SIC LIFE COMPANY LIMITED
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FINAL JOURNEY 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 DETAILS

Full Name	*Date of Birth*	*Age*	*Relationship*	*Share (%)*	*Address/Contact*

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F. COVER DETAILS

Initial Sum Assured

GH¢ _____

Primary Assured's Risk Premium (A)

GH¢ _____

PREMIUM FREQUENCY

☐ Monthly ☐ Quarterly

☐ Semi-Annual ☐ Annual

MODE OF PAYMENT

☐ Cheque ☐ Bank

☐ Pay source ☐ Mobile Money

ANNUAL INFLATION PROTECTOR

☐ 5% ☐ 20%

☐ 10% ☐ 25%

☐ 15% ☐ 30%

SUPPLEMENTARY BENEFITS

☐ *One week commemoration pay-out 30% of Sum Assured (SB1)*

☐ *Forty days commemoration pay-out 50% of Sum Assured (SB2)*

☐ *First Anniversary pay-out: 50% of Sum Assured (SB3)*

☐ *Extra premium to be paid into savings Fund (B)* **GH¢** _____

ADDITIONAL INSURED MEMBERS

Full Name	Date of Birth	Age	Relationship	Address/Contact	Sums Assured	SB1	SB2	SB3	Premium

ADDITIONAL INSURED RISK PREMIUM *(C)* = GH¢ _____

TOTAL PREMIUM PAYABLE *(A+B+C)* **= GH¢** _____

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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.**
_____		