Phobia Child Education Plan Application Form

Kindly complete this form in **BLOCK LETTERS**
(All names should be in full; initials are not accepted)

Loan/Advance Number _____ (CAGD only)

a. Personal details of the Proposer

Surname: KUZAGBE

Middle Name(s): MENSAH

First Name: FRANCIS

Date of Birth: 01/11/1990

Nationality: GHANAIAN
(*If non-Ghanaian provide passport and residence permit issued by the Ghana Immigration Service)

Gender: Male ☑ Female ☐

PEP STATUS:Are You a ☐ Politically Exposed or ☑ Family member or a known Close associate of a PEP

Marital Status: Single ☑ Married ☐ Divorced ☐ Widowed ☐

Occupation: GRAPHIC DESIGNER

Work Place Address: LAPAZ MUNICIPALITY P.O.BOX 144

Mobile 1: 0233456789 Mobile 2: 0245789025

Email: FRANCISKUZAGBE@GMAIL.COM

Permanent Address: LAPAZ. OPPOSITE VICTORY CHURCH

ID Type : Voters ☐ Passport ☐ Drivers' ☐ National ID ☐ Biometric NHIS ☑
(*ID Type provided must be valid(not expired))

ID Number: 0978353737

Date of Issue: 03-07-2019 Date of Expiry: 03-07-2024

b. Beneficiary (ies) of the Proposer

Surname: YAYRA

Other Name(s): KUZAGBE

Date of Birth: 30-11-1997 % 20 # 0233890367

Relationship: SISTER

Surname	AZAMATSI				
Other Name(s)	NOAH				
Date of Birth	12/09/1991	%	20	#	0592789036
Relationship	BROTHER				

Surname	JUNIOR				
Other Name(s)	KUZAGBE				
Date of Birth	12/03/2003	%	20	#	0233267890
Relationship	COUSIN				

Surname	KUZAGBE				
Other Name(s)	PETER				
Date of Birth	10/11/2000	%	20	#	0243333224
Relationship	COUSIN				

Trustee	YAYRA				
(Where a beneficiary is below 18 yrs of age)	KUZAGBE				
Date of Birth	01/012019		20	#	0248234567
Relationship	SISTER				

c. Cover Details

Policy Term (Minimum of 8yrs: Maximum of 25 yrs) 20

Do you wish to have the Benefits Increase option which maintains the value of your benefit through an automatic increase in premium and benefit as per the schedule below ? Yes ☑ No ☐

If yes, Kindly **tick** in the preferred option

	Annual Premium Increase	Annual Benefit Increase
Option 1 ☐	10%	6%
Option 2 ☑	15%	9%
Option 3 ☐	20%	12%

Riders

Total and permanent Disability	Yes ☐	No ☑
Retrenchment (12 months waiver of premium)	Yes ☐	No ☑
Dread Disease	Yes ☑	No ☐
Personal Accident for Child (Cover : Gh¢ 1,000)	Yes ☐	No ☑

Basic Premium	400
Extra Premium	400
Total Premium	800
Initial Sum Assured	100

MEDICAL LIMITS

BENEFIT/ SUM ASSURED		
AGES BETWEEN 18 & 45	**AGES BETWEEN 46 & 52**	**MEDICAL REQUIRED**
Up to Gh¢150,000.00	Up to Gh¢100,000.00	No Medicals
Gh¢150,001-GH¢200,000	Gh¢100,001-GH¢150,000.00	MER,ECG,LFT Hepatitis B, Fasting Blood Sugar, Hypertension Screen
Gh¢ 200,001+	Gh¢ 150,001+	MER,ECG,LFT Hepatitis B & C, Fasting Blood Sugar, Hypertension Screen, Urine RE, Full Blood Count,HIV,Kidney Function Test, Lipid Profile

d. Premium Payment

CAGD ☑ Corporate ☐ Bank Debit ☐

Staff ID Number: 23890083456

Bank and Branch: FNB, KASOA BRANCH

Account Number: 2325246666

Mobile Money Number **024 5287 497** ☑ Payment frequency; Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annually ☐

