APPLICATION FOR LIFE INSURANCE

All questions must be answered in full, in BLOCK letters, in the applicant's own handwriting or to his dictation. 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.

■ POLICY OWNER

Surname ______ Other names ______

Postal address ______

Telephone - Office ______ House ______ Mobile ______

Relationship to proposed insured ______

■ PROPOSED INSURED

Surname ______ Other names ______

Date of birth ______ Place of birth ______ Sex ☐ Male ☐ Female

Postal address ______

Email address ______ Occupation ______

Specific duties ______

Telephone - Office ______ House ______ Mobile ______

Name and address of employer ______

Beneficiary ______

Beneficiary Details			Guardian (if Beneficiary under 18 years of age)	
Name	Date of Birth	Relationship	Name	Relationship to Beneficiary

■ LIFE INSURANCE PROPOSED

Type of policy ______

Sum Assured Tshs. ______ Sum Assured ______ years

Premium Payable Tshs. ______

Mode of payment - Monthly/Quarterly/Semi-Annual/Annual ______

Method of payment - Banker's Order/Cash/Salary Order/Other (Specify) ______

Benefits covered: Death & Permanent Disability (TPD)

MEDICAL HISTORY OF THE PROPOSED INSURED

(a) Are you now in good health? Yes [ ] No [ ]
(b) have you consulted any doctor or medical facility either as in inpatient or outpatient in the last 3 years Yes [ ] No [ ]

If so, when and for what complaints?

(c) Part (c) applicable to females only
Are you pregnant? Yes [ ] No [ ]
If "Yes", how far advanced? [ ]

(d) Have you within the past six (6) months undergone any medical test? Yes [ ] No [ ]
(e) Have you ever met with serious injury? Yes [ ] No [ ]
(f) Are you currently taking any medication regularly or as needed? Yes [ ] No [ ]
(g) Have you ever had, been tested for, received treatment or counseling from a medical professional for; or been told you have:
(Tick appropriate item and give details where applicable)

i) Dizziness, fainting, convulsions, Epilepsy, paralysis, stroke or severe headaches? Yes [ ] No [ ]
ii) Depression, anxiety, Alzheimer's disease, mental or nervous disorder? Yes [ ] No [ ]
iii) Shortness of breath, Bronchitis, Emphysema, Asthma, Pleurisy, Pneumonia, Tuberculosis or persistent cough? Yes [ ] No [ ]
iv) Chest pain, angina, palpitations, irregular heartbeat, high blood pressure, heart attack, congestive heart failure or coronary artery disease? Yes [ ] No [ ]
v) Heart murmur, heart valve disorder, oedema or disorder of the heart or blood vessels? Yes [ ] No [ ]
vi) Ulcer, intestinal bleeding, Colitis, Ulcerative colitis, Crohn's disease, jaundice, hernia, diarrhoea, Hepatitis or any disorder to the stomach, intestines, spleen, liver or rectum? Yes [ ] No [ ]
vii) Diabetes, high blood sugar or sugar in your urine? Yes [ ] No [ ]
viii) Blood or protein in your urine, any disorder of the kidneys, bladder, prostate or urinary system? Yes [ ] No [ ]
ix) Venereal disease or any disorder of the reproductive system? Yes [ ] No [ ]
x) Thyroid, Thymus, Pituitary or lymph gland disorder? Yes [ ] No [ ]
xi) Cancer, Sarcoidosis, tumour or abnormal growth? Yes [ ] No [ ]
xii) Back pain, arthritis, Muscular Dystrophy or any disorder of the muscles, bones or joints? Yes [ ] No [ ]
xiii) Multiple Sclerosis, Parkinson's disease or any disorder of the brain or spinal cord? Yes [ ] No [ ]
xiv) Haemophilia, Sickle Cell anaemia, anaemia or any disorder of the blood? Yes [ ] No [ ]
xv) Any disease not mentioned above? Yes [ ] No [ ]

(h) Have you:
i) Ever had or been advised to have a blood test for AIDS or any AIDS-related conditions Yes [ ] No [ ]
ii) Received a blood transfusion within the last 5 years? Yes [ ] No [ ]

Please provide complete details of all "Yes" answers above (including dates, details of treatment, medical institution where treated ad name of treating doctor). Additional sheets, information or reports maybe attached to this form where required.

