

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)
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Do you have any Life Policy with Mlife?

YES		NO	
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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 (Please Tick)					Married					Single					Divorced					Widowed			
Type of I.D	NRC No.					Passport No.																	
Contact: Cell Phone No																							
Residential Address					Postal Address					Work Address													

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** **PAYMENT FREQUENCY** (Please Tick where applicable)
Note: Monthly premium payment frequency is not allowed under cash payment method.

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

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, canceroid, 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:					