

CHILDREN EDUCATION PLAN

“NOTE: An Insurance Agent who assists an applicant to complete this application / proposal for Insurance shall be deemed to have done so as the agent of the applicant in accordance with section 54 (2) Insurance Act 2003.

I apply for Insurance of ₦ on the life of:
 (Proposer: Last Name, First Name, Middle Name)

Age of Child: Male Female

Beneficiary: Relationship of Child to the Proposer:
 (Child: Last Name, First Name, Middle Name)

Children Education Plan Supplementary Contract (DPR) Disability Protection Rider with Income of 1% of face amount per month

Duration: Years

1.

A - QUESTIONS WITH RESPECT TO CHILD'S FAMILY						
If the parents are living				If parents are Deceased		
	Age	Face Amount	Company	Date	Age	Cause
Father						
Mother						

B - QUESTIONS WITH RESPECT TO CHILD		
2. Is child in good health?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If no, explain under Q 12		

3. Is child physically or mentally deformed? Yes No if 'yes' give details

4. Gender of Proposer Male Female

5. Date of birth:/...../..... Place:

6. Permanent Home:

7. Email Address: Tel: (1).....

(2).....

8. Occupation:

9. Employer: Self Employed:

10. Proof of Identity to be provided by applicant: National ID Int'l. Passport
 Voters Card Driving License Date of Issue:
 Date of Expiry: Identification No:

11. Bank Verification Number (BVN):

12. Have you ever suffered from:

(a) Heart attack, lungs, kidney, liver disease or any other abdominal organs?

YES NO

(b) High blood pressure, diabetes, rheumatic fever tuberculosis, nervous disorder, syphilis, ulcer or tumour on any part of the body YES NO

13. If yes to any of these questions 13, 15,16, 17 give full details:

14. Do you intend to seek medical advice, treatment, or have any medical tests performed? YES NO

15. AIDS (Acquired Immune Deficiency Syndrome)

Described in details any affirmative answer:

(a) Have you received medical advice or treatment in connection with AIDS or an AIDS-related condition or a sexually transmitted disease?

YES NO

(b) Have you been told you have AIDS or AIDS - related complication?

YES NO

(c) Have you had or been told you had positive blood test Antibodies to AIDS virus?

YES NO

(d) Do you have any of the following which are unexplained: Fatigue, weight loss, diarrhea, enlarged lymph? YES NO

16. Are you presently deformed or ever had any physical deformity or serious accident?? YES NO
17. Have you within the past 5 years been advised to have any operation or been subjected to a special medical regime? YES NO
18. Do you have a Life Insurance Policy? YES NO

19 Name and Address of your Doctor:

20. Mode of premium payment? Monthly Semi Annually Annually

Note: AIICO Insurance Plc does not accept cash payments to any agent/staff of the company and accepts no liability for such. All payments shall be made through designated payment channels in favour of AIICO Insurance Plc.

D - QUESTIONS WITH RESPECT TO CHILD'S FAMILY

21. (a) Are you pregnant now? YES NO
 (b) Have you ever had any disorder of menstruation, Pregnancy or of the female organs or breasts? YES NO

22. Use this space for additional details or special request.

CHILD

1. Do you personally observe child proposed for insurance? YES NO
2. Did the child appear healthy, physically and mentally sound? YES NO
3. Is the child wholly supported by the proposer? YES NO
4. Do you suspect anything unfavourable in the child's manner or place of living, physical condition, Occupation, habits, personal or family history? YES NO

E. NEXT OF KIN

1. Name:
 Occupation:..... Mobile No.:
 Address:
 Relationship.....

F- AGENTS CONFIDENTIAL REPORT

APPLICANT

1. How long and how well have you know the proposer?
 2. What is you estimate of the proposer's net-worth?
 3. Do you know anything about the proposer which can make the insurance undesirable? YES NO
4. Names, occupations and address of two references to whom we may refer regarding this application:
 (i)
 (ii).....
5. What is the purpose of this insurance?
 6. By whom will premiums be paid?
 7. Do you recommend issuance of policy? YES NO
 Standard () Substandard ()

Agent Code:.....
 Agent Signature:
 Agency Manager Code:
 Agency Manager Signature:

The liability of the company shall not commence until this application is accepted, the premium is paid in accordance with Section 50(1) of Insurance Act 2003, and policy document duly issued.

I. DECLARATION

I do hereby declare that I am at present in good health and all the foregoing answers are true. I have not concealed or withheld any information that could lead to my ineligibility for AIICO Children Education Plan. I agree that this and all statements that I have made or shall make to the Company in connection with this proposal shall be the basis of this contract. I agree that no cash payment shall be made by me to any agent in respect of premiums and other transactions on this policy and that all payments shall be made in the name of AIICO Insurance Plc.

I irrevocably authorize and request any person (including but not limited to medical doctors) who may be in possession of, or hereafter acquire, any information to disclose such information to the company, and I agree that this authority and request shall remain in force after the expiration of my policy as well as prior thereto. I hereby authorize sharing of the information furnished on this form with any registered KYC Registration Agencies.

That in compliance with relevant laws, I have considered all data request made by AIICO with respect to my personal data and hereby concede to (without any element of fraud, coercion, or undue influence) the release of all vital information. I acknowledge to have accepted all terms and conditions by reason of my sign-off and a waiver of my right of refusal shall be determined upon execution of all relevant documents on this transaction. I further affirm that in line with relevant laws, I have been duly informed about my right of withdrawal of consent in relation to personal data /information which shall not be unreasonably withheld.

Signature:

Date:

SIGNATURE OF APPLICANT

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