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

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

Proposal No: ....

Madison Family Funeral Expense, Personal Pension Plan Application Form

WRITE NAME OF LIFE ASSURANCE POLICY BEING PROPOSED

Section 1: PERSONAL DETAILS OF LIFE TO BE ASSURED

LIFE ASSURED

Are you an existing MLife Client?	Yes		No		Is this your first policy with MLife?	Yes	No
Title	Mr	Mrs	Miss	Other	(e.g)Professor, Reverend etc		
Surname							
First name(s)					Other Initials		
Date of Birth	/ /		Gender	M	F	Place of Birth	
Age Next Birthday			Age Last Birthday				
Maiden Name							
Marital Status	Married		Single		Widowed		
Name of Spouse							
Residential Address			Postal Address		Work Address		
Type of I.D.	Passport Number		NRC Number	/ /			
Telephone No			Mobile No.				
Fax No.			Home No.		Work No.		
E-mail Address							
Preferred Methods of Communication (Please Tick)	Fax		Letter		Telephone		E-mail
Employer' Name			Occupation				
Occupation Class/Code			Employee Number				
Gross monthly income (ZMK)			Earnings in foreign currency (USD, Pounds Sterling, Rand etc)				

Section 2: PROPOSER DETAILS (TO BE COMPLETED IF DIFFERENT FROM LIFE ASSURED)

PROPOSER

Title	Mr	Mrs	Miss	Other	(e.g) Professor, Reverend etc		
Surname							
First name(s)					Other Initials		
Date of Birth	/ /		Gender	M	F	Place of Birth	
Age Next Birthday			Age Last Birthday				
Maiden Name							
Type of I.D.	NRC Number	/ /	Passport Number				
Marital Status	Married		Single		Widowed		
Telephone Number	Mobile		Work				
E-mail Address							
Residential Address			Postal Address		Work Address		

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

PREMIUM PAYER													
Title		Mr		Mrs		Miss		Other		(e.g) Professor, Reverend etc			
Surname													
First Name(s)													
Also Known as										Other Initials			
Date of Birth	/ /			Gender		M		F		Place of Birth			
Type of I.D.	NRC Number									Passport Number			
Telephone Number	Mobile									Work			
E-Mail Address													

Section 4: PAYMENT DETAILS

PAYMENT METHOD	STOP ORDER		DDAC		CASH	
PAYMENT FREQUENCY	Monthly	Quarterly	Half Yearly	Annually	Single Premium	
STOP ORDER	Employer		Employee Number		Dept Number	
DDAC	Bank Name		Branch and Sort Code		Account Number	

I, the undersigned request Madison Life Insurance Company Zambia Limited, to arrange with my bank or employers to collect premiums payable in terms of the policy provisions (as they may be amended from time to time) against my bank or monthly salary.

The first debit/deduction is to be effected on the .....day of.....and the .....day of each month thereafter. Signature..... Date.....

(Only to be completed in handwriting of the proposer or life assured, whichever is applicable.)

Section 5: PERSONAL MEDICAL ATTENDANT'S DETAILS

Doctor's Surname/Hospital													
Approximate Date of last Consultation	/ /									Type of Doctor	(e.g General Practitioner, Specialist Physician, Gynecologist, Ear-Nose-Throat Specialist etc).		
Doctor's Address													

Section 6: DETAILS OF ASSURANCE

	PRODUCT TYPE	SUM ASSURED / ANNUITY AMOUNT	POLICY TERM/PREMIUM CEASING AGE	Escalation Percentage		PREMIUM
				% OF PREMIUM	% OF S/A	
BASIC PRODUCT		K				K
RIDER 1		K				K
RIDER 2		K				K
RIDER 3		K				K
RIDER 4						K
						K
					LOADING	
					TOTAL PREMIUM	

Section 6.1:

Where the choice of product type is personal pension plan provide the beneficieries below. If beneficieries are more than four (4) please provide a seperate list.

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

Section 7: MEDICAL HISTORY - STRICTLY PRIVATE AND CONFIDENTIAL

Proposer or Principal Life							
Spouse							
Child 1							
Child 2							
Child 3							
Child 4							
Child 5							
Child 6							
Dependants 1							
Dependants 2							
Parent 1							
Parent 2							
Parent in Law 1							
Parent in Law 2							
						TOTAL	

Cash Back option; Required ☐ or Not Required ☐

Section 8.: PHYSICAL DESCRIPTION

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

Section 9A: HABITS

1	What kind and quantity of alcohol do you consume per day, per week?.....		
2	Have you taken more in the past?	Yes ☐	No ☐
3	How much and what do you smoke per day?.....		
4	Have you ever received medical advice to reduce or discontinue your liquor or tobacco consumption? If "YES" please give full details in section 9B below	Yes ☐	No ☐
5	Have you ever taken drugs, medicines or tranquilizers prescribed by a medical practitioner for more than two weeks? If yes, please give full details in section 9B below	Yes ☐	No ☐
6	Have you taken drugs other than for medicinal purposes?.....If "YES" please give full details in section 9B below	Yes ☐	No ☐

If you have answered 'Yes' to any question in Section 9A above, please provide full treatment details under Section 9B below.

Section 9B: TREATMENT DETAILS

Details: if the space provided is insufficient for full details please give remaining details on a separate but similar schedule					
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 10 : FAMILY HISTORY

		If living	If deceased	
Relation	Age	Please state health condition	Age at death	Cause of Death
Father				
Mother				
No. of Brothers				
No. of Sisters				

Section 11: AGENCY DETAILS (OFFICIAL USE ONLY)

Submitting Office	
Team Number	
Sale Representative	
Office Yearly Premium (OYP)	
Agency Code Number	
Inside Staff if any	
Staff Number	

DECLARATION

I, the undersigned whose life is proposed for assurance do hereby declare that the statements in this proposal are true and complete and I 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 or 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 statement made above to the Medical Doctor acting for the company shall be the basis of the proposed contract between the company and myself, that if anything contrary to the truth, the stated or if any information which ought to be known to the company with reference to the proposed assurance be withheld or, concealed, any policy which may be granted in pursuance of this proposal shall be null and void.

Date.....this.....Day of .....20.....

Signatue of life to be assued.....

Signatue of witness.....

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 12: UNDERWRITING DETAILS (OFFICIAL USE ONLY)

Accepted	☐	Declined	☐	Deferred	☐

Underwriter's comments:

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