RC:2176

AFRICAN ALLIANCE
INSURANCE PLC

With you for life

An insurance agent who assists an applicant to complete an application or proposal form for insurance shall be deemed to have done so as the agent of the applicant.

APP. NO.....

NAME AND CODE NAME OF AGENCY

Please Affix 2 Passport Photograph

S/N

This proposal should be completed in proposer's Handwriting in BLOCK LETTERS.
PLEASE ANSWER EACH QUESTION FULLY.

Proposal No

SURNAME OTHER NAMES MAIDEN NAMES (if married)

RESIDENTIAL ADDRESS

EMPLOYER'S NAME OFFICE ADDRESS

POSTAL ADDRESS MARRIED ☐ SINGLE ☐ WIDOW(ER) ☐

Valid Means of I.D.(e.g Drivers License National I. D Card Int. Passport or Voters Card) *Please attach a copy*

PRECISE OCCUPATION (PLEASE GIVE FULL DETAILS) SOURCE OF FINANCE/INCOME

AGE NEXT BIRTHDAY YEARS DATE OF BIRTH

TEL: GSM: EMAIL:

PROPOSED SUM ASSURED Class of Assurance with profits

DURATION OF ASSURANCE YEARS, COMMENCEMENT DATE OF ASSURANCE

IS THE PREMIUM TO BE PAID YEARLY, HALF-YEARLY, QUARTERLY OR MONTHLY

BENEFICIARY (PRINT) INCLUDE ADDRESS IF NOT SAME AS 1 ABOVE

SURNAME OTHER NAMES MAIDEN NAMES (if married)

RESIDENTIAL ADDRESS

TEL: AGE RELATIONSHIP EMAIL:

Primary CONTINGENT

Except as otherwise directed: (A) the proceeds are to be divided equally among all persons who are named as primary beneficiary and who survive the insured. But if none survive, the proceed are to be shared equally among all persons who are named as contingent beneficiary and who survive the insured and (B) the right to change the beneficiary is reserved.

DO YOU DESIRE ANY ADDITIONAL BENEFIT?

Double Indemnity ☐ Disability Waiver of Premium ☐ Family Income Benefit ☐ (What percentage?) 10 15 20 Tick appropriate one

ARE THERE ANY CIRCUMSTANCES, Particularly Occupational which involve an additional risk of death by accident?

FOR AIIP ONLY

A. REGULAR PREMIUM B. Premium payable C. Guaranteed Death Benefit

Annually ☐ Semi - Annually ☐ Monthly ☐

DECLARATION

I, the undersigned, whose life is proposed for assurance, do hereby declare that the statements in this proposal are true and complete and hereby consent to the Company seeking any information it deems necessary from any hospital, clinic or doctor who has at any time attended to me seeking information from my bankers and employers and from any insurance to which a proposal for the assurance of my life has been made and I authorize the giving of such information. I further agree that this proposal and Declaration and the statements made above or to the Medical Examiner acting for the Company shall be the basis of the proposed contract between the Company and myself, that if anything contrary to the truth be stated or if any information which ought to be made known to the Company with reference to the Proposed Assurance to be withheld or, concealed and policy which may be granted in pursuance of this proposal Shall be null and void.

FOR OFFICIAL USE ONLY (CUSTOMER DUE DILIGENCE) PROPOSER SIGN:

AGENT NAME: AGENT CODE: AGENCY

SENIOR MANAGEMENT REMARK: APPROVED: ☐ UNAPPROVED ☐ SIGN & DATE

NAME: AGENCY MANAGER SIGN & DATE

4. MEDICAL ATTENTION DURING THE PAST FIVE YEARS

(a) Name and address of your doctor (HAVE YOU IN THE PAST FIVE YEARS CONSULTED):
(b) Your Doctor?
(c) Any other Doctor?
(Please give name and address)_____

For how long have you been consulting the doctor? Years.....

