Industrial and General Insurance Plc
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SCHOOL FEES INSURANCE SCHEME PROPOSAL FORM (SFIS)

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 _____ Web site _____
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 _____

Exact Nature of Occupation or Business _____

Employer?

Name of child	Date of Birth	Sex	Present Class	School Fees per Term

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		Yes	No
Tuberculosis			Paralysis of any kind		
Epilepsy			High Blood Pressure		
Insanity			Surgical Operation		
Diabetes			Cancer		
Heart Disease			Any other disease or Medical condition		
HIV/AIDS					

If YES, please provide details below

Question No.	Details where question answered YES

DECLARATION

I/We the life/lives to be insured declare to the best of my /our knowledge and belief, that the information given in this proposal form is true and complete. I/We irrevocably authorize any Doctor or other person(s) who may be in possession or acquire any information concerning my/our health to disclose such to the company. I/We declare that this proposal for life insurance is made in good faith and shall be incorporated in and form part of the contract under the normal terms and conditions of the company's Life Assurance Policy

Signature of the Life to be Assured _____ Date _____

Name of Witness _____ Signature _____ Date_____

Name of Agent _____ Signature _____ Date _____

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.