AIICO Plaza

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Please fill this form in ENGLISH and in BLOCK LETTERS.

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Type:

APPLICATION FORM FOR 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. A. IDENTITY DETAILS Name of Applicant (As appearing in supporting identification document) Title/ Surname **PHOTOGRAPH** Other name Please affix Maiden Name a recent passport size photograph and 2a. Gender ☐ Male ☐ Female sign across it ☐ Single ☐ Married 2b. Marital Status DD/MM/YYYY 2c. Date of Birth 3. Nationality ☐ Nigerian State of Origin: Non-Nigerian Please specify 4. Residential Status 🗆 Resident Individual 🔲 Non Resident 🗀 Foreign National (Passport copy mandatory for NRIs and Foreign Nationals) 5. Proof of Identity to be provided by applicant Int'l. Passport ☐ National ID Voter Card ☐ Driving License Date of Issue Date of Expiry Identification No 6. Bank Verification Number (BVN) **B. ADDRESS DETAILS** Residential Address 2. Contact Details Mobile (Home) Mobile (Home) Email Address Proof of address. Please submit ANY ONE of the following valid documents & tick () against the document attached. Registered Lease / Purchase Agreement of Residence Latest Bank Account Statement / Passbook □ Latest Electricity Bill ☐ Latest Gas Bill/Latest Waste Bill *Not more than 3 months old. ☐ Latest Telephone Bill Permanent Address of Resident Applicant if different from B1 above OR Overseas Address (Mandatory) for Non-Resident Applicant Postal Code City / Town / Village Country C. OTHER DETAILS Gross Annual Income Details ☐ Below N1m ☐ N2-5m ☐ N6-10m ☐ N11-20m ☐ N20m- above Net-worth inas on (date) DD / MM / YYYYY Occupation 2. ☐ Private Sector Service ☐ Public Sector ☐ Government Service ☐ Business ☐ Professional ☐ Agriculturist ☐ Retired ☐ Housewife ☐ Student ☐ Forex Dealer Others (Please specify): 2b. Principal: ______2c. Nature: _____2d. How long employed: _____ Please tick if applicable: ☐ Politically Exposed Person (PEP) ☐ Related to a Politically Exposed Person (PEP). 3. Any other information: Proposed Commencement Date: DD/MM / YYYYY 5. 7. Source of Fund: 8. Duration of Plan: ☐ Half Yearly
☐ Yearly Mode of Payment: ☐ Cheque ☐ Direct Debit Note: AllCO Insurance PIc 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. Deposit Premium Made: 11. Employment Status:

Employed Self Employed Others, Specify: Others, Othe 12. Business/Occupation: 14. Business Employer's Name: Business Employer's Address: 15. Bank Name: Account Number: Type: 16.

D. OTHERS DETAILS		
Has any application for any reinstatement of Li Yes No	fe, Accident or Health Insurance ever been declined, postpo	ned, rated or in any way modified?
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 condit	tion? Yes No	
If Yes, state details:		
E. NEXT OF KIN		
	Occupation:	Mobile No.:
Address:		tionship
F. BENEFICIARY		
Name	%Share	Relationship
		·
1 Named Beneficiary:		
2 Relationship with Beneficiary:		
3 Date of Birth of Beneficiary:/		
G. NAMES OF REFERENCE		
	:	
·	Mobile No.:	
2. Name:		1881 1818
Occupation: Address		
Mobile No.:		
OLOMATURE OF ARRIVANT		
H. DECLARATION	do hereby declare that I am at present in good health	SIGNATURE OF APPLICANT
and all the foregoing answers are true. I have not co	oncealed or withheld any information that could lead to my	
	I agree that this and all statements that I have made or shall sal shall be the basis of this contract. I agree that no cash	
	t of premiums and other transactions on this policy and that	
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 determin	ed upon execution of all relevant documents on this transa	action. I further affirm that in line with relevant laws, I
have been duly informed about my right of withdrawa	l of consent in relation to personal data /information which s	hall not be unreasonably withheld.
Place:	Date:	
	nmence until this application is accepted, the	premium is paid in accordance with
Section 50(1) of Insurance Act 2003, and	ooney aocument aary issued.	
FOR OFFICE USE ONLY IPV Done on DD/MM/YYYY		
AMC.Intermediary name OR code		
	Agency Manager's Signature	Agents Signature
Originals Verified) Self Certified Document copies received	Name:	Name:
(Attested) True copies of documents received	Code:	Code:
		L.B. M. W. O.
	Documents Attestation	In Person Verification