■ ADDITIONAL QUESTIONS

(a) Height [ ] Weight [ ]
(b) Have you any intention or prospect of
i) Flying other than as fare paying passenger on a recognised airline on scheduled air routes: Yes [ ] No [ ]
ii) Engaging in motor sport or water skiing or parachuting or gliding or mountain climbing as a hobby? Yes [ ] No [ ]

Alliance Life ASSURANCE

iii) Engaging in any other hazardous occupation, sport or pastime? Yes ☐ No ☐

Please provide complete details of all "Yes" answers above.

(c) How frequently, and in what quality do you use intoxicating drink, tobacco or nicotine products or habit-forming drugs?

Intoxicating drinks	Frequency		Quality	
Tobacco or nicotine products	Frequency		Quality	
Habit-forming drugs	Frequency		Quality	

(d) Have been convicted of a felony or misdemeanours within the last five (5) years or do you have charges currently pending? Yes ☐ No ☐

If so, give details.

FAMILY HISTORY

	Living		Dead			
	Present Age	State of Health	Age at Death	Cause of Death	Duration of Illness	Year of Death
Father						
Mother						
Brothers						
Sisters						
Spouse						

Please give full details of poor health or cause of death if so indicated in the above table:

Alliance Life ASSURANCE

PREVIOUS INSURANCE HISTORY

(a) Have you ever applied for life assurance? Yes ☐ No ☐

List all such applications below:

Insurance Company	Date of Application/ Proposal	Application/Proposal or Policy Number	Sum Assured	Extra Premium (or Special Terms) if any

DECLARATION

Each of the undersigned declares that the statements and answers contained in this application, whether in our own handwriting or not, are complete and true to the best of our knowledge and belief and that they shall form part of the policy. No change in amount, classification or benefits shall be effective unless agreed to in writing by each of the undersigned. We understand that any misstatement on this application form could result in its non-acceptance or the repudiation of the contract.

It is also agreed that Alliance Insurance will incur no liability under this application until:

(a) The application has been received and approved;

(b) The full modal premium has been paid to and accepted by Alliance Insurance.

The policy must be issued and the full modal premium paid while the health, habits, avocations and occupation of the proposed insured are as stated in this application.
I (we) understand the 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 Insurance.

Signed at (Place) ____________ this ________ day of ____________ 20____

____
Signature of Proposed Insured

____
Signature of Policy Owner (if other that Proposed Insured)

____
Name, Signature and Address of Witness

____
Name of Agent/Financial Planner

AUTHORISATION TO OBTAIN INFORMATION

Give the name and address of your personal doctor or medical facility where your records may be obtained:

Furthermore I authorize any
1) Physical, medical practitioner;
2) hospital, clinic, medical or medically related facility; or
3) Insurance company.

having any records or knowledge pertaining to me or my health, to provide Alliance Insurance or its reinsurers with any information sought.

Information obtained with this authorization may only be:
1) Used to determine insurability;
2) Released to reinsurance companies;
3) Used as lawfully required
4) Used as I may further authorize

Alliance Life
ASSURANCE

I agree that a photocopy of this authorization shall be as valid as the original. I request that any examination findings resulting in a rating, postponement or declination of any or all coverage requested on this application be forwarded directly to the above named doctor/medical facility or to the following:

Name of Doctor or Medical facility ______________________

Address ______________________

Date ____________ Signature of Proposed Insured ______________________

ADDITIONAL INFORMATION

Please use the space provided below to provide any additional information necessary.