**SIC LIFE COMPANY LIMITED**
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# EDUCATION PLAN PLUS PROPOSAL FORM

APPLICATION FOR LIFE ASSURANCE Doc. No.....

## A. PERSONAL DETAILS

Title: Surname: First Names:

Gender: Male Female Date of Birth: DD / MM / YYYY Marital Status: Single Married

Do you have a Policy with us? Yes No Divorced Widowed

If **YES**, Policy No. Client ID No.

## B. CONTACT INFORMATION

Telephone/Mobile: Email:

Birth Place: TOWN / COUNTRY Postal/ Digital Address:

Nationality:

Suburb: Town:

Region: ID. Type: ID NO.:

TIN:

## C. EMPLOYMENT DETAILS

Occupation: Staff ID:

Position: Employer's Address:

## D. HEIGHT & WEIGHT

1. Height (Ft/m): 2. Weight (Kg):

## E. BENEFICIARY & TRUSTEE DETAILS

| *Full Names of Beneficiary(ies)* | *Date of Birth* | *Relationship* | *Share (%)* | *Address/Contact* |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| Full Name of Trustee | Relationship | Date of Birth | Address/Contact |
|---|---|---|---|
| | | | |

## F. COVER DETAILS

**Initial Life Cover**

GH¢

**Term**

Year(s)

**PREMIUM FREQUENCY**

Monthly Quarterly

Semi-Annual Annual

**ANNUAL INFLATION PROTECTOR**

5% 20%

10% 25%

15% 30%

## EDUCATION PLAN PLUS PROPOSAL FORM

**NOTE**:

HEALTH STATUS

**G. Health Declaration by Proposer (or Primary Assured)**

| | YES | NO |
|---|---|---|
| 1. Are you actively working and able to perform all the usual duties of your occupation? | ☐ | ☐ |
| If NO, please state reasons: _____ | | |
| 2. Are you receiving any form of medical treatment or medication? | | |
| If YES, please state details: _____ | ☐ | ☐ |
| 3. Have you ever been treated for any of the following: | | |
| I. Asthma, bronchitis, tuberculosis, chronic coughing and blood spitting? | ☐ | ☐ |
| II. Paralysis or stroke, mental or nervous breakdown? | ☐ | ☐ |
| III. Chest pain, high blood pressure, rheumatic fever? | ☐ | ☐ |
| IV. Indigestion, ulcer, colitis, jaundice, liver or pancreatic disorder? | ☐ | ☐ |
| V. Gonorrhoea, syphilis, prostate cancer,or enlarged prostate? | ☐ | ☐ |
| VI. Diabetes, thyroid or other endocrine disease? | ☐ | ☐ |
| VII. Excessive use of alcohol? | ☐ | ☐ |
| 4. Have you ever used addictive drugs that were not prescribed by a doctor? | ☐ | ☐ |
| 5. Have you had an electro-cardiogram, x-ray or other diagnostic test in the past two (2) years? | ☐ | ☐ |
| 6. Do you have any relative who has suffered from cancer, tuberculosis, mental illness/disease, heart, kidney disease, or committed suicide? | ☐ | ☐ |
| 7. Have you been diagnosed with AIDS or an AIDS related complex? | ☐ | ☐ |
| 8. Do you have any of the following which are unexplained: fatigue, weight loss, diarrhoea? | ☐ | ☐ |
| 9. Do you or any of the Life Assureds named above suffer from any physical disability, illness, or have you undergone any surgical procedure in the last two years, or are you on any medication or undergoing treatment? | ☐ | ☐ |

If YES, give details

| |
|---|
| |

**DECLARATION**: I, _____ hereby declare that the information provided is **TRUE** and **COMPLETE** to the best of my knowledge. I have confirmed, checked and agree that any statement above that has been written on my behalf is true and complete.

**Proposer's Signature** _____

**Thumbprint** _____

**Date** _____

**Name of Agent/Broker:** _____

**Agent's/Brokerage Number**: _____

**OFFICE USE ONLY**

| **Approved by** | **Client No.** | **Issue Date** |
|---|---|---|
| | | DD / MM / YYYY |
| **Signed** _____ | **Proposal No.** | **Policy No.** |
| | | |