



ALLIANCE LIFE ASSURANCE LIMITED KEY MAN LIFE INSURANCE PROPOSAL FORM

Please ensure that all the questions are answered (Tick or fill in as appropriate). Alliance Insurance may need more information if this form is incomplete or if the questions are not clearly answered. This information forms part of the conditions of cover and any misleading or false statements may invalidate the cover.

1. DETAILS OF LIFE TO BE INSURED

(1) Full Names of Life to be Insured:											
(2) Date of Birth	D	D	M	M	Y	Y	Y	Y	(3) Gender	MALE	FEMALE
(5) Identification – Any of the following can be used to verify the identity of the assured, provided it contains a photograph of the assured. Please attach a copy.											
NSSF Number:											
Passport Number:											
Identity Number											
(6) Town where Employed:					(7) Occupation:						
(8) Details of your Employer:											
(9) Your position in the Employer's business:											
(10) Personal Postal Address:											
(11) E-mail address:											
(12) Telephone number:					(13) Mobile:						

2. DETAILS OF THE INSURANCE

(1) Type of Policy:	YES/NO	SUM INSURED IN USD	ANNUAL PREMIUM IN USD
One year level term insurance only			
Renewable one year level term insurance			
Three year renewable level term insurance			
Five year renewable level term insurance			
Total and permanent disability benefit			
Total annual premium in USD			



2. DETAILS OF BUSINESS THAT WILL OWN THE POLICY

(1) Name of the Business:

(2) Business Registration Number:

(3) Main activities of the Business:

(4) Telephone number:

(5) Fax No:

(6) Physical Address:

(7) Postal Address:

(8) Establishment date of business:

(9) Number of Employees:

(10) Percentage of business owned by the Life to be insured:

Where applicable, please attach a diagram of all the companies in the group and their relationships to each other.

(11) Please explain the basis on which the Sum Insured has been determined:

(12) Please give details of the turnover, gross profit and net profit before tax for the last 3 years and projected figures for the next financial year

Year	Turnover	Gross Profit	Net Profit before Tax

If a gross or net loss has been reported in these figures, please forward copies of the last 2 years' financial statements and an explanation of why the loss occurred. Where information is unavailable due to recent formation of the company, please forward a summary of the current business plan and projections.

(13) What proportion of the gross or net profits can be fairly attributed to the life insured?:

(14) Why is the life insured considered valuable?

Please enclose a copy of the life insured's CV

(15) Is there a Service Agreement?

If YES, please provide a copy or summary of remuneration, contract term, expiry date, notice period and responsibilities.

(16) Is a successor to the life insured being trained?

If YES, please give details including when the successor will be able to handle all aspects of the key person's job. If NO, please explain why there is no succession planning.



(17) Has the business effected, or does it intend to effect, policies on the lives of other key personnel?

(18) If YES, please give details:

Name	Position	Date effected	Cover type	Sum Insured	Reason

(19) If the insurance is related to a loan, please provide the following details:

(19.1) Reason for the loan:

(19.2) Details of any increase in the value of assets that will be obtained through the loan:

(19.3) Please provide the following details of the loan (or alternatively forward a copy of the full and final loan offer from the principal lender, in which case the following questions need not be answered)

(19.3.1) Name of lender:

(19.3.2) Name of borrower:

(19.3.3) Amount of the loan:

(19.3.4) Term of the loan in years:

(19.3.5) Interest rate %

(19.3.6) Please give details of the repayment terms:

(19.3.7) Is there provision to roll over the loan at the end of the term?

If YES, please provide a copy of the conditions

(19.3.8) Will immediate assignment/cession of the Policy be arranged?

(19.3.9) If YES, to whom?

3. DECLARATION BY THE APPLICANT BUSINESS

I, _____(insert full names), confirm that to the best of my knowledge the information contained herein is correct and is supported by evidence provided separately and which forms the basis of this insurance. I understand that Alliance Insurance Corporation Limited and their reinsurers will rely on this information in assessing the application. I also declare that I am authorised to sign this declaration on behalf of the company/business.

