

# Life Insurance Application Form

## INSTRUCTION

To be completed by all applicants

## PERSONAL DETAILS

Surname  First name  Middle name

Sex  Female  Male  Marital status (please tick)  Single  Married  Other

Current residential and postal address

Occupation

Employer  Business address

Telephone no.  Cell phone no.

Date of birth  Day  Month  Year

Place of birth

Email

Fax no.

## Next of kin

Name

Telephone no.

Address

## Existing Insurance

• Do you have any assurance on your life? Yes  No

• Policy number and commencement date if with GLICO  Policy number  Commencement date

• Have you ever made a claim under any existing/previous policy? Yes  No

Policy number

Has your proposal for any life policy ever been accepted with an extra premium?

Yes  No  Day / Month / Year  Company

Has your proposal for any life policy ever been declined? (If so, when and by which company)

Yes  No  Day / Month / Year  Company

## MORTGAGE DETAILS

1. Cost of property (\$)

3. Loan term (years)

2. Loan amount (\$)

2. Sum to be assured (\$)

# CONFIDENTIAL QUESTIONNAIRE

Have you ever had

- 1. Unexplained recurrent and persistent fever or skin disorder? Yes  No
- 2. Unexplained persistent night sweat? Yes  No
- 3. Unexplained weight loss? Yes  No
- 4. Unexplained infections or swollen glands? Yes  No
- 5. Chronic or recurrent diarrhea? Yes  No
- 6. Persistent cough? Yes  No
- 7. Hepatitis B or Sexually Transmitted Disease, including genital discharge or sore? Yes  No

If you answered yes to any of the questions above please provide details (date, duration, treatment, test physician consulted and so on)

Condition	Date	Duration	Result of treatment/test	Doctor/Hospital

- 8. Have you ever had or been advised by a doctor to have a blood test for AIDS related condition? Yes  No
- 9. Have you ever been refused as a blood donor? Yes  No

Give details of 8 & 9 if the answer is yes

## Health information

### PERSONAL

1a. Name & address of personal doctor

1b. Date on which you joined his panel

1d. Treatment prescribed or advice given at last consultation

1c. Date and reason for last consultation

1e. Name & address of any other doctor consulted while on the panel of present doctor in the last five years.

1f. Date and reason for answer(1e.)

Height   ft/ins

Weight   kg/lbs

**BLOOD PRESSURE READING**

Systolic   Diastolic

If the answer to any question is "Yes", Identify the question number and include diagnoses, dates, duration, degree of recovery of results and name and addresses of all doctors or hospitals consulted.

	Yes	No
2a. Are you under medical care?	<input type="checkbox"/>	<input type="checkbox"/>
b. Are you now receiving, taking tablets, medicine, injections or on a diet prescribed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you any physical defect or health impairment?	<input type="checkbox"/>	<input type="checkbox"/>
3a. Do you drink beer, wine or spirit? (Give quantity)	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you smoke?(Give quantity)	<input type="checkbox"/>	<input type="checkbox"/>
c. Have quantities of any of the above, ever exceeded current consumption?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever:		
a. Been medically examined for Life Assurance? If so give company name and date	<input type="checkbox"/>	<input type="checkbox"/>
b. Been requested or received a pension, benefits or payment because of injury, sickness or disability? <b>NB. Include payments from GLICO</b>	<input type="checkbox"/>	<input type="checkbox"/>
c. Suffered any serious personal accident involving unconsciousness, fractured skull, spine or ribs.	<input type="checkbox"/>	<input type="checkbox"/>
d. Had any cysts, tumors, cancer or other growth?	<input type="checkbox"/>	<input type="checkbox"/>
e. Taken tablets over a period of more than two(2) weeks?	<input type="checkbox"/>	<input type="checkbox"/>
f. Been hospitalised?	<input type="checkbox"/>	<input type="checkbox"/>
g. Had mass x-rays which were abnormal or had to be repeated or followed up due to abnormal or doubtful findings?	<input type="checkbox"/>	<input type="checkbox"/>
h. Had x-rays other than mass x-rays or been treated by deep x-ray therapy?	<input type="checkbox"/>	<input type="checkbox"/>
i. Had blood tests, ECG or other special investigations?	<input type="checkbox"/>	<input type="checkbox"/>
j. Been rejected or discharged from military service on health grounds?	<input type="checkbox"/>	<input type="checkbox"/>

5. Other than recorded above, have you ever been treated for, been suspected of or had symptoms of Diabetes, sugar in your urine, kidney disease, rheumatic fever, any heart disorder, high blood pressure, lung disease, asthma, ulcer, disorder of the digestive tract, epilepsy or mental or nervous disorder?      Yes       No
6. Have you had an injury, illness or symptoms during the last three(3) years, not covered above?      Yes       No
7. Has your weight changed by more than 3.5kg/7lbs in the last year? If "yes" give change details.      Yes       No

**FEMALES ONLY**

8. To the best of your knowledge and belief, you had:
- a. Any disorder of menstruation, pregnancy or female organs (including breasts)?      Yes       No
- b. Birth by caesarean section?
- c. Are you pregnant? If so, how many months?

