MLife
MADISON LIFE INSURANCE COMPANY ZAMBIA LTD
Protecting you all the way

Head Office
Dar-es Salaam Place, Mlife Building,
South of the Main Post Office, Cairo Road
P O Box 33384, LUSAKA
Tel: +260-211-233112 Fax: 233936
Email: mlife @mlife.co.zm
www.mlife.co.zm

FORM 1

Serial No.

PROPOSAL / TERMS AND CONDITIONS FOR MADISON LIFE ASSURANCE POLICIES

This Form should be completed in the Proposer's own handwriting in BLOCK LETTERS. PLEASE ANSWER EACH QUESTION FULLY. IT IS NOT SUFFICIENT TO PUT A "DASH"

AGENCY DETAILS (OFFICIAL USE ONLY)

Agency Code Number			Submitting Office		Branch Office Code No.
Signature of Agent		Date:	Team Code Number		
Inside Staff if any			Sales Representative (Name)		
Staff Number			Office Yearly Premium (OYP)		

Type of Policy: 1) Baby Present 2) Endowment, 3) Cash Benefit Plan, 4) Whole Life, 5) Enhanced Whole Life and 6) School Fees.

Section 1: NAME OF LIFE ASSURANCE POLICY BEING PROPOSED:-

1)	**2)**	**3)**

Do you have any Life Policy with MLife?

YES ☐ **NO** ☐

If Yes, Please name the Policy/ies below:-

1)	**3)**
2)	**4)**

Section 2: PERSONAL DETAILS OF PROPOSER (life Assured):-

Surname of Proposer **(Tick as applicable)**	Mr ☐	Mrs ☐	Miss ☐	Other					
First Name									
Other Initials					Gender (Tick as applicable)	F ☐	M ☐		
Maiden Name									
Date of Birth			Place of Birth						
Marital Status **(Tick as applicable)**	Married ☐	Single ☐	Divorced ☐	Widowed ☐					
Name of Spouse									

Residential Address	**Postal Address**	**Work Address**

Type of I.D	NRC No.		Passport No.	
Preferred Contact: Phone No.				
Work Phone No.		Home Phone No.		
WhatsApp No.		Email Address		
Preferred Methods of Communication **(Tick as applicable)**	**WhatsApp** ☐	**Telephone** ☐	**E-mail** ☐	**Letter** ☐
Occupation				
Employer's Name		Employee No.		
Gross Monthly Income (ZMW)		Earnings in Foreign Currency (USD, Pound Sterling, Rand etc.)		

Section 3: PROPOSER/PREMIUM PAYER DETAILS (TO BE COMPLETED IF DIFFERENT FROM LIFE ASSURED)

Surname of Proposer/Premium Payer **(Tick as applicable)**	Mr ☐	Ms ☐	Mrs ☐	Other			
First Name					Other Initials		
Maiden Name					Gender **(Tick as applicable)**	F ☐	M ☐
Date of Birth		Place of Birth					
Marital Status (PleaseTick)	**Married** ☐	**Single** ☐	**Divorced** ☐	**Widowed** ☐			
Type of I.D	NRC No		Passport No				
Contact: Cell Phone No							

Residential Address	**Postal Address**	**Work Address**

Work Phone No.		WhatsApp Number	
Home Phone No.		Email Address	

Preferred Methods of Communication ***(Please Tick)***	**WhatsApp**		**Telephone**		**E-mail**		**Letter**

Occupation			
Employer's Name		Employee No.	
Gross Monthly Income (ZMW)		Earnings in Foreign Currency (USD, Pound Sterling, Rand etc.)	

Section 4: LIFE ASSURED'S PERSONAL MEDICAL ATTENDANT'S DETAILS

Medical Institution / Hospital			
Doctor's Name		Initial (s)	
Last Consultation	DD MM YYYY		
Type of Doctor (eg General Practitioner, Specialist Physician, Gynecologist, Ear-Nose-Throat Specialist etc)			
Doctor's Address			