Signature:

Date:

Title/Capacity:



FURTHER INFORMATION ON THE LIFE INSURED

4. OTHER INSURANCES

(1)	Do you currently have any life insurance or insurance against sickness or accident cover under any other policies?	YES	NO
If YES, state full particulars of insurer and amounts of insurance:			
(2)	Have you ever been refused life or sickness insurance, or has an insurance company offered you cover subject to a higher premium or on special terms?	YES	NO
If YES, give the name of the insurance company, type of policy and amount insured for:			
(3)	Please list any other life insurance cover that you have with Alliance Insurance Corporation		
(4)	Are any concurrent applications for life insurance being made with other insurers?		
If YES, please give details:			

5. OCCUPATION AND PURSUITS

(1)	Have you at any time been employed underground in the mining industry?	YES	NO
If YES, give details:			
(2)	Have you at any time been engaged in the liquor trade?	YES	NO
If YES, give details:			
(3)	Have you at any time, or do you intend to engage in any aviation other than as a fare-paying passenger?	YES	NO
If YES, give details:			



(4)	Do you take part in any activity of a hazardous nature?	YES	NO
If yes, give details:			
(5)	Do you intend engaging in such activities in the future?	YES	NO
If yes, give details:			

6. STATE OF HEALTH

(1)	Height (without shoes) in cm's.		
(2)	Weight in kg's.		
(3)	Has your weight changed by more than 5kg in the last year?	YES	NO
If yes, give details:			
(4)	Do you smoke?	YES	NO
If yes, give details of how long have you smoked, what you smoke and how much per day?:			
(5)	If you don't smoke now, have you ever smoked in the past?	YES	NO
If yes, give details of how long and the type of tobacco and how much per day?:			
(6)	Do you drink alcohol?	YES	NO
If yes, please indicate type and quantity per week:			
(7)	Are you in good health as far as you are aware?	YES	NO
(8)	State name and address of your usual medical practitioner:		
Name:		Address:	
Phone:			
(9)	How long has the above-mentioned medical practitioner been your doctor?		



(10) Give the names and address of the medical practitioners that have treated you in the past 5 years and give details of the complaints and treatment.

Doctor's Name	Address	Dates	Complaint & Treatment

(11) Have you been hospitalised within the past five years? YES NO

If yes, give details where these have not been provided above:

(12) Have you ever had an X-Ray examination or other specialised treatment? YES NO

If yes, give details where this has not already been provided of the examination, who performed them and at what date:

Examination	Doctor or Institution	Date	Result



(13)	Have you ever suffered any serious or prolonged illness (3 months) or injury or chronic condition or is there any other matter that you consider likely to affect the risk of this insurance?	YES	NO
If yes, give details:			

(14)	Have you ever been tested for or received any medical advice, counseling or treatment in connection with HIV/ AIDS or any HIV/AIDS-related conditions?	YES	NO
If yes, give details:			

(15)	Have you ever been tested for or received medical advice or treatment in connection with any sexually transmitted diseases, including Hepatitis B?	YES	NO
If yes, give details:			

(16)	Is there anything at all that you know of that may affect the risk of insuring your life?	YES	NO
If yes, give details:			

(17) Have any of your parents, brothers or sisters suffered from any disease of the heart, circulatory system, stroke, high blood pressure, diabetes, kidney disease, cancer, eye disorder, paralysis, epilepsy, mental illness or hereditary disease such as porphyria, haemophilia, huntingdon@s chorea or retinitis pigmentosa? If yes, please give details as set out below:

Relationship	Age	If Living: State of Health	If Deceased: Cause of Health



7. FINANCIAL DETAILS

(1)	Please give details of your personal earnings as assessed for income tax for the past two years.	
	Year	Year
Salary/ Remuneration		
Dividends		
Bonuses/Commission		
Share profit		
Other (please give details		
Total		

(2)	Please give estimated values of your assets and liabilities	
Assets in USD		
Liabilities in USD		
Please provide recent financial statements		

(3)	Are you currently or have you ever in the past been insolvent? Please provide full details where relevant:
-----	--

(4)	Has any company of which you were a director been insolvent or gone into receivership? Please provide full details where relevant:
-----	--

DECLARATION BY THE LIFE INSURED

I, _____ (insert full names), declare that all the statements made in this declaration are true. I agree that such statements, together with those made, or to be made, to a medical officer and signed by me, shall be the basis of any insurance granted and that any material non disclosures or false statements will invalidate this insurance.	
I hereby irrevocably authorise any doctor, hospital, medical institution or other person who may be in possession of, or hereafter acquire, any information concerning my health, including the results of any blood tests, to disclose such information to the company. I agree that this authority shall remain in force after my death as well as prior thereto.	
Signature:	Date: