

D. OTHERS DETAILS

1. Has any application for any reinstatement of Life, Accident or Health Insurance ever been declined, postponed, rated or in any way modified?

Yes No

If Yes, state details:

2a. What life insurance is now in force on your life?

2b. Year issued:.....

2c. Company:.....

2d Amount:.....

3a. Present State of health:

3b. Any deformity: Yes No

3c. Height:..... Weight:.....

4. Have you in the last 5 years:

4a. Been ill? Yes No

4b. Consulted a physician? Yes No

4c. Been under observation for any medical condition? Yes No

If Yes, state details:

.....

E. NEXT OF KIN

1. Name: Occupation:..... Mobile No.:

Address: Relationship.....

F. BENEFICIARY

Name	%Share	Relationship
1
2
3
4
5
6

G. NAMES OF REFERENCE

1. Name:

Occupation: Address:

Mobile No.:

2. Name:

Occupation: Address:

Mobile No.:

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 AllCO Moneywise Term Assurance 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 in respect of premiums and other transactions on this policy and that all payments shall be made in the name of AllCO 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 AllCO 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.

Place: Date:

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.

SIGNATURE OF APPLICANT

FOR OFFICE USE ONLY

IPV Done on DD / MM / YYYY

AMC.Intermediary name OR code

.....

(Originals Verified) Self Certified Document copies received

(Attested) True copies of documents received

Seal/Stamp of the intermediary should contain
Staff name
Designation
Name of the Organization
Signature
Date
.....
Documents Attestation

Seal/Stamp of the intermediary should contain
Staff name
Designation
Name of the Organization
Signature
.....
In Person Verification