Section 5: LIFE COVER POLICY DETAILS:-

				ESCALATION PERCENTAGE		
POLICY TYPE	**TYPE OF RIDER**	**PROPOSED SUM ASSURED / ANNUITY AMOUNT**	**PROPOSED POLICY TERM/ PREMIUM CEASING AGE**	**% OF PREMIUM**	**% OF S/A**	**PREMIUM**
BABY PRESENT		K				K
RIDER 1		K				K
RIDER 2		K				K
RIDER 3		K				K
INSURANCE LEVY @ 3%						K
POLICY FEE						K
				SUB TOTAL		K
	TYPE OF RIDER	**PROPOSED SUM ASSURED**	**PROPOSED POLICY TERM**	**% OF PREMIUM**	**% OF SUM ASSURED**	**PREMIUM**
ENDOWMENT/ CASH BENEFIT		K				K
RIDER 1		K				K
RIDER 2		K				K
RIDER 3		K				K
INSURANCE LEVY @ 3%						K
POLICY FEE						K
				SUB TOTAL		K
	TYPE OF RIDER	**PROPOSED SUM ASSURED**	**PREMIUM CEASING AGE**	**% OF PREMIUM**	**% OF SUM ASSURED**	**PREMIUM**
WHOLE LIFE/ ENHANCED WHOLE LIFE		K				K
RIDER 1		K				K
RIDER 2		K				K
RIDER 3		K				K
INSURANCE LEVY@ 3%						K
POLICY FEE						K
Please tick Premium Ceasing Age						
				SUB TOTAL		K
	TYPE OF RIDER	**PROPOSED SUM ASSURED**	**PROPOSED POLICY TERM**	**% OF PREMIUM**	**% OF SUM ASSURED**	**PREMIUM**
SCHOOL FEES		K				K
RIDER 1		K				K
RIDER 2		K				K
RIDER 3		K				K
INSURANCE LEVY @ 3%						K
POLICY FEE						K
				SUB TOTALS:		K
				GRAND TOTALS:		K

Lien Option	Yes		No	
Medical	Yes		No	

NOTE:

- MLife reserves the right to adjust the sum assured in line with the premium being paid.
- Where a premium escalation option is chosen, premium increases will be automatically effected. The increase of the sum assured is always 60% of the percentage of the premium increase.

Indicate Cash and Security Benefit as a % of sum assured (5%, 10%, 15% or 20%) ☐

Note: Premium escalation does not apply to Cash and Security Benefit Rider.

Permanent Disability Rider under whole life, Premiums are payable to age 50 yrs, ☐ 55yrs ☐ or 60 yrs ☐

Tick type of Permanent Disability Rider; Inability to perform any occupation ☐ Or Inability to perform own or similar occupation ☐

Section 6: PREMIUM PAYMENT DETAILS

PAYMENT METHOD *(Please Tick where applicable)* ☐ **STOP ORDER** ☐ **DDACC** ☐ **CASH**

Note: Monthly premium payment frequency is not allowed under cash payment method.

PAYMENT FREQUENCY *(Please Tick where applicable)*

Monthly ☐ Quarterly ☐ Half Yearly ☐ Annually ☐ Single Premium ☐

STOP ORDER	EMPLOYER	EMPLOYEE NUMBER	DEPARTMENT NUMBER

DDACC	Bank Name	Branch Name	Sort Code	Account Number

I,…….. request Madison Life Insurance Company Zambia Limited to arrange with my bank or employers to collect premiums of K…….. as quoted in the section above, payable in terms of the policy provisions against my bank account or monthly salary.

The first debit/deduction is to be effected on D D M M Y Y Y Y

Signature ……..…… Date……

Section 7: CASH BENEFIT PLAN

Policy term can be 10, 15 or 20 years. The Cash benefit payable is fixed at 20% of the basic sum assured. The benefit is payable after every five years for the duration of the policy. Premium Escalation Rider is optional at 10%, 20% and 30%. Premium increases can be effected after every five years.

Section 8: BABY PRESENT AND SCHOOL FEES APPLICANTS PLEASE COMPLETE THE FOLLOWING

NAME OF CHILD/BENEFICIARY	DATE OF BIRTH	PREMIUM PAYMENT PERIOD	SCHOOL FEES PAYMENT %	RELATIONSHIP TO LIFE ASSURED	SEX
					M ☐ F ☐

Other than Baby Present and School Fees products, provide the beneficiaries below. If beneficiaries are more than four (4) attach a separate list.

