SIC LIFE COMPANY LIMITED
No. 1 Jones Nelson Road, Adabraka Freetown—Accra
P. O. Box CT 3242, Cantonments—Accra
030 267 8130 / 050 157 0652
www.siclife-gh.com @SICLifeGhana

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

Height (Ft/m): Weight (Kg): Divorced Widowed

Do you have a Policy with us? Yes No

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

B. CONTACT INFORMATION

Telephone/Mobile: Email:

Birth Place: TOWN / COUNTRY

Nationality:

ID Type:

ID No.:

TIN:

Postal/ Digital Address:

Suburb/Town:

Region:

C. EMPLOYMENT DETAILS

Occupation: Staff ID:

Position:

Employer's Address:

D. BENEFICIARY & TRUSTEE DETAILS

Full Name of Beneficiary(ies)	*Date of Birth*	*Relationship*	*Share (%)*	*Address/Contact Number*

Full Name of Trustee	Date of Birth	Relationship	Address/Contact

E. COVER DETAILS

Initial Life Cover

GH¢

Term

Year(s)

Premium Amount (GH¢)

Premium Frequency

Monthly Quarterly

Semi-Annual Annual

Annual Inflation Protector

5% 20%

10% 25%

15% 30%

Mode of Payment: Cheque Bank Pay Source Mobile Money

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NOTE:

F. HEALTH STATUS

	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 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 _____ **Date** _____ **Thumbprint**

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.**