ALLIANCE LIFE ASSURANCE LIMITED
P.O. BOX 11522, DAR ES SALAAM, TANZANIA
Tel: 2103300/101 Fax. 2103305 - email: life@alliancelife.co.tz

APPLICATION FORM FOR GROUP MORTGAGE PROTECTION LIFE ASSURANCE SCHEME

The Borrower must complete this form in his or her own handwriting

Please ensure that all the questions are answered. The company may need more information if this form is incomplete or if the questions are not clearly answered.

NAME OF POLICY HOLDER: _____

AMOUNT OF LOAN/SUM INSURED: _____

START AND END DATE: **TERM (In years):** **Start date:** **End date:**

OCCUPATION: _____

PRIVATE ADDRESS: _____

PERSONAL CONTACT NO. AND E-MAIL ADDRESS: _____

DATE OF BIRTH: _____

GENDER: _____

PLEASE TICK (√) WHERE APPLICABLE

1. INSURANCE INFORMATION

1.1.	Do you currently have any life/disability insurance under any other policies?	**YES**	**NO**

If yes, state full particulars _____

_____

1.2.	Have you ever been refused life/disability 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

_____

2. STATE OF HEALTH

2.1. Height (without shoes) in cms.

2.2. Weight (in Kgs)

2.3.	Has your weight fluctuated by more than 5kg in the last year?	**YES**	**NO**

If yes, give details

_____

2.4.	Do you smoke?	**YES**	**NO**

If yes, how many per day?

2.5. Have you ever smoked?

YES	NO

If yes, give details

3. MEDICAL INFORMATION

3.1. Are you currently suffering from any defect or medical condition that would lead a reasonable and prudent person, if they were suffering from the same thing (s), to conclude that they are not in good health? If so provide details:

……

……

YES	NO

3.2. Give the name and address of your usual medical attendant and those of any medical practitioners (except dentists or opticians) who treated you in the past five years and state the ailment.

Doctor's name	Address	Dates	Ailment

3.3. Have you ever had an x-ray examination or other special examinations?

YES	NO

If yes, please complete the following:

Reason	Nature of investigation	Date	Result

3.4. Have you suffered any other serious or prolonged illness or injury or is there any other matter that you consider likely to affect the risk of this insurance?

YES	NO

If yes, give details

3.5. Have you ever been tested for or received any medical advice, counseling or treatment in connection with AIDS or any AIDS-related condition?

YES	NO

If yes, give details

3.6. 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

3.7. Have you been hospitalised within the past five years?	YES	NO

If yes, give details _____

4. MEDICAL PRACTITIONER'S DETAILS

4.1. State name and address of your medical attendant

Address: Phone No:

4.2. How long has the above-mentioned medical attendant been your doctor? _____

5. FAMILY HISTORY

Please give us the health status of your parents, brothers and sisters as well as details, of those who have 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, hemophilia, Huntington's chorea or retinitis pigmentosa as set out below :

If living			If deceased		
Relationship	Age	State of health	Relationship	Age	Exact cause of death

6. BORROWER'S DECLARATION

I, the life to be insured, declare that all the statements made in this declaration of health are true. I agree that such statements, together with those made, or to be made, to the medical officer and signed by me, shall be the basis of any assurance granted under the said scheme.

I hereby irrevocably authorize 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.

I am aware and fully understand the following:

a) My proposal for Mortgage Insurance Life Cover will only be considered following approval to grant a loan/facility to me by _____ (Name of Policy holder) and further;
b) If I have not declared any pre-existing illness and/or chronic conditions, the cover on my life will become ineffective from the date of first disbursement of the loan or from the date when the facility is captured in the account maintained at the bank whichever comes earlier.

OR

If I have declared any pre-existing illness and/or chronic conditions, the cover on my life will only become effective following acceptance of the proposal by the insurer.

Signature : **Date :**