



Website:www.provident-gh.com E-mail:admin@provident-life.com

**PROPOSAL FORM 50 PLUS !  
PROVIDENT SECURITY PLAN**

POLICY NO:

AGENTS NO:

ADDRESS:

KINDLY COMPLETE THIS APPLICATION IN BLOCK CAPITALS USING BLACK INK

APPLICANT'S SURNAME:	SEX:	M	F	DATE OF BIRTH	OCCUPATION
FIRST NAME/S:				: : : : : :	

FULL NAME OF BENEFICIARY:	DATE OF BIRTH
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RELATION TO APPLICANT (LIFE ASSURED)  
ADDRESS:

LIFE ASSURED	Age <input type="text"/>	SEX:	M	F	DATE OF BIRTH	SUM ASSURED
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FULL NAME OF LIFE ASSURED				: : : : : :	GH¢
ADDRESS:					

E-mail: \_\_\_\_\_ Tel: \_\_\_\_\_

Is there any fact or circumstance affecting your eligibility for assurance which ought to be stated? .....

What payment have you made with this proposal? GH¢.....

**MEDICAL HISTORY**

Do you suffer from any physical impairment, current illness or are you taking any health drug, having Medical advice, treatment, test or investigations? YES  NO   
If yes state the ailment and give details

**FAMILY HISTORY**

	IF LIVING! AGE(S)	IF DEAD	AGE(S) AT DEATH
Father : No.....	<input type="text"/>	<input type="text"/>	.....Cause of death.....
Mother : No.....	<input type="text"/>	<input type="text"/>	.....Cause of death.....
Brother(s) : No.....	<input type="text"/>	<input type="text"/>	.....Cause of death.....
Sister(s) : No.....	<input type="text"/>	<input type="text"/>	.....Cause of death.....

I declare and warrant that the above declaration in all respects complete and true and I understand that the same, together with the proposal and declaration and any other declaration or declarations signed or to be signed relative to application, will form the basis of the contract of assurance in pursuance of such application. I further, irrevocably authorize any doctor, hospital, medical institution or any other person to disclose any information, which may be relevant to my physical or mental, including the results of any test, and I agree that this authorization shall remain in force after my death.

DATE: \_\_\_\_\_ SIGNATURE OF APPLICANT/LIFEASSURED \_\_\_\_\_