



SIC LIFE COMPANY LIMITED

No. 33 - 34 Kwame Nkrumah Avenue, Island Property Building, Accra
 P. O. Box CT-3242 Cantonments - Accra
 Tel: (+233-302) 664756 / 662286 / 2672356
 Toll Free No.: 080010007 Fax: (+233-302) 678125 / 2671072
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APPLICATION FOR LIFE ASSURANCE (GUARANTEED ENDOWMENT PLAN)

HEAD OFFICE USE ONLY

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Date of Issue: / /
 D D M M Y Y Y Y

Receipt Number:.....

Receipt Date / /
 D D M M Y Y Y Y

Policy Number:.....

Approved By:

1. POLICY HOLDER details Title: Mr. Mrs. Miss. Dr.

2. Surname..... First / Middle name:.....

Marital Status:..... Date of Birth: / / Age
 D D M M Y Y Y Y

Place of birth:..... Occupation..... Duration.....

Phone number(s)..... E-mail address:.....

| | | | | |
|---|---|---|--|---|
| 3. Mailing Address | | 4. Residential Address | | 5. Height |
| | | | | 6. Weight |
| 7. Sum Assured GH¢ <input type="checkbox"/> 3,000 <input type="checkbox"/> 5,000 <input type="checkbox"/> 10,000 <input type="checkbox"/> 15,000 <input type="checkbox"/> 20,000 | 8. Policy Duration (in years) <input type="checkbox"/> 5 <input type="checkbox"/> 10 <input type="checkbox"/> 15 <input type="checkbox"/> 20 | 9. Additional Benefits a. Premium Waiver? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 10. Payment Mode <input type="checkbox"/> Payroll <input type="checkbox"/> Direct Debit <input type="checkbox"/> Out of pocket |
| | | b. Terminal Bonus? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

12. BENEFICIARY(IES) in the event of death

| Full Name of Beneficiaries | Gender (M/F) | Age | Share (%) | Relationship with the insured |
|----------------------------|--------------|-----|-----------|-------------------------------|
| | | | | |

13. TRUSTEES

| Full Name of Trustee | Age | Phone Number(s) | Address |
|----------------------|-----|-----------------|---------|
| i | | | |
| ii | | | |

13. MEDICAL DETAILS

| | |
|--|----------|
| a. Have you been hospitalized at any time during the last six months? | YES / NO |
| b. What is your average daily consumption of alcohol? | |
| c. How much Cigarette / Tobacco do you smoke daily | |
| d. Do you currently have or have you ever had:- | |
| a) Any Chest Pains, Blood Pressure or Heart Discover? | 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 |
| e. Been diagnosed or treated for an immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any Sexually Transmitted Disease? | YES / NO |
| f. Have you received any medical or surgical advice or treatment for any ailment, injury or sickness during the past 5 years other than those listed above? | YES / NO |
| g. Are you currently taking any medication? If "yes" give type of medication and dosage | YES / NO |

h. GIVE DETAILS OF "YES" ANSWERS TO ABOVE QUESTIONS:
(You may attach extra sheets of paper if necessary)

i. Do yo have any life assurance policy? If so, list names of companies and sums assured.

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 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 the following conditions are met:-

- a) This 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.....20.....

.....
Signature of Life Proposed **Name of Authorised Agent and Number**