UT Life **Insurance Company Limited**

HEAD OFFICE: No. 9/1&2 Saxel Avenue, Tesano, Opposite Tesano Police Station, Accra
P. O. Box AT 1975 Achimota Market, Accra, Ghana.
TEL.: (233-302) 245737/249601 Fax. 0302-250343

APPLICATION FOR LIFE ASSSURANCE

A **IDENTITY**

1. **SURNAME** ……

OTHER NAMES ……

2. **POSTAL ADDRESS** ……..……..**TEL. NO.**:……

3. **RESIDENTIAL ADDRESS:** ……

4. **OCCUPATION**:……E-MAIL ADDRAESS:……
(*PLEASE GIVE PRECISE DETAILS*)

5. **EMPLOYER'S NAME AND ADDRESS** ……

6. **DATE OF BIRTH**	7. **AGE NEXT BIRTHDAY**	8. **SEX**	9. **MARITAL STATUS**
D M Y		☐ MALE ☐ FEMALE	☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOWED

B. **BENEFITS AND PREMIUM**

10. PLAN OF ASSURANCE: …….. 11. TERM:…… 12. SUM ASSURED …… ……..

13. RIDERS REQUIRED: PERSONAL ACCIDENT ☐ PERMANENT DISABILITY BENEFIT ☐

14a. PAYMENT FREQUENCY

☐ MONTHLY ☐ SEMI-ANNUALLY
☐ QUARTERLY ☐ ANNUALLY

15. BASIC PREMIUM US$/GH¢ ……
ADDITIONAL PREMIUM US$/GH¢……
EXTRA PREMIUM US$/GH¢……
TOTAL PREMIUM US$/ GH¢……

14b. MODE OF PAYMENT: Cash ☐ Cheque ☐ Standing Order ☐ Employer Deductions ☐

C. **GENERAL**

16. DO YOU HAVE ANY ASSURANCE ON YOUR LIFE? YES ☐ NO ☐

IF YES STATE COMPANY…… AMOUNT US$/GH¢…… POL. No……

17. HAS ANY PROPOSAL ON YOUR LIFE EVER BEEN DECLINED, POSTPOND OR ACCEPTED WITH EXTRA PREMIUM? YES ☐ NO ☐

IF YES WHEN AND WHICH COMPANY? ……

YOUR STATE OF HEALTH

18. HEIGHT……CM/FT. WEIGHT……KG/LB.

19.

	FAMILY HISTORY			
	LIVING		DEAD	
	Age	State Of Health	Age At Death	Cause Of Death
Father				
Mother				
Brother 1				
2				
3				
4				
Sister 1				
2				
3				
4				

20. ARE YOU LIKELY TO ENGAGE IN ANY SPORTING ACTIVITIES OR OTHER LEISURE PURSUITS WHICH INVOLVE ADDITIONAL RISK OF DEATH BY ACCIDENT?

☐ YES ☐ NO

(PLEASE GIVE DETAILS IF YOUR ANSWER IS YES).

……

21. HOW WOULD YOU RATE YOUR ALCOHOL CONSUMPTION?

☐ NIL ☐ LIGHT

☐ MODERATE ☐ HEAVY

22. HOW MUCH DO YOU SMOKE DAILY?

……

23. ARE YOU AT PRESENT IN GOOD HEALTH?

☐ YES NO☐

24. HAVE YOU HAD ANY ILLNESS, ACCIDENT OR UNDERGONE ANY TREATMENT IN A HOSPITAL OR SANATORIUM WITHIN THE LAST 5 YEARS?

YES ☐ NO ☐

25. HAVE YOU EVER HAD AN OPERATION OR ANY MEDICAL EXAMINATION SUCH AS X'RAY ECG, BLOOD OR URINE TEST?

YES ☐ NO ☐

26. HAVE YOU EVER BEEN MEDICALLY ADVISED IN CONNECTION WITH AIDS OR ANY SEXUALLY TRANSMITTED DISEASE?

YES ☐ NO ☐

IF QUESTION 23 IS ANSWERED 'NO' OR ANY OF THE QUESTIONS 24-26 ABOVE IS ANSWERED 'YES', PLEASE GIVE DETAILS BELOW.

ILLNESS OR INVESTIGATION	DATE	DURATION	RESULTS	DOCTOR'S NAME AND ADDRESS

27. BENEFICIARIES OR FINANCIER (FOR MORTGAGE PROTECTION)

	NAME	AGE	RELATIONSHIP	%	ADDRESS
1.					
2.					
3.					
4.					
5.					

NAME	AGE	RELATIONSHIP	%	ADDRESS

DECLARATION

I DO HEREBY DECLARE THAT ALL THE ANSWERS TO THE FORGOING QUESTIONS ARE IN EVERY RESPECT TRUE AND CORRECT AND DO HEREBY AGREE THAT THIS PROPOSAL AND DECLARATION TOGETHER WITH ANY STATEMENT MADE TO A MEDICAL EXAMINAR SHALL BE THE BASIS OF THE CONTRACT BETWEEN ME AND UT LIFE INSURANCE COMPANY. I AGREE THAT ASSURANCE SHALL BE IN EFFECT ONLY WHEN A DULY SIGNED POLICY IS RECEIVED BY ME AND FIRST PREMIUM PAID IN FULL.

DATED: THIS…… DAY OF…… 20……..

……. SIGNATURE OF PROPOSER

……. SIGNATURE OF AGENT

FOR HEAD OFFICE USE

ISSUE DATE D M Y	**ACCEPTED BY ISSUE BY**	**AGENT NUMBER**
POLICY NO.	**APPROVED BY**	**PLACE**

SUPPLEMENTARY QUESTIONNAIRE

FULL NAME: ……

ADDRESS: ……

AGE: ……

Please give full details of all positive answers:

			DETAILS
1.	HAVE YOU EVER HAD?		
	a) Unexplained recurrent or persistent Fever or skin disorder?	YES/NO	
	b) Unexplained, persistent night sweats?	YES/NO	
	c) Unexplained weights loss?	YES/NO	
	d) Unexplained infections or swollen glands?	YES/NO	
	e) Chronic or recurrent diarrhoea?	YES/NO	
	f) Persistent cough?	YES/NO	
	g) Hepatitis B or sexually transmitted diseases including genital sores or discharge?	YES/NO	
2.	HAVE YOU EVER HAD OR BEEN ADVISED TO HAVE A BLOOD TEST FOR AIDS OR AN AIDS RELATED CONDITION?	YES/NO	
3.	Have you ever been refused as a blood donor?	YES/NO	
4.	Have you received a blood transfusion within the last five (5) years?	YES/NO	

I declare that the foregoing answers are true, that I have not withhold any important circumstance or detail, and I agree that this declaration shall be held to form part of the proposal for life assurance now made to UT Life Insurance Company Limited

Dated ……..

Signature ……

Witness ……

DECLARATION OF GOOD HEALTH

FULL NAME:……

ADDRESS:……

……

AGE:……

With reference to my proposal dated…….for a policy of assurance for US$…….. on my life I hereby declare that since the date of the above proposal I have not suffered from any illness nor has my state of health changed in any way except as stated below.

I agree that this declaration together with the above dated proposal shall be the basis of the proposed contract.

Signed…….. Date……

Please give full details of any illness etc., including dates, names and addresses of doctors consulted if the above declaration so requires.