LIGHTHOUSE
INSURANCE ADVISORS SAL

PROPOSAL FORM FOR LIFE ASSURANCE

Group :
Sub-group :

1 First name(s)	2 Father's name	3 Family name
4 Nationality (ies)	5 Date of Birth (dd/mm/yyyy)	6 Sex Male ☐ Female ☐
7 Marital status Married ☐ Single ☐ Divorced ☐	Beneficiary : *As per the attached Application*	
8 Country of residence:		
9 Occupation (please give exact nature of duties).		

10 Are you likely to:		Please give detail below
1) Engage in aviation other than as a fare paying passenger on a commercial airline ?	Y / N	
2) Reside or travel outside your country of residence other than on holiday?	Y / N	
3) Undertake any hazardous pursuit or pastime, such as diving, mountaineering, etc.?	Y / N	

11 Please provide name and address of your usual medical attendant below. If this contact has been your medical attendant for less than twelve months please also indicate name and address of previous attendant:

12 Please give details of :

(a) Your Height (cm) (b) Your Weight (Kg)

13 What is your daily habit regarding:

(a) Alcohol …… (b) Tobacco ……

Applicant's name:

14 Are you currently receiving any treatment, medications, or on any special diet?

If YES Please give full details, including dates, durations, names and addresses or doctors attended in the table on the next page.

15 Have you ever received a medical diagnosis of any of the following conditions?
If YES, please give full details below or enter 'No' as appropriate.

i.	Rheumatic Fever.	YES / NO
ii.	Heart or any Circulatory Trouble.	YES / NO
iii.	Raised Blood Pressure, (whether subject to treatment or otherwise)	YES / NO
iv.	Raised Cholesterol or Blood Lipids.	YES / NO
v.	Diabetes Mellitus.	YES / NO
vi.	Asthma, Bronchitis or other Respiratory Trouble.	YES / NO
vii.	Anxiety, Depression or Nervous Trouble.	YES / NO
viii.	Tumor, Growth or Swelling of any kind.	YES / NO
ix.	Any other serious condition or ailment.	YES / NO

16 Have you ever received (or expect to receive) any medical advice, counseling treatment, blood test or any other test in connection with AIDS, any AIDS related condition, hepatitis B or any sexually transmitted disease ?

17 During the last 5 years have you been incapacitated from work for more than one week, suffered from any serious illness or injury, consulted any medical adviser or attended hospital?

If YES Please give full details, including dates, durations, names and addresses or doctors attended in the table on the next page.

18 Have any of your immediate family members (parents, brothers, sisters) ever suffered from diabetes, stroke, cancer or heart disease? If YES, please state current age or age at death.

Applicant's name:

Additional details to Questions answered YES

Question No	Date occurring	Condition	Treatment	Duration

DECLARATION

I declare that to the best of my knowledge and belief the above statements are true and I agree that they shall be the basis of the assurance on my life under the above Scheme. I consent to the Insurance Company seeking medical information from any doctor who at any time has attended me concerning anything which affects my physical or mental health or seeking information from any insurance office to which a proposal has been made for insurance on my life and I authorize the giving of such information.

I understand that failure to disclose relevant information may invalidate any claim.

Signature of Proposer…… Date ……..

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BENEFICIARY DESIGNATION FORM

for Group Life Assurance Policy

Proposal full name: _____

Home address:

Building ..... Street .....

Area ..... City .....

Country .....

Phone(s) ( ) ..... ( ) .....

I hereby appoint as beneficiary(ies) in event of my death the person(s) named below:

Full name	Relationship	Address

It is noted and agreed that the beneficiary in case of any disability, when covered under the Policy, will remain l.

Signature of the employee ..... Date ..... /..... /.....

Seal and Signature of the Policyholder .....

Notes on designating Beneficia ries.

- A C*ontingent Beneficiary* is a person designated to receive the proceeds of the policy if the primary beneficiary should die before the person whose life is insured. Should you want to include in your designation such a beneficiary, please precede his/her name with the mention “Contingent Beneficiary”.
- *Concurrent Beneficiaries* are more than one beneficiary designated to share the proceeds of the policy. The shares will be distributed equally *unless* otherwise provided.