

**PART 1
OF APPLICATION
FOR INSURANCE IN**

An insurance agent who assists an applicant to complete an application or proposal form for insurance shall be deemed to have done so as the agent of the applicant.

**AFRICAN ALLIANCE INSURANCE
PLC.** RC2176

APP. NO.....
NAME AND CODE
NAME OF AGENCY

S/N: /12

Proposal No.....

**This Proposal Form should be completed in Proposer's Handwriting in BLOCK LETTERS
PLEASE ANSWER EACH QUESTION FULLY.**

1. SURNAME.....
OTHER NAMES.....
Maiden Name if married woman.....
Residential Address.....
Employer's Name.....
Office Address.....
Postal Address.....
Valid Means of I.D. (e.g Drivers License National I. D Card Int. Passport or Voters Card)
Precise Occupation (please give full details).....
Married, Single or Widowed..... Place of Birth.....
Source of Finance (Proof of Age to be submitted)
Age next Birthday..... Years..... Date of Birth.....
Tel:..... GSM..... E-mail:.....

2. Proposed Sum Assured N.....
Class of Assurance..... with profits
Duration of Assurance..... years
Is the premium to be paid yearly, half-yearly, quarterly or monthly.....
Commencement date of Assurance.....
Beneficiary (print) include address if not same as 1 above
Full Name Tel: Age Home Address Relationship E-mail Address
Primary.....
Contingent.....

Except as otherwise directed: (A) the proceed are to be divided equally among all persons who are named as primary beneficiary and who survive the insured, But if none survive, equally among all persons who are named as contingent beneficiary and who survive the insured and (B) the right to change the beneficiary is reserved.

DO YOU DESIRE ANY ADDITIONAL BENEFIT? Tick appropriate one

- (a) Double Indemnity
- (b) Disability Waiver of Premium
- (c) Family Income Benefit (What percentage?) 10 15 20
- (d) ARE THERE ANY CIRCUMSTANCES, Particularly Occupational which involve an additional risk of death by accident?.....

FOR AIIP ONLY

- A. Regular Premium
- B. Premium payable Annually Semi - Annually Monthly
- C. Guaranteed Death Benefit

DECLARATION

I, the undersigned, whose life is proposed for assurance, do hereby declare that the statements in this proposal are true and complete and hereby consent to the Company seeking any information it deems necessary from any hospital, clinic or doctor who has at any time attended to me seeking information from my bankers and employers and from any insurance Company to which a proposal for the assurance of my life has been made and I authorize the giving of such information.
I further agree that this proposal and Declaration and the statements made above or to the Medical Examiner acting for the Company shall be the basis of the proposed contract between the Company and myself, that if anything contrary to the truth be stated or if any information which ought to be made known to the Company with reference to the Proposed Assurance to be withheld or, concealed and policy which may be granted in pursuance of this proposal Shall be null and void.

Dated this..... Day of20.....

Agency Manager Signature

Signature of Applicant if other than proposed insured

African Alliance Ins Plc.

RC 2176

112, Broad Street, Lagos.
Post Office Box 2276, Lagos.
TEL: 01-8964888, 7433471.

E-MAIL: info@africanallianceinsurance.com Website: www.africanallianceinsurance.com

Received from..... who has applied to
African Alliance Ins Co. Ltd for insurance in the amount of
.....on the Plan
The sum of..... offered as a binding deposit on account
of the first premium, in accordance with the conditions stated on the back hereof.
Dated at..... this..... day of.....20.....

S/N: /12

This receipt is to be completed and given to the applicant only when a binding deposit, made in accordance with the rules of the Company has been paid with the application.

Unless such payment is made this receipt must not be detached.

The amount for which this receipt is given MUST appear in the application in answer to question No. 19.

Agent's Name

Agent's Code

Agent's Signature

NOTICE TO APPLICANT: We accept cheques or cash to a limit of N5,000 for Initial Premium Payment. However for renewal payments please pay by cheque or Direct Debit Mandate (DDM). This receipt shall not be binding upon the Company for any payment by cheque or other form of remittance unless such remittance is received by the Company. If you do not hear from the Company regarding your proposed Insurance within ninety days, notify African Alliance Ins. Plc at the nearest Local Office or Head Office.

*Kindly demand for Company's receipt for subsequent payments made through Agents as the Company will not be liable for claims made without evidence of official and stamped receipt.