Yes or No	Date	REASONS FOR THE CONSULTATIONS

5. Has any proposal on your life ever been made If so, state (a) the name of the office (b) the date of the proposal and (c) whether it was accepted at ordinary terms, special terms postponed or declined

(a)
(b)
(c)

6. Have you any intention or expectation:
(a) of becoming a member of the Armed Forces?
(b) of engaging in aviation (other than as a fare-paying passenger on a regular route) If so, give full particulars

(a)
(b)

7. Is there any other fact or circumstances affecting your eligibility for assurance which ought to be stated? If, yes give details

8. To whom is the Sum Assured payable other than self:
(a) Legal Estate
(b) Name beneficiary (Please state full names, date of birth and relationship)

(a)
(b)

9. FAMILY HISTORY OF THE LIFE PROPOSED
Has any of your near relatives, i.e. parents, brothers or sisters , wife (or husband) or children suffered from - DIABETES, STROKE, HEART DISEASE, CANCER, TUBERCULOSIS OR MENTAL ILLNESS

Yes or No	Relationship	Details (Mentioning condition and approximate age at onset)

10. PHYSICAL DESCRIPTION:
(a) What is your Height?.....
(b) What is your Weight?.....
(Accurate Up-to-date figures should be given in ordinary indoor clothing and outdoor footwear)
Have you any bodily infirmity or deformity (for example, Rupture" or Hernia, Varicose Veins)?

Yes or No		Full Details (s)

11. HABITS
(a) Do you now take or have been taking any medicines regularly (particularly stimulants antibiotics, sleeping pills or sedatives),
(b) How many cigarettes and/or cigars do you smoke daily?
(c) What is your average daily consumption of alcohol?.....

Yes or No		

12. WHAT SPECIAL INVESTIGATIONS AND/OR TREATMENTS HAVE YOU HAD

	Yes or No	Date	Details (including part of body and result)
(a) X-Ray Examination (Chest, Barium Meal etc)?			
(b) E. C. G.?			
(c) Any other Hospital or Pathological investigation and/or Treatment?			

13. ILLNESS AND AILMENTS:

HAVE YOU EVER SUFFERED OR DO YOU NOW SUFFER FROM?	Yes or No	Date
(a) Epilepsy, Fits or Fainting attacks or other Mental disturbances?		
(b) Tuberculosis, Asthma, persistent Cough, Pneumonia or any other Chest Disease?		
(c) Rheumatic Fever, Hypertension, Circulatory or Heart trouble?		
(d) Indigestion, Gastric or duodenal Ulceration, Jaundice, Gall Bladder Complains, Diabetes Mellitus?		
(e) Nervous disease or nervous breakdown, Frequent Headaches?		
(f) Any Infection of the kidney, Urinary or Genital Organs, Renal Stones, Difficult or Painful Urination, Bloody Urine?		
(g) Syphilis, Gonorrhea or other Venereal Diseases?		

14. FOR FEMALES ONLY

	Yes or No	Date	Full Details (s)
(a) Have you suffered from any Disease of the Breast or Sexual Organ?			
(b) Have you had any premature Birth, Miscarriage or Still Birth?			
(c) Are you now pregnant? (If so when due)?			

15. HAVE YOU EVER HAD:

	Yes or No	Date
(a) Unexplained Recurrent or Persistent fever or Skin disorder?		
(b) Persistent or Unexplained night Sweats?		
(c) Unexplained Weight Loss?		
(d) Unexplained infections or Swollen Glands?		
(e) Chronic or recurrent diarrhoea?		
(f) Persistent Cough?		
(g) Hepatitis B or any sexually transmitted disease Including genital sores or discharge?		

16. Have you ever been refused as a blood donor? Yes or No _____ Date _____

17. Have you ever received any blood transfusions within the last five years? Yes _____ No _____
Please give full details of all positive answers_____

18. GENERAL
Is there any other fact, circumstance or information regarding your health and way of living which wasnot specifically mentioned above?

Amount of Deposit paid N _____ Cash/Cheque _____
Receipt No..... Date.....