PHOENIX LIFE ASSURANCE CO. LTD

Kanda Hightway, Phoenix House, P. O. Box 17753, Accra – Ghana
E-mail: info@phoenixlifegh.com Website: www.phoenixlifegh.com

PLAN: **Phoenix Education** ☐ **Phoenix Pension** ☐ **Micro Pension** ☐ **Micro Education** ☐

1. Name of Applicant _____ **Title** _____
First Middle Last (Mr., Mrs., Ms., Dr.)

2a. Date of Birth (i) Day _____ (ii) Month _____ (iii) Year _____ 2b. Age _____

3. Gender: ☐ **M** ☐ **F** **4. Place Of Birth** (i) city _____ (ii) Country _____ (iii) Nationality _____

5. Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

6. Full Address:

Residence _____

Permanent Mailing Address _____

7. Telephone Nos.: **Business** _____ **Residence** _____

8. Fax No.: _____ **9. Email** _____

10. Occupation _____ **How long in occupation?** _____ Years

11. Name of Employer _____

Address _____

12. Amount Applied for (Sum Insured): ¢ _____

13. a. **Mode of Premium payment:** ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly ☐ Daily

b. **Billing Type will be Direct Collection unless otherwise noted as below:**

☐ Direct Collection ☐ Salary Deduction

☐ Pre-Anthorised Cheque (Q&M only) ☐ Accountant General's Department Deduction

14. Flexible Premium Plans: Non-Participating

a. Planned Periodic Premium ¢ _____ per ☐ **A** ☐ **S** ☐ **Q** ☐ **M**

b. Lump Sum + ¢ _____

c. Total Initial Payment = ¢ _____

15. i. Accidental Indemnity Rider: Yes ☐ **No** ☐ If Yes, Specify Amount ¢ _____

ii. Waiver of Monthly Deductions Rider: Yes ☐ No ☐

16. Beneficiary (State full name and relationship to proposed Insured. If more than one, then will distribute proceeds equally to the survivors unless otherwise indicated).

	NAME	DATE OF BIRTH	RELATIONSHIP	% SHARE TO BE PAID
1.				
2.				
3.				

17. Total Insurance in Force *(All companies):*

a. **Life Insurance now in force** *(All companiew)* ¢ _____

b. Accidental Death Insurance *(including Principal Sum)* now in force ¢ _____

	Yes	No
18. Smoking Habits *(if "Yes" give details in Remarks):*		
a. Have you smoked tobacco cigarettes in the last 12 months?	☐	☐
b. Have you used any form of tobacco in the last 24 months?	☐	☐
19. Other Insurance*(if 'Yes' give details in Remarks):*		
a. Have you had any life or health insurance with any company declined, cancelled, rated, modified, or been refused issue, renewal, or reinstatement?	☐	☐
b. Will insurance, including annuities, in any company be discontinued or changed if the insurance applied for is issued?	☐	☐
c. Is any application for life or health insurance pending in any other company?	☐	☐
20. Aviation, Military, Avocation and Sports *(If "Yes," give details in Remarks):*		
a. Does any person to be covered intend to fly other than as a passenger or has he or she flown other than as a passenger during the past two years? *(If "Yes," complete Aviation Questionnaire):*	☐	☐
b. Is any person to be covered a member, or does he or she intend to become a member, of the armed forces including reserves?	☐	☐
c. Does any person to be covered participate in recreational activities involving: Powered racing, competitive vehicles *(including motorcycles, automobiles and motor boats),* Aeronautics *(including hand gliding, sky diving, ballooning)*?	☐	☐
21. Is any person to be covered now so disabled by sickness or injury as to be unable to perform any of the duties of his/her normal job? *(If "Yes", who and since when? Give details in Remarks)*	☐	☐
22. Within the last five years, to the best of your knowledge, have you or any person to be covered:		
a. Had or been told you had high blood pressure, heart disease, diabetes or cancer?	☐	☐
b. Had or been told you had an immune deficiency disorder, AIDS, or the AIDS Related Complex (ARC), or any reproductive transmitted disease? *(If "Yes" , give details in Remarks, including name and address of attending physician).*	☐	☐
c. Had, been told or you received advice from your doctor that you are suffering from any illness (if yes, please specify _____)	☐	☐

REMARKS (If you answered "Yes", to any of the above, give details

FUNERAL RIDER: (MICRO ONLY)

	Name	Relationship
1.		
2.		

