

APPLICATION FOR LIFE ASSURANCE & PERSONAL ACCIDENT BENEFITS

to the  
**SIC LIFE COMPANY LIMITED**

P.O. BOX CT-3242

Cantonments – Accra.

Tel: (021) 664756/666682/672356/663387/ 666107

Fax: (021) 678125 / 671072

E-mail: [info@siclife-gh.com](mailto:info@siclife-gh.com)

Website: [www.siclife-gh.com](http://www.siclife-gh.com)



HEAD OFFICE USE ONLY

DATE OF ISSUE	POLICY NUMBER
---------------	---------------

LIFE PREMIUM GH¢ .....	RECEIPT NUMBER .....
P/A PREMIUM GH¢ .....	DATE .....
TOTAL PREMIUM GH¢ .....	APPROVED BY .....

1. Full Name of Proposed Assured <i>First Middle Surname</i>			2. Permanent Address  E-mail:	
-----------------------------------------------------------------	--	--	-------------------------------------	--

3. Height	8. Weight	3. Sex <i>Male Female</i> <input type="checkbox"/> <input type="checkbox"/>	5. Employer's Name
-----------	-----------	-----------------------------------------------------------------------------------	--------------------

6. Occupation	Nature of Work	4. Marital Status <input type="checkbox"/> <i>Single</i> <input type="checkbox"/> <i>Married</i> <input type="checkbox"/> <i>Widowed</i> <input type="checkbox"/> <i>Divorced</i>
---------------	----------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

9. Date of Birth	10. Age Next Birthday	11. Place of Birth	12. Mailing Address  Phone No.:  E-mail:
------------------	-----------------------	--------------------	------------------------------------------------------

14. Plan of Assurance <input type="checkbox"/> Ultimate Life Plan <input type="checkbox"/> Any Other (State below)	15. Initial Life Cover
	16. Personal Accident Cover

17. LIFE PREMIUM AMOUNT - GH¢  Premium Payment Mode: <input type="checkbox"/> <i>Monthly</i> <input type="checkbox"/> <i>Quarterly</i> <input type="checkbox"/> <i>Semi-Annually</i> <input type="checkbox"/> <i>Annually</i>	PERSONAL ACCIDENT PREMIUM AMOUNT - GH¢  Premium Payment Mode: <input type="checkbox"/> <i>Monthly</i> <input type="checkbox"/> <i>Quarterly</i> <input type="checkbox"/> <i>Semi-Annually</i> <input type="checkbox"/> <i>Annually</i>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

18. Full Name(s) of Beneficiary(	Relationship and Age	Address of Beneficiary(ies)
----------------------------------	----------------------	-----------------------------

19. Do you have any physical defects or infirmity? YES / NO  
If "YES" please describe it: . . . . .

20. Do you current have or have you ever had:-

a) Any Chest Pain, Blood Pressure or Heart Disorder? YES / NO

b) Any disorder of the Kidney, Liver, Urinary Tract or Respiratory, Nervous, Digestive or Reproductive System? YES / NO

c) Cancer, Tumour, Diabetes, Ulcer, Epilepsy, Emotional or Mental Disorder? YES / NO

21. Have you been diagnosed or treated for an immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Reproductive Transmitted Disease? YES / NO

22. Have you received any medical or surgical advise or treatment for any ailment, Injury or sickness during the past 5 years other than those listed above? YES / NO

23. GIVE DETAILS OF "YES" ANSWERS TO QUESTIONS 19-22:

24. Are there any circumstances connected with your occupation, health, pursuits or habits of life which render you particularly liable to injury or illness? YES / NO

25. a) Have you ever claimed or received compensation under any form of accident and / or sickness policy? YES / NO

b) If so, please give particulars:      **Date**                      **Amount Received**                      **Nature of Claim**                      **Name of Company**

26. a) Have you ever proposed for a Personal Accident Insurance? YES / NO

b) Has any Insurance Company: i) Declined to issue a Personal Accident Policy to you? YES / NO  
ii) Declined to continue your Personal Accident Insurance? YES / NO  
iii) Not invited the renewal of your Personal Accident Policy? YES / NO  
iv) Imposed special conditions or exclusions? YES / NO  
v) Will this insurance be additional to any other Personal Accident Policy? YES / NO

I REPRESENT that all statements and answers made above or attached to this application are true and complete to the best of my knowledge and belief, and that I have not withheld any material fact. I AGREE that this application shall be the basis of and form part of this Contract. I UNDERSTAND that the policy shall not be in effect until the Effective Date specified in the Contract and when all of the following conditions are met:-

- a) The application is approved by the SIC Life Company Limited ("the Company");
- b) The first premium is paid;
- c) The policy has been issued to and received by me and I am in good health; and
- d) The statements and answers made above or attached hereto continue to be true and complete.

I also confirm that I have checked and found correct any statement that is not in my handwriting.

DATED, this ..... day of .....

.....  
**Name of Authorized Agent and Number**

.....  
**Signature of Insured.**