Source of income; Salary ☐ Business ☑ Other ☐

If Business or Other, Please specify nature of Business or other source of income: BAKERY

e. Medical History

Do you have or have you ever had any of the following **If yes, provide details**			**Year**	**Clinic/Hospital**	**Results**	
					Treated & Discharged	Undergoing Treatment
Asthma, persistent cough, blood spitting, bronchitis, chest pains, tuberculosis, pneumonia, hypertension? TENSION	Yes ☑	No ☐	2001	RIDGE	☑	☐
Fits, fit of dizziness, paralysis, stroke or any other nervous or mental disorder? FEVER	Yes ☑	No ☐	2003	TEMA COM. HOS	☑	☐
Diabetes Mellitus?	Yes ☑	No ☐	2002	AKAWAY	☑	☐
Rheumatism, sciatica, or any disorder of the bones, joints or the spine? DRY COUGH	Yes ☑	No ☐	2007	DALTON CLINIC	☑	☐
Skin disease, tumor or growth? SORENESS	Yes ☑	No ☐	2005	LEGON HOSP.	☑	☐
Disorder of the eyes, ears nose or throat? COLD	Yes ☐	No ☑	2010	MILITARY HOSP.	☑	☐
Diagnostic test such as X-ray examinations, electrocardiogram? SKIN IRRITATION	Yes ☐	No ☑	2006	RIDGE	☑	☐
Bilharzia?	Yes ☐	No ☑	2017	RIDGE	☐	☑
Any surgical operation, accident or severe injury, mutilation or amputation, any hospital treatment or medical attention not mentioned? DRY MOUTH	Yes ☐	No ☑	2011	MILITARY HOSP.	☑	☑
Are you currently taking any medication?	Yes ☑	No ☐	If yes give type of medication and dosage: SYRUP 4 TIMES			
Do you take in any alcoholic drink?	Yes ☑	No ☐	If yes, state weekly consumption: 9 BOTTLES			
Do you smoke cigarette?	Yes ☑	No ☐	If yes, how many sticks a day? 7			

f. Insurance History (Please tick Yes/No)

Do you have any life assurance policy? Yes ☑ No ☐

If yes, list company(ies) and the sum(s) assured

1. STARLIFRE 2. PRUDENTIAL

Have you ever been refused life assurance, Your application deferred or had special terms imposed on it ? Yes ☑ No ☐

How would you like to receive your policy certificate ? Soft Copy ☑ Hard copy ☐

If soft copy,provide e-mail address /whatsapp No. FRANCISKUZAGBE@GMAIL.COM

g. Declaration

I declare that every statement in response to questions asked in this application is true and correct to the best of my knowledge. I agree that this application shall serve as the basis and form part of the contract. All the questions have been explained to me in the ENGLISH *language by* FRANCIS MENSAH KUZAGBE*, which I understand, and I have been made to understand that this contract shall not become operative until all the following conditions have been met.*

1. This application has been approved by StarLife Assurance Company Limited, the underwriter of the policy.

2. The first premium has been paid.

3. I satisfy all the conditions precedent to the policy especially those pertaining to my health

Proposer's Signature _____ Date 12-08-2020

Sales Executive Name MAUDLYN WUNCH AGT No. AGT12356

S.E Signature_____ Date 12-08-2020 S.E Contact No. 0546782901

Sales Manager's Name ELIJAH BUCK Signature _____ Date 12-08-2020

Branch Manager's Name NATHAN IMMANUEL Zonal Manager's Name PAULINA ELDERS

I hereby consent to the processing of personal data for the purposes of targeted and direct marketing. Yes ☑ No ☐

I hereby consent to the processing of my personal data for business relationship and further acknowledge and agree that my personal data may be disclosed to entities associated or affiliated to StarLife Assurance Company Limited to achieve the purpose of processing under this consent. Yes ☐ No ☑

Office Use

Approved by

Policy Number

Signature _____ Date Issue Date

Underwritten by:

StarLife ...your solid partner for life

* Terms and Conditions apply