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

StarLife SUPREME HOMECALL PLAN

APPLICATION FORM

NB. EVERY QUESTION MUST BE ANSWERED. PLEASE COMPLETE THIS FORM IN BLOCK LETTERS (ALL NAMES SHOULD BE IN FULL. INITIALS ARE NOT ACCEPTABLE)

[A] PERSONAL DETAILS

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 (please tick): Male ☐ Female ☐

If Female, are you Pregnant? Yes ☐ No ☐

If yes, for how long:

Marital Status: Single ☐ Married ☐ Divorced ☐ Divorced ☐

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: WhatsAPP ☐ Mobile Money no. ☐

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:

Facsimile:

E-mail:

[C] PAYMENT DETAILS

Payment Mode:

i. CAGD ☐ ii. Corporate ☐

iii. Debit Order ☐ iv. Cash/Cheque ☐

v. Mobile Money ☐ 024 528 7497

Staff ID No.:

State Bank & Branch

Bank A/C No.:

Payment Frequency: Monthly ☐ Semi-Annually ☐ Quarterly ☐ Annually ☐

Source of Income:

Salary ☐ Business ☐ Other ☐

If Business or Other, please specify nature of Business or Other source of income:

Currency Ghana Cedis ☐

[D] COVER DETAILS

Policy Term (years):

10 ☐
15 ☐
20 ☐
25 ☐
30 ☐

Sum Assured GH₵ (Benefits Category)
Please tick your preferred option:

	GH₵		GH₵
Option 1 ☐	2,000	Option 6 ☐	20,000
Option 2 ☐	5,000	Option 7 ☐	25,000
Option 3 ☐	7,500	Option 8 ☐	30,000
Option 4 ☐	10,000	Option 9 ☐	40,000
Option 5 ☐	15,000	Option 10 ☐	50,000

End of Term Benefit *(please tick your preferred option)*

Refund ☐ Free Cover ☐

Assureds	Surname	Name	Date of Birth	Age	Premium
Principal Assured ***(not above 64 years)***			98989		
Spouse ***(not above 64 years)***					
1st Child ***(not above 23 years)***					
2nd Child ***(not above 23 years)***					
3rd Child ***(not above 23 years)***					
4th Child ***(not above 23 years)***					
Mother ***(not above 74 years)***					
Father ***(not above 74 years)***					
Mother-in- law ***(not above 74 years)***					
Father-in- law ***(not above 74 years)***					
Extended Family Member: ***(Only 1 is allowed. Not above 74 years)*** ***(Specify Relationship)***					

If at the 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₵): _____ **Extra Premium (GH₵):** _____ **Total Premium (GH₵):** _____

Beneficiaries

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	First Name	Other Names	Date of Birth	Relationship	Address/Contact No.

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

If yes tick your preferred option	Annual Premium Increase	Annual Sum Assured Increase
Option 1 ☐	5%	3%
Option 2 ☐	10%	6%
Option 3 ☐	15%	9%

Optional Benefit for:

Personal Accident (Cover ends at Age 60)

(If yes ,tick preferred option)

Yes ☐ No ☐

		GH₵ Annual Benefit
Option 1	☐	5,000
Option 2	☐	10,000
Option 3	☐	15,000
Option 4	☐	20,000

Hospital Benefit (Cover ends at Age 60)

(If yes ,tick preferred option)

Yes ☐ No ☐

		GH₵ Annual Benefit
Option 1	☐	1,400
Option 2	☐	2,500
Option 3	☐	3,600
Option 4	☐	5,000

[E] STATEMENT OF HEALTH *(please tick yes or no)*

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] HOW DID YOU GET TO KNOW STARLIFE?

Advertisement ☐ Website ☐ Referral ☐ Agent ☐ Broker ☐ Others ☐

If Others, Kindly specify _____

[F] DECLARATION

Declaration by Applicant

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 that I understand and I have been made to understand that this contract shall become operative until all of the following conditions have been met:

1. This application has been approved by StarLife Assurance Company Limited.
2. The appropriate premium has been paid.
4. I satisfy all the conditions precedent to the policy especially those pertaining to my health and that of all the proposed lives assured.
5. All the persons proposed for cover are alive and in good health.

_____			
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*
	_____		
Sales Managers Name	*Sales Manager's Signature*		*Date*

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Policy Number: _____ Approved By: _____

Issue Date: _____ Signature: _____

Issue Age: _____ Date: _____

Plot No. Z 20B, Airport Residential Area, Accra
on the Mankata Avenue P. O. Box AN 5783, Accra-North
Tel: +233 302-258943-6 Fax: +233 302-258947 **Email:**info @starlife.com.gh
Website: www.starlife.com.gh

DEBIT MANDATE

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

POLICY HOLDER'S NAME _____

BANK NAME:

BRANCH _____

ACCOUNT NO: _____

DEDUCTION AMOUNT GH¢ : _____

DATE OF FIRST DEDUCTION: _____

FREQUENCY OF PAYMENT: MONTHLY ☐ ANNUAL ☐

ANNUAL BENEFITS INCREASE OPTIONS? YES ☐ NO ☐

STATE RATE OF INCREASE (%) N/A

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

Bank Customer's Signature Date _____

Contact No. _____

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Policy No. _____ Date _____