ProvidentLife

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

FUNERAL EXPENSES POLICY PROPOSAL FORM

AGENTS NO:

POLICY NO:													

ADDRESS:

KINDLY COMPLETE THIS APPLICATION IN BLOCK CAPITALS USING BLACK INK

APPLICANT'S SURNAME:	SEX	M	F	DATE OF BIRTH	SUM ASSURED
FIRST NAME/S:				: : : : :	¢

NAME OF BENEFICIARY:	DATE OF BIRTH
RELATION TO APPLICANT:	: : : : :

PULL NAME/S OF SPOUSE:	SEX:	M	F	DATE OF BIRTH	SUM ASSURED
				: : : : :	¢

FULL NAME/S OF APPLICANTS CHILD/CHILDREN	SEX:	M	F	DATE OF BIRTH	SUM ASSURED
				: : : : :	¢
				: : : : :	¢
				: : : : :	¢
				: : : : :	¢
				: : : : :	¢
				: : : : :	¢

FULL NAME/S OF PARENTS OF APPLICANTS: (MAX: 4)	SEX:	M	F	DATE OF BIRTH	SUM ASSURED
				: : : : :	¢
				: : : : :	¢
				: : : : :	¢
				: : : : :	¢

Do any of the lives to be assured suffer from any disability or congenital disorder, or have they had tests, including ECG, X-Rays or blood tests, operations or been hospitalised, taken medication for medical or any other reasons, or consulted any medical practitioner for any reason, and ever received medical advice counselling, tests for AIDS or any AIDS related disorder, or received treatment for any sexually transmitted disease including Hepatitis B?

YES	NO

If you answered "YES" to any of the above, please provide details below

LIVES TO BE ASSURED	FIRST CONSULTATION	NATURE, DURATION AND RESULTS OF EXAMINATION, CONSULTATIONS AND TREATMENT	LAST CONSULTATION	NAME AND ADDRESS OF DOCTOR, SPECIALIST OR HOSPITAL

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 authorise 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 authorisation shall remain in force after my death.

DATE: _____ SIGNATURE OF APPLICANT/LIFE ASSURED _____