4. MEDICAL ATTENTION DURING THE PAST FIVE YEARS (a) Name and address of your doctor HAVE YOU IN THE PAST FIVE YEARS CONSULTED: (b) Your Doctor? (c) Any other Doctor? (Please give name and address).....	For how long have you been consulting the doctor?Years		
	YES or NO	Date	REASONS FOR THE CONSULTATIONS
5. Has any proposal on your life ever been made If so, state (a) the name of the office (b) the date of the proposal and (c) whether it was accepted at ordinary terms, special terms postponed or declined			(a) (b) (c)
6. Have you any intention or expectation: (a) of becoming a member of the Armed Forces? (b) of engaging in aviation (other than as a fare-paying passenger on a regular route) If so, give full particulars			(a) (b)
7. Is there any other fact or circumstances affecting your eligibility for assurance which ought to be stated? If yes give details			
8. To whom is the Sum Assured payable other than self: (a) Legal Estate (b) Name beneficiary (Please state full names, date of birth and relationship)			(a) (b)
9. FAMILY HISTORY OF THE LIFE PROPOSED Has any of your near relatives, i.e. parents, brothers or sisters, wife (or husband) or children suffered from - DIABETES, STROKE, HEART DISEASE, CANCER, TUBERCULOSIS OR MENTAL ILLNESS	Yes or No	Relationship	Details (Mentioning condition and approximate age at onset)
10. PHYSICAL DESCRIPTION: (a) What is your Height?.....(b) What is your Weight?..... (Accurate Up-to-date figures should be given in ordinary indoor clothing and outdoor footwear)			
Have you any bodily infirmity or deformity (for example, Rupture or Herina, Varicose Veins)?	Yes or No		Full Details (s)
11. HABITS (a) Do you now take or have been taking any medicines regularly (particularly stimulants, antibiotics, sleeping pills or sedatives) (b) How many cigarettes and/or cigars do you smoke daily? (c) What is your average daily consumption of alcohol?.....	Yes or No		Full Details (s)
12. WHAT SPECIAL INVESTIGATIONS AND/OR TREATMENTS HAVE YOU HAD (a) X-Ray Examination (Chest, Barium Meal etc)? (b) E. C. G.? (c) Any other Hospital or Pathological investigation and/or Treatment?	Yes or No	Date	Details (including part of body and result)
13. ILLNESS AND AILMENTS: HAVE YOU EVER SUFFERED OR DO YOU NOW SUFFER FROM? (a) Epilepsy, Fits or Fainting attacks or other Mental disturbances? (b) Tuberculosis, Asthma, persistent Cough, Pneumonia or any other Chest Disease? (c) Rheumatic Fever, Hypertension, Circulatory or Hear trouble? (d) Indigestion, Gastric or duodenal Ulceration, Jaundice, Gall Bladder Complains, Diabetes, Mellitus? (e) Nervous disease or nervous breakdown, Frequent Headaches? (f) Any Infection of the kidney, Urinary or Genital Organs, Renal Stones, Difficult or Painful Urination, Bloody Urine? (g) Syphilis, Gonorrhoea or other Venereal Diseases?	Yes or No	Date	Details (including duration and treatment given)
14. FOR FEMALES ONLY (a) Have you suffered from any Disease of the Breast or Sexual Organ? (b) Have you had any premature Birth, Miscarriage or Still Birth? (c) Are you now pregnant? (If so when due)?	Yes or No	Date	Full Details (s)
15. HAVE YOU EVER HAD: (a) Unexplained Recurrent or Persistent fever or Skin disorder? (b) Persistent or Unexplained night Sweats? (c) Unexplained Weight Loss? (d) Unexplained infections or Swollen Glands? (e) Chronic or recurrent diarrhoea? (f) Persistent Cough? (g) Hepatitis B or any Sexually transmitted disease Including genital sores or discharge?	Yes or No	Date	Full Details (s)
16. Have you ever been refused as a blood donor?	Yes or No		Give Details.....
17. Have you ever received any blood transfusions within the last five years? Please give full details of all positive answers.....	Yes	No	
18. GENERAL Is there any other fact circumstance or information regarding your health and way of living which was not specifically mentioned above?			
19. Amount of Deposit paid N	Cash/Cheque		
Receipt No.....	Date.....		