H.O. USE ONLY	MORTGAGE/KEYMAN PROPOSAL FORM	PHOENIX LIFE ASSURANCE CO. LTD.
DATE OF ISSUE		
POLICY NUMBER		Tel: 233 21 225238, 911023/4, Fax 233 21 222008

1. Full Name of Proposed Assured (Print) *Surname* *Other Name(s)*		9. Plan of Assurance	11. Amount of Premium
2. Residence Address		10. Sum to be Assured GH¢	13. How Payable Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually ☐
3. Date of Birth	4. Age Next Birthday	12. Extra Premium	
5. Place of Birth	6. Occupation		15. Marital Status Single ☐ Married ☐ Widowed ☐ Divorced ☐
7. Employer's Name	8. Business Address	14. Sex ☐ Male ☐ Female	

16. Name of Beneficiary, Relationship and Age	17. Address of Beneficiary

18. Do you suffer, or have you suffered from any illness, accident, disease, injury or physical, or mental disability or undergone any surgical operation? If so, give details as to date, duration and treatment.

19. Height	20. Weight	21. Are you in good health?	22. Have you ever been refused Assurance by any Company?

23. Do you have any assurance on your life? If so list names of companies and amounts.

24. If female, are you pregnant?	25. E-mail Address:

I hereby declare that the above statements are true and accurate and I further agree that this declaration, and any other declaration made by me in connection with this application, including any answers made in any medical statement shall be the basis of the contract with the Phoenix Life Assurance Co. Ltd. I agree that no Assurance shall be in effect until such time as a duly signed policy is delivered to and received by me, and the first premium thereon paid in full and then only if I am in good health.

DATED THIS . . . . . DAY OF . . . . . 20. . . . . .

Authorised Agent *(Number)* *Signature of Proposed Assured*

Signature

Amount of Deposit with Application:

NON-MEDICAL APPLICATION - PART II

1. FULL NAME	AGE NEXT BIRTHDAY	3. ARE YOU MARRIED?

4.RESIDENCE ADDRESS:	5. OCCUPATION How Long? Is change likely?

6. Have you consulted any doctor or specialist during the past five years?	Yes or No
8) Have you ever had an X-ray, ECG or other Special investigation?	
9) Do you have Physical Deformity or Defect?	
10) Are you currently under medical treatment?	
11) Has any member of your family died from Heart Disease or ever suffered from Tuberculosis, Diabetes or Mental Disease?	
12) Have you had Epilepsy, Paralysis, Nervous Breakdown, Fainting Spells, Nervous or Mental Injury?	
13) Have you had Habitual Cough,Tuberculosis Asthma, Lungs or Throat Infection or any Disease or Infection of the Eye or Ear or Respiratory System?	
14) Do you have any disease relating to Blood Vessels or Arteries, High or Low Blood Pressure?	
15) Do you have any Heart, Cardiac, Cardiovascular or Circulatory Condition?	
16) Have you been diagnosed for any kind of Tumor, Cancer, Cyst, Disorder of Blood, Glands, Goiter or Skin Disease?	
17) Have you had any Infection of the Kidneys Or Bladder, Colon, Prostate, Rheumatic Fever Rheumatism, Gout or Diabetes?	
18) Have you been tested positive, been Diagnose, or treated for Acquired Immune Deficiency Syndrome (AIDS) Aids Related Complex (ARC) Human Immunodeficiency Virus (HIV) or other Immune System	
19) Have you had Varicose veins, Piles, Hernia Syphilis or any form of Venereal Disease?	
20) Have you had any surgical operation or Suffered from any serious illness, disease, Accident or injury that is not stated above?	

7. **FAMILY RECORD**	**IF LIVING**		**IF DEAD**	
	Age	Health	Age	Cause of Death
Father				
Mother				
Brothers: How many?				
Sisters: How many				

IF ANY QUESTION IS ANSWERED "YES", GIVE DETAILS BELOW

Disease or Injury	Date	Duration	Results	Name of Doctor or Hospital

21) In the case of a female, a] Are you pregnant? . . . . . . b] Have you any children? . . . . . . c] I) How many children alive? . . . . . . ii) How many children dead? . . . . . . iii) State cause of death . . . . . . d] If married, how long? . . . . e] Any female disease?	22) Have you ever resided in any mining area in West Africa? If so where, and for how long? 23) What is your average daily consumption of Alcohol? 24) How much do you smoke daily?