DECLARATION:

It is represented that the statements and answers given in this application are true, complete, and correctly recorded to the best of my/our knowledge and belief. It is agreed that:

(1) This application shall consist of Part 1 (and Part 2) and shall be the basis for my policy issued on this application;

(2) Any policy issued on this application shall not take effect until after all the following conditions have been met:

(a) The full first premium is paid,

(b) The owner has personally received the policy during the lifetime of and while person(s) to be covered by such policy is/are in good health, and

(c) All of the statements and answers given in this Application to the best of my/our belief must be true and complete as of the date of the owner's personal receipt of the policy and that the policy will not take effect if the facts have changed;

(3) I/we understand that omissions or misstatements in the application will cause an otherwise valid claim to be denied under any policy issued from this application, subject to the incontestability of the policy;

(4) No waiver or modification shall be binding upon the Company unless in writing and signed by the Managing Director and the Life Manager;

(5) The Company may indicate changes in the space for Home Office Changes in the application for administrative purposes only. Any other changes in this application shall be subject to written consent by the owner.

Signed at: _____ on _____, _____
Day/ Month / Year

Signatures: _____ _____
Witness to all signature (Licensed Resident Agent, as required) *Signature of adult to be insured*

_____ _____

If owner is a corporation, an authorized officer other than the Proposed Printed name of above adult to be insured tnsw'.d must sign on the above line. Give title and full name of the Corporation on the above line.

Phoenix Life Assurance Company Ltd

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Tel. 233 0302 225 238, Fax 233 0302 222 008
E-mail: info@phoenixghana.com Website: www.phoenixghana.com

PHOENIX LIFE TRAVEL PROPOSAL FORM

A) Name of Applicant
(i) First (ii) Middle (iii) Last

B) Place of Birth (i) City (ii) Country (iii) Nationality

C) Date of Birth (i) Day (ii) Month (iii) Year (iv) Male/Female

D) Full Address
(i) Residence

(ii) Business

E) (i) P. O. Box (ii) City (iii) Country

F) Telephone No (s)
(i) Residence (ii) Business

G) Fax No H) Email Address

I) Passport No J) Issuing Country

K) Country of Residence

L) Beneficiary M) Relation to Applicant
(The Applicant will be beneficiary for spouse & children)

N) Date of Departure
(i)Day (ii) Month (iii) Year

O) Date of Return to Country of Residence
(i)Day (ii) Month (iii) Year

P) Country(ies) of Destination Q)Purpose of Trip

SUBSCRIPTION: I (we) hereby apply and subscribe to Phoenix Life Assurance Company Ltd. understand and agree:
a) the insurance applied for is not general health insurance, but it is intended for my (our) use in the event of an accidental and sudden illness or injury for which eligible coverage is available.

b) to pay premiums in advance and no coverage will be effective until the Application has been accepted in writing by the Company.

ACKNOWLEDGMENT: I (we) understand and agree that this insurance does not provide benefits for an injury, illness, sickness, disease or other physical, medical, mental or nervous condition, disorder or ailment that existed at the time of application or at any time during the five years prior to the effective date of insurance including any subsequent chronic or recurring complications or consequences relating there to or arising there from (a "pre-existing condition whether or not previously manifested or known, diagnosed, treated or diagnosed, and all that all charges and/or claims for pre-existing conditions will be excluded from coverage under this Insurance.

MEDICAL RELEASE: I (we) hereby authorize any doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, insurance company, employee or benefit plan administrator having information as to my (our)state of health or mental condition, to provide such information to the company.

CERTIFICATION: I hereby certify, represent and warrant that: (1) I have read the foregoing statement or they have been read to me, and I understand them, (ii) I am (we are) eligible to participate in this insurance program, (iii) I am (we are) currently in good health and have not been diagnosed with, treated for, and do not suffer from any pre-existing or other medical condition which I (we) foresee may require treatment in the future or for which I (we) intend to claim under this insurance. If signed as proxy of the insured, the undersigned warrants their authority and capacity to so act and to bind the insured. By acceptance or coverage, the insured ratifies the authority signatory to bind insured.

Signature of insured or Proxy Date----------

Signature of Agent Date----------