Sanlam

Sanlam Life Insurance (U) Limited

# Educare

**Sanlam Life Insurance (U) Limited**
Plot 15 Princess Anne Drive
Bugolobi
P.O. Box 25495, Kampala

T: +256 41 772 6526
C: +256 71 272 6526
E: helpdesk@sanlam.co.ug
www.sanlam.co.ug

## APPLICATION FOR INSURANCE

**Proposal No:**

## 1. Child's details

First Name(s) sdfsdf Surname sdfsdf

Date of Birth Y 2021-06-09 M D D Gender ☐ Male ☒ Female Relationship sdf

## 2. Principal Life to be Assured

First Name(s) sdf

Surname sdf

ID Number sdf Passport No sdf Title sdf

Marital Status ☒ Married ☐ Single Date of Birth 2021-06-14 M M D D Gender ☐ Male ☒ Female

Occupation sdf Pin Number sdf

Nationality sdf Tax Identification Number (TIN) sdf

Citizenship sdf

Residency sdf

### 2.1. Employment Details

Employed ☒ Yes ☐ No

Employer sdf

Employer Code sdf

Department Code sdf

Employee terms ☒ Temporary ☐ Permanent ☐ Contract

Employee Number sdf

### 2.2. Business Details

Business Name sdf

Nature of Business sdf

Role of proposer in business sdf

### 2.3. Telephone Numbers and Email

Cell (Pre-fix for other countries) sdf

Work Phone sdf

Home Phone sdf

Email Address sdf

### 2.4. Postal Address

P.O. Box sdf

Building sdf

Town sdfsd

Postal Code sd

### 2.5. Physical Address

Building / Village sdf

Street / Location sdf

Town / County sdf

Postal Code sdf

### 2.6. USA Physical Address (For USA citizens only)

Street sdf

Town / City sdf

Region / State sdf

Postal Code sdf

**Proposal No:**

## 3. Statement of Health of the Life Assured

This section covers your medical history. Please read the following questions and provide as much information as possible.

1. Has an application for life, sickness, disability, or critical illness insurance on your life ever been declined, deferred withdrawn or accepted with a loading or exclusion? Y/N [d]
2. Have you ever claimed any benefit from sickness, disability, critical illness, or accident policies? Y/N [d]
3. Have you in the last 5 years: consulted any medical professionals; had medical examinations and/or special investigations (including blood tests); taken medication or received medical treatment; been hospitalized or received medical advice to alter or discontinue your alcohol consumption? Y/N [d]
4. Have you, in the last 5 years, suffered from or been diagnosed with any form of: (Tick appropriately)

- [d] blindness, hearing or speech problems asthma, tuberculosis, chronic cough.
- [ ] heart attack, heart disease or disorder, high blood pressure, raised cholesterol diabetes, stroke.
- [ ] cancer, tumors (state of benign or malignant)
- [ ] kidney disease, blood, or protein in the urine
- [ ] HIV/AIDS or HIV/AIDS related conditions, Sexually Transmitted Diseases (STDs)
- [ ] psychological problems or disability
- [ ] Body or limb defects, paralysis, physical disability
- [ ] any condition other than colds, flu or other minor, curable ailments
- [ ] blindness, hearing or speech problems asthma, tuberculosis, chronic cough.
- [ ] heart attack, heart disease or disorder, high blood pressure, raised cholesterol diabetes, stroke.
- [ ] cancer, tumors (state of benign or malignant)
- [ ] kidney disease, blood, or protein in the urine
- [ ] HIV/AIDS or HIV/AIDS related conditions, Sexually Transmitted Diseases (STDs)
- [ ] psychological problems or disability
- [ ] Body or limb defects, paralysis, physical disability
- [ ] any condition other than colds, flu or other minor, curable ailments

5. Are you currently experiencing health-related symptoms, or do you intend to seek medical advice or testing for any condition other than colds, flu or other minor, curable ailments in the next 6 months? Y/N [ ]
6. What is your height? (Ft, Ins) [ ][ ] What is your weight? (Kgs) [ ][ ][ ]

   Is your weight ☐ Stationary? ☐ Increasing? ☐ Decreasing?
7. If you answered 'yes' to any of the questions, please give full details in the table below indicating: -

**Nature of complaint or symptoms, Type of treatment or medication, Date of first symptoms or diagnosis, Date of last symptoms, Name, and telephone number of attending doctor**

| |
|---|
| |

**You may use additional Paper for more information.**

You are required to tell us anything that you may know about your health that may affect our decision to insure you. If you do not provide this information, you may not be able to claim the risk benefits under this policy.

Please use the space below to provide such information

| |
|---|
| |

**You may use additional Paper for more information.**

I declare that the information I have given above is correct and a true representation of my medical history.

I understand that any medical history not mentioned may invalidate the application for life assurance or a claim.

Name Date Y Y Y Y M M D D