**FAMILY HISTORY**

		Yes	No		
9.	Has any member of your family had diabetes, tuberculosis, cancer, high blood pressure, heart or kidney disease, blood disorder or mental illness.	<input type="checkbox"/>	<input type="checkbox"/>		
10.	<b>Age, if alive</b>	<b>State of health</b>	<b>Age at death</b>	<b>Cause of death</b>	
	Father	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Mother	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Brother/s	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Sister/s	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

I agree that this application and others already completed shall be the basis of the contract which will commence on the acceptance of this application by GLICO, on its normal terms and conditions. I have read over the replies to all questions in this application form and declare that, to the best of my knowledge and belief, all information given are TRUE and COMPLETE.

Date..... Applicant's signature.....

**Witness**

Name..... Date..... Signature.....

## Medical Examiner's Report

We would be grateful, if you could examine the bearer, on the medicals ticked below and kindly report your findings in the summary and opinion section above.

<input type="checkbox"/>	Medical Examination	<input type="checkbox"/>	Full Blood Count	<input type="checkbox"/>	E.C.G.	<input type="checkbox"/>	Microscopic Urinalysis
<input type="checkbox"/>	Renal function	<input type="checkbox"/>	Lipid profile	<input type="checkbox"/>	Liver function test	<input type="checkbox"/>	Fasting blood sugar
<input type="checkbox"/>	Chest X-ray	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Hepatitis B profile		

### SUMMARY AND OPINION

1a. How long have you known the proposed insured? Years..... month.....

b. Are you related? Yes  No

Actual weight/measurements (no estimates)

c. Height (in shoes)

.....ft .....ins

Chest (Forced Inspiration & Expiration)

.....ins .....ins

Weight (in normal clothing)

.....kg/lbs

Abdomen at Umbilicus

..... ins

d. Is the applicant's appearance unhealthy or older than given?

Yes  No

2. Does examination reveal or suggest any abnormality of  
(Please tick applicable items and give details)

	Yes	No
a. Eyes, ears, nose, mouth, pharynx?	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin, including surgical scars, lymph nodes, varicose veins or peripheral arteries?	<input type="checkbox"/>	<input type="checkbox"/>
c. Nervous system (include reflexes, gait, paralysis)	<input type="checkbox"/>	<input type="checkbox"/>
d. Respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
e. Abdomen?	<input type="checkbox"/>	<input type="checkbox"/>
f. Genitourinary system? (include prostate)	<input type="checkbox"/>	<input type="checkbox"/>
g. Endocrine system (include thyroid and breasts)?	<input type="checkbox"/>	<input type="checkbox"/>
h. Musculoskeletal system (include spine, joints amputations and deformities)?	<input type="checkbox"/>	<input type="checkbox"/>

3. Are there any hernias?

<input type="checkbox"/>	<input type="checkbox"/>
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4. Do you know or suspect anything adverse about the proposed insured's health, character, mentality, habits or morals not covered above? (a confidential report may be sent to the Glico's Medical Director)

Yes

No




5. URINALYSIS (Chemical)

Specific Gravity	Albumin	Sugar	Other findings or comments
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

6. Blood pressure (If over 140/90 record 3 readings)

7.

SYSTOLIC	<input type="text"/>	<input type="text"/>	<input type="text"/>
DIASTOLIC 4th change in sound	<input type="text"/>	<input type="text"/>	<input type="text"/>
5th Disappearance of sound	<input type="text"/>	<input type="text"/>	<input type="text"/>

PULSE	<input type="text"/>
RATE	<input type="text"/>
IRREGULARITIES PER MINUTE	<input type="text"/>

SUMMARY AND OPINION

I consider the person examined (please tick appropriate classification)

- A. Acceptable at normal rate
- B. Acceptable with a small extra premium
- C. Acceptable with a substantial extra premium
- D. Not acceptable on any terms

  
  
  


Name and address of hospital.....

Name of medical doctor.....

Tel. no. ....

Email address.....

Signature .....

Official stamp .....

Date .....