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AIICO INSURANCE
AMERICAN INTERNATIONAL

MONEYWISE TERM ASSURANCE PROPOSAL FORM

Application No: .....

Ver. 07-2019

Please fill this form in ENGLISH and in BLOCK LETTERS.

"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

1. **Name of Applicant** (As appearing in supporting identification document)

Title/ Surname

Other name

Maiden Name

PHOTOGRAPH
Please affix a recent passport size photograph and sign across it

2a. Gender ☐ Male ☐ Female

2b. Marital Status ☐ Single ☐ Married

2c. Date of Birth DD / MM / YYYY

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

☐ National ID ☐ Int'l. Passport ☐ Voter Card ☐ Driving License Date of Issue ..... Date of Expiry .....

Identification No .....

6. Bank Verification Number (BVN) .....

B. ADDRESS DETAILS

1. Residential Address

2. Contact Details

Mobile (Home)		Mobile (Home)	
Email Address			

3. Proof of address. Please submit ANY ONE of the following valid documents & tick ( ) against the document attached.

☐ Tenancy Agreement ☐ 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

4. Permanent Address of Resident Applicant if different from B1 above OR Overseas Address (Mandatory) for Non-Resident Applicant

City / Town / Village		Postal Code	
State		Country	

C. POLICY DETAILS

1. Proposed Commencement Date DD / MM / YYYY

2a. Sum Assured: ..... **2b. Rider:** ☐ Waiver of Premium (WP) on disability ☐ Accidental Death Cover (AX)

3. Source of Fund: ..... ☐ Critical Illness Cover ☐ PermanentTotal disability Cover

4. Duration of Plan ..... (Duration not less than 5years and not more than 20years)

5. Frequency of Payment: ☐ Single ☐ Monthly ☐ Quarterly ☐ HalfYearly ☐ Yearly

6. Mode of Payment: ☐ Cheque ☐ Direct Debit ☐ Standing Order ☐ Others (Please specify).....

D. OTHER DETAILS

7. Gross Annual Income Details ☐ Below N1m ☐ N2-5m ☐ N6-10m ☐ N11-20m ☐ N20m- above

[OR]

Net-worth in ..... as on (date) DD / MM / YYYY
(*Net worth should not be older than 1 year)

8a. Occupation

☐ Private Sector ☐ Public Sector Others (Please specify): .....

8b. Employer: ..... **8c. Designation:** ..... **8d. How long in employment:** .....

9. Please tick if applicable: ☐ Politically Exposed Person (PEP) ☐ Related to a Politically Exposed Person (PEP).

10. Any other information: .....

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.

11. Deposit Premium Made: .....

12. Employment Status: ☐ Employed ☐ Self Employed ☐ Others, Specify: .....

13. Employer's Name: .....

14. Employer's Address: .....

15. Bank Name: ..... **Account Number:** ..... **Type:** .....

D. OTHER 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. Do you have a life insurance cover? ☐ Yes ☐ No

2b. Year issued:..... 2c. Insurer:.....

2d Sum Assured:.....

3a. Present State of health: .....

3b. Any deformity: ☐ Yes ☐ No

3c. Height:..... Weight:..... 3d. Do you smoke? ☐ Yes ☐ No

4. Have you in the last 5 years been ill? Yes ☐ No ☐

4a. Consulted a physician? ☐ Yes ☐ No

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

If Yes, state details: .....

.....

5. Family Medical history (hereditary ailment). .....

E. BENEFIT DETAILS

Main Cover	100% of Cover amount	
Cashback	Basic % of premium	% ☐ ☐ ☐ 50 75 100
Critical illness	100% of Cover only	
Waiver of Premium	Yes / No	
Accidental Death Benefit	120% of Cover only	
Total Permanent Disability	• 100% of Main Benefit • In the case of physical impairment benefit is 50% of Sum assured • In the Case of Spinal Cord Injury benefit is a maximum of 50% Sum assured (given that the policy holder passes the activity of daily living test as stated in the policy document).	

F. NEXT OF KIN

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

Address: .....Relationship.....

G. BENEFICIARY

Name	%Share	Relationship	Primary	Contingent
1	.....	.....	☐	☐
2	.....	.....	☐	☐
3	.....	.....	☐	☐
4	.....	.....	☐	☐
5	.....	.....	☐	☐
6	.....	.....	☐	☐

H. NAMES OF REFERENCE

1. Name: .....

Occupation: ..... Address: .....

..... Mobile No.: .....

2. Name: .....

Occupation: ..... Address: .....

..... Mobile No.: .....

I. DECLARATION

SIGNATURE OF APPLICANT

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 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 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.

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.

FOR OFFICE USE ONLY

IPV Done ☐ on D D / M M / Y Y Y Y

AMC.Intermediary name OR code

.....

☐ (Originals Verified) Self Certified Document copies received
☐ (Attested) True copies of documents received

Agency Manager's Signature
Name:
Code:
Date:

.....
Documents Attestation

Agent's Signature
Name:
Code:
Date:

.....
In Person Verification