I declare that the foregoing answers are true, that I have not withheld any important circumstance, and I agree that this declaration shall be held to form part of the proposal for Life Assurance now made to the Company.

Date: . . . . . Signature of Proposer: . . . . . .

Form ME 3.56

MEDICAL EXAMINER'S REPORT

APPLICATION - PART II

1. FULL NAME	AGE NEXT BIRTHDAY	3. ARE YOU MARRIED?

4.RESIDENCE ADDRESS:	5. OCCUPATION How Long? Is change likely?

6. Have you ever had or been told you had:	Yes or No
a) Fits, Nervous Breakdown, Overwork or any Nervous or Mental disorder, Anaemia? …	
b) Blood-spitting, Pleurisy, Tuberculosis or any Lung Disorder? … … … … … …	
c) Ulcer, intestinal, liver or biliary disease, or any other abdominal disorder? … … …	
d) Kidney stone, colic, bladder trouble, or any other genito-urinary disorder? … … …	
e) Rheumatism, heart disease, goiter, apoplexy, high blood pressure, Sickle Cell disease? …	
f) Albumen, blood or sugar in the urine? … …	
g) Varicose veins, hernia, physical deformity, injury or any other ailment? … … … …	
h) Yaws, leprosy, malaria, syphilis, gonorrhea, Bilharzia, Onchocerciacis and Trypanosomiasis?	
i) An X-ray or other special investigation?	

7. **FAMILY RECORD**	**IF LIVING**		**IF DEAD**	
	Age	Health	Age	Cause of Death
Father				
Mother				
Brothers: How many?				
Sisters: How many				

8. Has any member of your family ever had:

a) Any heart Ailment?

b) Nervous or mental disease?

c) Tuberculosis?

IF ANY QUESTION IS ANSWERED "YES", GIVE DETAILS BELOW

Disease or Injury	Date	Duration	Results	Name of Doctor or Hospital

9. In the case of a female,

a] Are you pregnant? . . . . . .

b] Have you any children? . . . . . .

c] I) How many children alive? . . . . . .

ii) How many children dead? . . . . . .

iii) State cause of death . . . . . .

d] If married, how long? . . . .

e] Any female disease? . . . . . .

10. Have you ever resided in any mining area in West Africa? If so where, and for how long?

11. What is your average daily consumption of Alcohol?

12. How much do you smoke daily?

I declare that the foregoing answers are true, that I have not withheld any important circumstance, and I agree that this declaration shall be held to form part of the proposal for Life Assurance now made to the Company.

Date: . . . . . Signature of Proposer: . . . . . .

Form ME 3.56

The result in this examination must not be disclosed to the life concerned.

1. Height Weight	2. Chest at nipple line full inspiration complete expiration Abdominal girth (at umbilicus)
3. State of Heart? Rate and state of Pulse. Blood pressure? (when the Systolic Blood Pressure exceeds 145mm or the Diastolic exceeds 90mm.) Fresh readings should be taken in the reclining position after resting for 5 minutes in this position.	Systolic……Diastolic…….. Systolic……Diastolic…….. (2nd reading – if required)
4. State of Lung?	
5. Nervous System. Are the pupils equal? Do they react both to light and accommodation? Are the knee jerks normal, absent or exaggerated?	
6. State of (a) teeth, (b) digestive organs?	(a) (b)
7. Where there is or has been infection of the cars, (a) what is the condition of the drums? Is there any discharge?	
8. Genitor-urinary system- specific gravity of urine? Does it contain (a) albumen, (b) sugar?	(a) (b)
9. What is the build and general appearance? Are there any signs of past or present intimance? Is there any evidence or suspicion of venereal disease past or present?	
10. Apart from the foregoing is there any other condition or circumstance calling for remark?	
11. From examination and general observation do you think he/she seems likely to live as long as any other person of his/her age, and do you recommend his/her life to be accepted? (a) If so, whether at ordinary rate? (b) If not, what addition to the age do you advise?	(a) (b)
12. Additional Remarks	

Name of Physician……..

Signature and Medical qualifications……

Address……...

Date……