Proposal No.: A 001903

Alliance Life
ASSURANCE

APPLICATION FOR LIFE INSURANCE
Life Plan & Education Plan

All questions must be answered in full, in BLOCK letters, in the applicant's own handwriting or to his dictation and appropriate boxes ticked. Proof of age of the applicant is required by submitting a copy of anyone of the National Identity Card (NID), Passport (PP), Voter ID (VID) or Birth Certificate (BC) together with this application, apart from Banker's Order (BO) or Salary Standing Order (SSO) as applicable.

Policy Number:

1. APPLICANT:

Surname | Forenames

Type of ID (Tick ✓) ☐ NID ☐ PP ☐ VID ☐ BC Gender (Tick ✓) ☐ Male ☐ Female

NID/PP/VID/BC No.

Date of Birth | Mobile No.

Email Address

Postal Address | P. O. Box No.

2. BENEFICIARY:

Surname | Forenames

Type of ID (Tick ✓) ☐ NID ☐ PP ☐ VID ☐ BC Gender (Tick ✓) ☐ Male ☐ Female

NID/PP/VID/BC No.

Date of Birth | Mobile No.

Relationship to the Applicant | Email Address

In case the beneficiary is Minor, Please give the details of Appointee / Guardian below:

Surname | Forenames

Type of ID (Tick ✓) ☐ NID ☐ PP ☐ VID ☐ BC Gender (Tick ✓) ☐ Male ☐ Female

NID/PP/VID/BC No.

3. METHOD OF PREMIUM PAYMENT (Tick ✓): ☐ Salary Standing Order ☐ Bankers Order

3.1 Salary Standing Order:

Employee's Number | Employer's Name

3.2 Banker's Order:

Account Holder | Account Number

Name of the Bank | Branch Name

Branch Code | Deduction Day | Day of the Month

4. POLICY DETAILS: (Please Tick ✓): ☐ Life Plan ☐ Education Plan

Cash Back Option (Please Tick ✓): ☐ Yes ☐ No

Policy Term (Please Tick ✓): ☐ 10 Years ☐ 12 Years ☐ 15 Years

Sum Assured (Mill Tsh.) (Please Tick ✓): ☐ 5.0 ☐ 7.5 ☐ 10.0 ☐ 12.5 ☐ 15.0 ☐ 17.5 ☐ 20.0

Monthly Premium Tsh. _____

5. INSURABILITY QUESTIONS: (Please Tick ✓):

	YES	NO
5.1. What is your Height? _____ What is your Weight? _____		
5.2. Have you ever applied for a fully underwritten insurance policy for life cover only and been refused terms or declined for medical or health related reasons?	☐	☐
5.3. Have you ever tested positive for HIV or received treatment or medical advice for any sexually transmitted diseases including hepatitis B or C?	☐	☐
5.4. Have you ever been diagnosed with: Disease of the heart muscle or valves; Heart attack; Stroke; Heart related chest pain?	☐	☐
5.5. Have you ever had any of the following procedures: Heart bypass; Stent inserted or Pacemaker inserted?	☐	☐
5.6. Are you on treatment for high cholesterol following diagnosis by a medical practitioner?	☐	☐
5.7. Have you ever suffered from or been treated for high blood pressure following diagnosis by a medical practitioner?	☐	☐
5.7.1. If "Yes", has your medical practitioner continuously cautioned (i.e. after more than two years of being on treatment) that your blood pressure is poorly controlled or fluctuates drastically?	☐	☐
5.8. Have your parents or siblings died from heart problems, high cholesterol or high blood pressure before the age of 60?	☐	☐
5.9. Do you suffer from diabetes, raised blood sugar or sugar in the urine?	☐	☐
5.9.1. If "Yes", are you insulin dependent?	☐	☐
5.9.2. If "No", do you suffer from any of the following as a result of your diabetes?	☐	☐
(a) Pain and poor circulation in the feet.	☐	☐
(b) Poor vision.	☐	☐
(c) Kidney problems or disease.	☐	☐
5.10. Have you ever been diagnosed with any form of cancer (including cancer of the blood)?	☐	☐
5.11. Have you ever been diagnosed with any bleeding/coagulation or clotting disorder?	☐	☐
5.12. Have you ever been diagnosed with any other life threatening condition which currently requires, or may in future require, specilized medical treatment or the assistance of a caregiver (including but not limited to home oxygen, frail care and renal dialysis)?	☐	☐
5.13. Do you intend seeking medical advice in the next 12 week (other than routing dentistry or treatment for minor conditions such as colds, influenza, etc.)	☐	☐
5.14. I, confirm that the answers provided above are correct and understand that my benefit may be denied at claim stage should there be any non-disclosure on my part.	☐	☐

6. DECLARATION:

I, the undersigned, declare that statement and answers contained in this application, whether in my own handwriting or not, are complete, true to the best of my knowledge and belief and that they shall form part of the policy. I understand that any misstatement on this application form could result in its non-acceptance or the repudiation of a claim. I also agree that alliance Life may seek information from any doctor who has attended me or any Life Insurance Company to which I have made a proposal for life, sickness or accidental insurance and I authorize the giving of such information, and release of any primary data sought through any medical examiner or institution.

It is also agreed that Alliance Life will incur no liability under this application until
(a) the application has been received and approved, and
(b) a full premium has been paid to and accepted by Alliance Life.

I understand that no intermediary has the authority to waive the answers to any of the questions in this application or to make or alter any contract for Alliance Life.

Signed at (place) _____ this _____ day of 20 _____.

Signature of Proposer _____

Signature of Intermediary _____

Date: ☐☐☐

Full Name of the Intermediary: _____

Intermediary Code: _____