S/N	Name(s) of Beneficiary(ries)	Date of Birth	Relationship	% of Total Benefits
1				
2				
3				
4				
			Total	**100%**

Section 9: MEDICAL HISTORY – STRICTLY PRIVATE AND CONFIDENTIAL

Section 9.1: PERSONAL STATEMENT OF THE LIFE TO BE ASSURED

	PLEASE TICK	YES	NO
1	Do you intend living outside Zambia? If yes please give details:……..……...……		
2	Have you ever been or are you likely to be employed or engaged in: a. Any Branch of the mining industry (surface or underground) if yes please complete mining questionnaire.		
	b. Aviation other than as a fair paying passenger? If Yes, please complete aviation questionnaire.		
	c. The liquor trade. If so please give details: ……...		
	d. Any Hazardous pursuit? If so, please give details:……....		
3	Has any application for assurance or disability benefits or for membership of a retirement annuity fund on your life to this or any other life office been declined, deferred or accepted on special terms? If so please give details: ……		
4	Is an application for assurance or for membership of a retirement annuity fund on your life now being considered by MLife or any other life office? If so, please give details:……..……		

Section 9.2: LIFE ASSURED'S PERSONAL MEDICAL STATEMENT

A	MEDICAL HISTORY – HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING: Please Tick	YES	NO
1	Disorder of the heart e.g rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath, palpitations etc?		
2	High blood pressure varicose veins, disease of the blood vessels or circulatory disorder, etc?		
3	Respiratory or lung trouble e.g asthma, bronchitis, persistent cough, tuberculosis, pneumonia etc?		
4	Disorder of the digestive system, gall bladder or liver e.g actual or suspected gastric or duodenal ulcer, recurrent indigestion, hiatus hernia, Persistent diarrhea, hepatitis, gallstones etc?		
5	Disease or disorder of the kidneys, bladder or reproductive organs, protein in urine, stones, abnormal pregnancy, prostatitis, STD, urethral discharge, cancroid, urethritis, genital sores or HIV infection etc?		
6	Nervous or mental complaint e.g. epilepsy, blackouts, paralysis, anxiety state or depression etc?		
7	Ear, nose and throat disorder, e.g ear discharge, defective vision, recurrent tonsillitis, thrush, deafness, recurrent sores etc?		
8	Diabetes, sugar in urine, thyroid, or other glandular or blood disorder etc?		
9	Cancer, growth or tumor of any kind etc?		
10	Any tropical disease. e.g malaria or bilharzia etc?		

11	Herpes zoster (shingles) or herpes simplex?		
12	Do you or have you ever had any other illness, operation or an accident?		
13	Have you during the last five years consulted a doctor, any hospital or specialist for any other reason or undergone any medical investigation including ECG's, X-ray or any other tests?		
14	Are there any other circumstances however trivial which may affect the assessment or the risk under the proposed assurance?		
	FOR FEMALE APPLICANTS ONLY		
15	To the best of your knowledge have you ever had menstrual disorders?		
16	Have you had any premature delivery, miscarriage or still birth?		
17	Are you pregnant? (If so, what is the delivery date)?		

If you have answered 'Yes' to any question in Section 9.2 above, please provide full treatment details under Section B below.

B TREATMENT DETAILS

Question No.	Nature of Complaint or symptoms	Date	Medicine used for treatment and duration	When did you last have symptoms?	Name and address of attending doctor or hospital.

Section 9.3: PHYSICAL DESCRIPTION

a	**Height (without shoes in cms)**		**Weight (clothed) Kg)**		**Measured and weighed**	**Yes**		**No**	
b	**Has your weight altered by more than 5 kilograms over the past year? If yes, please state by how much?**					**Yes**		**No**	

Section 9.4: HABITS

Do you consume or have consumed any of the following

Substance Consumed	Yes/No	Quantity/Day	Quantity	No. of Years
Tobacco	Y/N	Cigar/Cigarette	Quantity/Day	
Alcohol	Y/N	Beer/Win/Hard Liquor	Quantity/Day	
Any Narcotics	Y/N			

Section 9.5: FAMILY HISTORY

		If Living	If deceased	
Relationship	**Age(s)**	**Please state health condition of each family member**	**Age(s) at death**	**Cause of Death**
Father				
Mother				
No. of Brothers				
No. of Sisters				

Declaration:-

I, the undersigned, have received, read, understood and accepted the terms and Conditions under this policy.

Signature of Proposer		**Signature of the Witness**	
Signature of the Life Assured, if different from the Proposer		Place:	
Place:		Date:	
Date:			

Declaration by sales representative / Staff: I _____ (Name of the sales representative) have explained the terms and conditions under this policy to the proposer (Life Assured.)

Signature of the sales representative:.....

Signature of Team Leader / Regional Manager: .....

Place:..... Date:.....

Notes;

(i) The Company is only bound by documents bearing the signature of the Managing Director or anybody authorized to sign on his/her behalf

(ii) The Company would not be on risk until the proposal has been accepted in writing and the first premium received at Company's Head Office

Section 11: UNDERWRITING DETAILS (OFFICIAL USE ONLY)

Accepted		Declined		Deferred	
Underwriter's Comments:					