



Industrial and General Insurance Plc

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LIFE ASSURANCE PROPOSAL FORM (INDIVIDUAL)

IMPORTANT: Kindly complete this form carefully and fully, failure to disclose all facts likely to influence the acceptance and assessment of this proposal could affect settlement of claims or invalidate your policy. If you are aware of any fact likely to influence the proposal kindly disclose them in the space provided at the end of this proposal. If any answer has been written by any other person(s), such person(s) shall for that purpose be regarded as the agent of the proposal and the agent(s) Insurer.

PERSONAL DETAILS

PLEASE COMPLETE IN BLOCK LETTERS

Proposer:
Surname Firstname Middlename

Please specify Title Mr Mrs Miss Others Sex: Male Female

Marital Status: Single Married Divorced Separated Widowed

Date of Birth (dd/mm/yyyy)

Occupation Are you self employed? Yes No

Resident Address: Line 1
 Line 2
 Line 3 Town State

Postal Address: (if different from above) Line 1
 Line 2
 Line 3 Town State

Telephone Nos. Home Office
 Mobile / GSM Fax
 Email Website
 Wedding Anniversary Date (if applicable)
 Insurance Required (Dates) From To

NEXT OF KIN / EMERGENCY CONTACT

Name Relationship
 Contact Address: Line 1 Telephone
 Line 2
 Line 3 Town State

Marital Status: Single Married Divorced Separated Widowed

For female proper: Maiden Name

Husband's Name if married

Are you pregnant? Yes No If Yes how many months

OCCUPATIONAL DETAILS

i) Exact Nature of Occupation or Business

ii) Employer?

(If self employed describe business or activities)

(iii) Have you changed your job in the last 3 years? Yes No
(iv) Are there any notable accidents and / diseases particularly associated with your occupation? Yes No
(v) How often do you travel? (a) within the country (b) abroad

Give details where question has been answered Yes from 2 (iii) to (v) above

COVER REQUIRED

3. (i) Sum Assured =N=
(ii) (a) Plan of Assurance (b) Term of Assurance (c) Commencement Date
(d) With Profit (e) Without Profit

Note: Bonus on policies is Reversionary

(iii) **Tick Additional (Riders)**
(a) Waiver of premium (b) Accidental Death Benefit

(iv) (a) **Provisional Premium** =N=

(v) (a) Tick frequency of payment: Annually Half Yearly Quarterly Monthly
(b) Method of premium payment Cash Cheque Direct Debit

Medical Details

Name and Address of Personal Physician within the last 3 years

Reason(s) for consultation(s)

Date of last treatment Height Weight

Have you ever suffered/experienced, or been treated for, or told you are suffering from any of the following health conditions? Please, tick Yes or No as appropriate.

	Yes	No		Yes	No
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis of any kind	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Insanity	<input type="checkbox"/>	<input type="checkbox"/>	Surgical Operation	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Any other disease or Medical condition	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>			

If YES, please provide details below

Question No.	Details where question answered YES

(i) Sum Assured

COVER REQUIRED

(ii) (a) Plan of Assurance

(b) Term of Assurance

(c) Commencement Date

(d) With Profit

(e) Without Profit

Note: Bonus on policies is Reversionary

(iii) Tick Additional (Riders)

(a) Waiver of premium

(b) Accidental Death Benefit

(c) Personal Accident Benefit

(iv) (a) Provisional Premium

(b) Payment accompanying this proposal

(v) (a) Tick frequency of payment
 Annually Half Yearly Quarterly Monthly

(b) Method of premium payment

Cash Cheque Direct Debit

MEDICAL DETAILS

4. (a) Name and Address of your personal physician within the last 3 years	Reason (s) for consultation	Date of Treatment

(b) Has any of your relatives (i.e. Father, Mother, Brothers, Sisters, Wife, Husband, Uncle, Cousin, Nephew) Ever suffered or now suffering from: (Please, tick YES or NO)

	YES	NO
(i) Tuberculosis	<input data-bbox="380 1556 440 1604" type="checkbox"/>	<input data-bbox="456 1556 516 1604" type="checkbox"/>
(ii) Epilepsy	<input data-bbox="380 1604 440 1652" type="checkbox"/>	<input data-bbox="456 1604 516 1652" type="checkbox"/>
(iii) Insanity	<input data-bbox="380 1652 440 1701" type="checkbox"/>	<input data-bbox="456 1652 516 1701" type="checkbox"/>
(iv) Diabetes	<input data-bbox="380 1701 440 1749" type="checkbox"/>	<input data-bbox="456 1701 516 1749" type="checkbox"/>
(v) Heart Disease	<input data-bbox="380 1749 440 1797" type="checkbox"/>	<input data-bbox="456 1749 516 1797" type="checkbox"/>
(vi) A.I.D.S	<input data-bbox="380 1797 440 1845" type="checkbox"/>	<input data-bbox="456 1797 516 1845" type="checkbox"/>

YES NO

- © Have you ever suffered from: (tick as appropriate)
- (i) Physical defect or infirmity or any nervous or mental or hearing or sight difficulties
 - (i) Clinical depression or anxiety or fainting or paralysis of any kind
 - (i) High blood pressure or heart condition hemorrhoids, varicose veins or other circulatory disorder or rheumatic fever etc?
 - (i) Any respiratory, urinary or allergic condition or any disorder of the digestive system?
 - (i) Any special medical investigation e. g X-rays or laboratory test including blood studies?
 - (i) Any surgical Operation?
 - (i) If a woman: Any disease of the breast, miscarriage, premature birth, still birth, or nay caesarian operation?

If any question in 4b and 4c has been answer YES, please provide details below

Ques. No	Details where question answer YES

DECLARATION

I / We declare that to the best of my / Our knowledge and believe, the information supplied in this proposal form is true and complete.
 I / We understand that cover is not effective until acceptance of this proposal is confirmed and payment effected.

Signature of Proposer _____

Date _____

Agent _____

IMPORTANT NOTICE

Keep a record of all information supplied to us (including copies of letters) as part of this Proposal

A copy of the Completed Proposal form will be supplied on request.

A copy of the policy form is also available on request for verification prior to completion of the Contact.

No Insurance is in force until the proposal has been accepted by the Company and the Premium or Deposit paid except as provided by an official covering note issued by the Company.