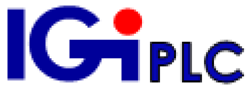

Industrial and General Insurance Plc

Plot 741, Adeola Hopewell Street, V/Island, Lagos.
P.M.B. 80181, Victoria Island, Lagos.
Tel: +234-1- 6215010-4, Fax: +234-1-2621146
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LIFE ASSURANCE PROPOSAL FORM (INDIVIDUAL)

IMPORTANT: Kindly complete this form carefully. Failure to disclose all facts likely to influence the acceptance and assessment of this proposal could affect settlement of claims or invalidate your policy. If you are aware of any fact likely to influence the proposal kindly, disclose them in the space provided at the end of this proposal. If any answer has been written by any other person(s), such person(s) shall for that purpose be regarded as the agent of the proposal and the agent(s) Insurer.

PERSONAL DETAILS

PLEASE COMPLETE IN BLOCK LETTERS

Proposer: ______ ______ ______
Surname *Firstname* *Middlename*

Please specify Title Mr ☐ Mrs ☐ Miss ☐ Others ______ Sex: Male ☐ Female ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Date of Birth ______ (dd/mm/yyyy)

Occupation ______ Are you self employed? Yes ☐ No ☐

Resident Address: Line 1 ______
Line 2 ______
Line 3 ______ Town ______ State ______

Postal Address: (if different from above) Line 1 ______
Line 2 ______
Line 3 ______ Town ______ State ______

Telephone Nos. Home ______ Office ______

Mobile / GSM ______ Fax ______

Email ______ Website ______

Wedding Anniversary Date (if applicable) ______

Insurance Required (Dates) From ______ To ______

NEXT OF KIN / EMERGENCY CONTACT

Name ______ Relationship ______

Contact Address: Line 1 ______ Telephone ______

Line 2 ______

Line 3 ______ Town ______ State ______

Marital Status: Single Married Divorced Separated Widowed

For female proper: Maiden Name

Husband's Name if married

Are you pregnant? Yes No If Yes how many months

OCCUPATIONAL DETAILS

i) Exact Nature of Occupation or Business

ii) Employer?

(If self employed describe business or activities)

		Yes	No
(iii)	Have you changed your job in the last 3 years?		
(iv)	Are there any notable accidents and / diseases particularly associated with your occupation?		

(v) How often do you travel? (a) within the country (b) abroad

Give details where question has been answered Yes from 2 (iii) to (v) above

COVER REQUIRED

3. (i) Sum Assured =N=

(ii) (a) Plan of Assurance (b) Term of Assurance (c) Commencement Date
(d) With Profit (e) Without Profit

Note: Bonus on policies is Reversionary

(iii) **Tick Additional (Riders)**
(a) Waiver of premium (b) Accidental Death Benefit

(iv) **(a) Provisional Premium** =N=

(v) (a) Tick frequency of payment: Annually Half Yearly Quarterly Monthly
(b) Method of premium payment Cash Cheque Direct Debit

Medical Details

Name and Address of Personal Physician within the last 3 years

Reason(s) for consultation(s)

Date of last treatment Height Weight

Have you ever suffered/experienced, or been treated for, or told you are suffering from any of the following health conditions? Please, tick Yes or No as appropriate.

	Yes	No
Tuberculosis		
Epilepsy		
Insanity		
Diabetes		
Heart Disease		
HIV/AIDS		

	Yes	No
Paralysis of any kind		
High Blood Pressure		
Surgical Operation		
Cancer		
Any other disease or Medical condition		

If YES, please provide details below

Question No.	Details where question answered YES

(i) Sum Assured =N=

COVER REQUIRED

(ii) (a) Plan of Assurance

(b)Term of Assurance

(c) Commencement Date

(d) With Profit

(e) Without Profit

Note: Bonus on policies is Reversionary

(iii) Tick Additional (Riders)

(a) Waiver of premium

(b) Accidental Death Benefit

(c) Personal Accident Benefit

(iv) (a) Provisional Premium =N=

(b) Payment accompanying this proposal =N=

(v) (a) Tick frequency of payment

Annually Half Yearly Quarterly Monthly

(b) Method of premium payment

Cash Cheque Direct Debit

MEDICAL DETAILS

4. (a) Name and Address of your personal physician within the last 3 years	Reason (s) for consultation	Date of Treatment

(b) Has any of your relatives (i.e. Father, Mother, Brothers, Sisters, Wife, Husband, Uncle, Cousin, Nephew) Ever suffered or now suffering from: (Please, tick YES or NO)

	YES	NO
(i) Tuberculosis		
(ii) Epilepsy		
(iii) Insanity		
(iv) Diabetes		
(v) Heart Disease		
(vi) A.I.D.S		

YES NO

© Have you ever suffered from: (tick as appropriate)

(i) Physical defect or infirmity or any nervous or mental or hearing or sight difficulties

(i) Clinical depression or anxiety or fainting or paralysis of any kind

(i) High blood pressure or heart condition hemorrhoids, varicose veins or other circulatory disorder or rheumatic fever etc?

(i) Any respiratory, urinary or allergic condition or any disorder of the digestive system?

(i) Any special medical investigation e. g X-rays or laboratory test including blood studies?

(i) Any surgical Operation?

(i) If a woman: Any disease of the breast, miscarriage, premature birth, still birth, or nay caesarian operation?

If any question in 4b and 4c has been answer YES, please provide details below

Ques. No	Details where question answer YES

DECLARATION

I / We declare that to the best of my / Our knowledge and believe, the information supplied in this proposal form is true and complete. I / We understand that cover is not effective until acceptance of this proposal is confirmed and payment effected.

Signature of Proposer ___________________________________ Date ___________________

Agent ____________________________________

IMPORTANT NOTICE

Keep a record of all information supplied to us (including copies of letters) as part of this Proposal

A copy of the Completed Proposal form will be supplied on request.

A copy of the policy form is also available on request for verification prior to completion of the Contact.

No Insurance is in force until the proposal has been accepted by the Company and the Premium or Deposit paid except as provided by an official covering note issued by the Company.