



Proposal for Life Assurance

POLICY NUMBER

YOU ARE TO DISCLOSE IN THE APPLICATION FORM, FULLY AND FAITHFULLY ALL THE FACTS YOU KNOW OR OUGHT TO KNOW ABOUT YOURSELF OR THE LIFE TO BE ASSURED OTHERWISE YOU MAY INVALIDATE THE POLICY AND RECEIVE NOTHING FROM IT. ALL QUESTIONS MUST BE ANSWERED IN BLOCK LETTERS AND IN INK. DASHES ARE NOT ACCEPTABLE.

1. PERSONAL DETAILS OF THE LIFE TO BE ASSURED

Title	Surname	Given Names
<input type="text"/>	<input type="text"/>	<input type="text"/>

Date of Birth	NIN No.	Place of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>

NOTE 1: A copy of the Birth Certificate, National ID Card or Passport must be submitted as proof of identity.

Are you or your immediate family or your close associates a Politically Exposed Person (PEP)? Yes No

If YES, please complete and attach a supplementary PEP form.

Residential Address

Mailing Address (if different from above)

NOTE 2: A copy of a recent utility or telephone bill, bank statement or other, must be submitted as proof of address.

Telephone (Mobile)	Telephone (Home)	Telephone (Work)	Telephone (Other)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Email address

2. PROPOSER'S EMPLOYMENT AND SOURCES OF INCOME

Please state your current employment status. (Insert an 'X' as appropriate)

Are you: Employed Self Employed Unemployed Student

Job title or Occupation	Approx annual income
<input type="text"/>	<input type="text"/>

Employer's Name and Correspondence Address (if applicable)

Main Source of Income	Other sources of income (if any)
<input type="text"/>	<input type="text"/>

3. PROPOSED LIFE ASSURANCE PLAN

Type of Plan	Term(yrs)	Sum Assured (SCR)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Additional benefits (if any)	Preferred Start Date
<input type="text"/>	<input type="text"/>

4. PREMIUM PAYMENTS AND BANKING DETAILS OF THE LIFE TO BE ASSURED

Please answer by inserting an 'X' as appropriate.

Frequency of payment: Monthly Quarterly Half Yearly Annually Single

Method of payment: Direct Bankers Order Salary Deduction Online

Name of Bank or employer that will be paying the premiums (if applicable)

Please provide bank account details into which any future monetary benefit is to be credited

Name of Bank

Name of Branch

Account Name

Account Number

5. NOMINATION OF BENEFICIARIES

In the event of death of the life assured while the policy is in force, the pertaining benefits are to paid to the following;

Name of beneficiary(s)	NIN	Share %	Relationship
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Are any of the beneficiaries, their immediate family or their close associates a Politically Exposed Person (PEP)?

Yes No

If YES, please complete and attach a supplementary PEP form for each person who is a PEP.

6. OTHER PROPOSALS PERTAINING TO THE LIFE TO BE ASSURED

Has any proposal for assurance on your life been made to this or any other office before?

Yes No

If Yes, was it:

Accepted Declined Deferred Withdrawn

Do you currently hold or have you ever held a life assurance policy with the Company?

Yes No

Is this proposal to be in addition to an existing life assurance policy with the Company?

Yes No

7. FAMILY HISTORY OF THE LIFE TO BE ASSURED

Relation	If living		If dead	
	Age(s)	State of health	Age at Death	Cause of death
Father				
Mother				
No. of brothers <input type="text"/>				
No. of sisters <input type="text"/>				

8. OCCUPATION AND HAZARDS QUESTIONNAIRE FOR THE PROPOSER

Please answer ALL questions by placing an 'X' as appropriate. Provide details for all positive answers.

Hazards	Yes	No	If Yes, please give details
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you consume alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	
For female lives, are you now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you intend or have expectations to;	Yes	No	If Yes, please give details
Change your current occupation?	<input type="checkbox"/>	<input type="checkbox"/>	
Travel or live abroad for a period of time?	<input type="checkbox"/>	<input type="checkbox"/>	
Be engaged in naval or military services?	<input type="checkbox"/>	<input type="checkbox"/>	
Participate in any dangerous activity or sport?	<input type="checkbox"/>	<input type="checkbox"/>	

9. MEDICAL HISTORY AND QUESTIONNAIRE FOR THE PROPOSER

What is your height and weight? cm kg

Please answer ALL questions by placing an 'X' as appropriate. Provide details for all positive answers.

Medical History	Yes	No	If Yes, please give details
Have you ever suffered from mental illness or received psychiatric care?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any bodily infirmity, deformity or limitation?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had a stroke, suffered from a circulatory disorder or high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been diagnosed or treated for any form of cancer?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had hepatitis or any form of liver disorder or sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had any respiratory disorder such as asthma, bronchitis or other?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any pre-existing condition(s) not indicated above, such as diabetes, anemia, AIDS, gastritis or other?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any disease or disorder of the bowels, eyes, heart, kidneys, skin, throat, thyroid or any other gland, organ or bodily system not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you currently being treated for any medical disease or condition?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been refused as a blood donor?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had:	Yes	No	If Yes, please give details
Injuries requiring special attention?	<input type="checkbox"/>	<input type="checkbox"/>	
Or are you due to have an operation?	<input type="checkbox"/>	<input type="checkbox"/>	
A medical checkup during the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	
An x-ray, ECG or scan during the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	

Any other additional medical information (if applicable)

10. FOR THE ATTENTION OF THE PROPOSER AND LIFE TO BE ASSURED

- a) It is your responsibility to ensure that premium payments are kept up to date in order to keep the policy in force and enjoy the benefits that come with it.
- b) If your policy has been in force for less than three years and you fail to pay the next premium before the expiration date of the days of grace, the policy will lapse and provide no further cover.
- c) If your policy has lapsed for several months, you may be required to undergo a medical examination at your own expense and satisfy any other conditions the Company may stipulate before the policy would be considered for reinstatement.
- d) If your policy is allowed to lapse for a period of TWO years, it will consequently be cancelled and all the premiums paid shall be forfeited and remain vested in the Company.
- e) Should you cancel your policy before THREE years from the commencement date of your policy, the premiums paid shall be forfeited and are not refundable.
- f) Should you cancel your policy after it has been in force for THREE years or more, you will be entitled to the cash surrender value of the policy less any debt owed to the Company. This value may be less than the total of premiums paid.
- g) Bonus rates may vary from year to year depending on the investment performance of the life fund.
- h) Policy loans are considered only after a policy has been in force for THREE years or more and approvals are at the Company's discretion.
- i) It is your responsibility to notify the Company of any changes to your personal or banking details.

11. DECLARATION BY THE PROPOSER

I hereby declare that to the best of my knowledge and belief, the foregoing answers written and/or dictated by me and which I have read over are true and complete. I also agree that the answers, together with my statements which are required to be given by me to the medical examiner acting on behalf of the company, shall be the basis of the life assurance contract between the life being assured and SACOS LIFE ASSURANCE COMPANY LIMITED. I authorise the assurer to seek medical information from any doctor who has previously attended me or the life to be assured and may make any enquiries or seek information from any office to which a proposal for life assurance has previously been made, and consent to the giving of such information. I further declare that I shall inform the company of any changes to any material fact in this proposal and understand that failure to do so may result in the proposed contract becoming void.

Signed at

Signature

Date

A. FOR SALES AGENT'S USE ONLY

- a) Is the physique of the life assured, Robust Average Below average
- b) Is a medical examination recommended? Yes No

If Yes, state referred doctor

Reason for recommending medical examination and notes (if applicable)

Agent's Name

Signature

Date