Type provided must be valid(not expired))

ID Number

Date of Issue Date of Expiry

b. Cover Details

Please select a product option Cover Basic (2,500) Standard (5000) Prestige (10,000) Elite (15,000) Ultimate (30,000)

Assureds	Name	Date of Birth	Age	Premium
Principal Assured (<i>not above 64 years</i>)				
Spouse (<i>not above 64 years</i>) 100% of P.A				
1 st Child (<i>not above 23 years</i>) 30% of P.A				
2 nd Child (<i>not above 23 years</i>) 30% of P.A				
3 rd Child (<i>not above 23 years</i>) 30% of P.A				
4 th Child (<i>not above 23 years</i>) 30% of P.A				
Mother (<i>not above 74 years</i>) 50% of P.A				
Father (<i>not above 74 years</i>) 50% of P.A				
Mother-in- law (<i>not above 74 years</i>) 50% of P.A				
Father-in- law (<i>not above 74 years</i>) 50% of P.A				
One extended family member: Specify <i>(not above 74 years) 50% of P.A</i>				

IF AT 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¢

Total Premium GH¢

Extra Premium GH¢

Initial Sum Assured GH¢

c. Beneficiary (ies) of the Proposer

Surname
 Other Name(s)
 Date of Birth % #
 Relationship

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

d. Increment Option (Please tick applicable option)

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

If yes tick your preferred option	Annual Premium Increase	Annual Sum Assured Increase
<input type="checkbox"/> Option 1	10%	6%
<input type="checkbox"/> Option 2	15%	9%
<input type="checkbox"/> Option 3	20%	12%

e. 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

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

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.

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

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"/>	

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



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Website: www.starlife.com.gh

DEBIT MANDATE

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

POLICY HOLDER'S NAME _____

BRANCH _____

DEDUCTION AMOUNT GH¢ : _____

DATE OF FIRST DEDUCTION: _____

FREQUENCY OF PAYMENT: MONTHLY ANNUAL

ANNUAL BENEFITS INCREASE OPTIONS? YES NO

STATE RATE OF INCREASE (%) _____

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 authorisation has been issued, stating when such cancellation shall be effective or until termination of this premium payment by StarLife Assurance Company Ltd.

Customer's Signature _____ Date _____

Contact No. _____

FOR OFFICIAL USE ONLY

Policy No. _____ Date _____