



# FAMILY ETERNITY PLUS APPLICATION

The applicant is hereby notified that, providing false information while completing This proposal form will result in policy cancellation and decline of claim

**METROPOLITAN LIFE**  
Together We Can

PLEASE WRITE CLEARLY USING BLOCK LETTERS AND TICK APPROPRIATE BOX

POLICY NUMBER:

Change of Cover:  Change of Premium Payer:  Additional Lives:  New Business:  Other Alterations:

## A PERSONAL DETAILS

Title:  Surname:  First Names:

Date of Birth:           Place of Birth:  Gender:  M  F

Home Language:  Nationality:

Email Address:  Phone Number:

Home Address:

Postal Address:

TIN Number:           Digital Location Address:

Marital Status: Single  Married  Widowed  Separated  Divorced  Occupation:

Form of Identification: Passport  SSNIT Card  Voter's ID  Driver's License  National ID

Provide Identity Number  *Please, attach copy of identification document*

## B PLAN DETAILS

### Standard Benefit Option

Benefit Options (GHS)	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7
Policy Owner	5,000 <input type="checkbox"/>	7,500 <input type="checkbox"/>	10,000 <input type="checkbox"/>	20,000 <input type="checkbox"/>	30,000 <input type="checkbox"/>	50,000 <input type="checkbox"/>	60,000 <input type="checkbox"/>

### Optional Benefit Options

Benefit Options (GHS)	40 Days Benefit <input type="checkbox"/>	1st Anniversary Benefit <input type="checkbox"/>	Hospital Cash Benefit <input type="checkbox"/>	Savings Benefit <input type="checkbox"/>
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## C FAMILY MEMBERS TO BE INSURED

S/No.	Name	Gender (M/F)	Date of Birth							Relationship	Proposed Sum Assured GHS	Premium GHS	
			D	D	M	M	Y	Y	Y			Y	Standard
1.			D	D	M	M	Y	Y	Y	Y			
2.			D	D	M	M	Y	Y	Y	Y			
3.			D	D	M	M	Y	Y	Y	Y			
4.			D	D	M	M	Y	Y	Y	Y			
5.			D	D	M	M	Y	Y	Y	Y			
6.			D	D	M	M	Y	Y	Y	Y			
7.			D	D	M	M	Y	Y	Y	Y			
8.			D	D	M	M	Y	Y	Y	Y			
9.			D	D	M	M	Y	Y	Y	Y			
10.			D	D	M	M	Y	Y	Y	Y			
11.			D	D	M	M	Y	Y	Y	Y			
12.			D	D	M	M	Y	Y	Y	Y			
MONTHLY RISK PREMIUM													

## D PREMIUM PAYMENT

Monthly Risk Premium: GHS  Savings Premium: GHS  Total Monthly Premium: GHS

### Automatic Inflation Management:(Annual Premium Increase):

Premium Increase Options	10%	20%	30%	40%
Tick Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Mode of Premium Payment: Bank Debit Order  Employer Deduction  Mobile Money  Card Payment

If you ticked Mobile Money, please provide your Mobile Money Number:

## E MEDICAL INFORMATION

1. Do you have any life insurance policy with us? YES  NO  If YES, please provide policy number

2. Has any Life Insurance Company refused your proposal for Life Insurance or accepted with an extra premium or special terms on any of the proposed lives? YES  NO  If YES, please state the reason for refusal

3. Please state your Height  cms and Weight  kgs

4. Are you and any of your proposed family members currently in good health, free from any illness or disease and not undergoing any medical treatment or surgery? YES  NO  **If NO, please provide details:**

Name of Proposed Life	Illness or Injury	Hospital Attended	Duration	Present Condition

**F) BENEFICIARY (IES)**

Name	Gender (M/F)	Date of Birth						Relationship	% of Benefit	Address/Contact Telephone No.	
		D	D	M	M	Y	Y	Y	Y		
		D	D	M	M	Y	Y	Y	Y		
		D	D	M	M	Y	Y	Y	Y		

**G) TRUSTEE (applicable where a named beneficiary is less than 18 years)**

Name	Gender (M/F)	Date of Birth						Relationship	Address	Contact Telephone No.	
		D	D	M	M	Y	Y	Y	Y		

**H) DECLARATION**

- I warrant that the information in this application and in all documents submitted to Metropolitan Life Insurance Ghana Ltd (herein referred to as Metropolitan Life) in connection with it, whether in my handwriting or not, is true, correct and complete and will form the basis of the proposed contract.
- In order to facilitate the assessment of the risks, I irrevocably authorize Metropolitan Life:
  - To obtain from any person, any information which Metropolitan Life deems necessary, and
  - To share with other insurers that information and any information contained in this proposal or in any related contract or other document, either directly or through a database operated by or for insurers as a group, at any time (even after my death or any other Insured Life) and in such detailed, abbreviated or coded form as may from time to time be decided by Metropolitan Life or by the operators of such database.

I understand and accept that my right of privacy and that of the other Insured Lives may be infringed to the extent permitted by me in this authorization and I waive our right to that extent.
- I agree that if any material information concerning the risk on any of the insured lives has not been fully disclosed, or if I have given any untrue, incorrect or incomplete answers, Metropolitan Life reserves the right to cancel our cover and shall forfeit all premiums paid.
- I understand that I am entitled to cancel this application within 30 days from the commencement date of the policy for a refund of all premiums paid, provided that, no claim has been made. Cancellation after the thirty (30) days period shall be subject to surrender conditions. I understand that this right applies also to any application to increase the Funeral Cover on an existing contract and that any refund refers to the difference between old and new premium.
- Replacement of Contract: I understand that it is not in my best interest to replace an existing contract with new contract.
- I agree that if the premium received is less than the agreed premium for the chosen level of cover, should be adjusted to commensurate the premium received.

Signature of Applicant:  or RTP

Date:

**Note:**

- On signing this proposal form, you confirm that any statement that is not in your handwriting is accurate and the information provided is complete.
- Your policy shall come to effect only after this proposal has been accepted and the full payment of first premium.

**I) INTERMEDIARY INFORMATION**

Agency Code:  Name of Financial Consultant (FC):

Branch/Agency:  Zone:  Sector:

Broker/Corporate Agent Name:  Tel:

Signature or RTP:  Date:

I confirm that this application was completed in my presence by the applicant and the premium calculation has been checked by me.

**J) OFFICE USE ONLY**

**1. SALES TEAM MANAGER**

I confirm that the application form and the premium payment mandate is fully completed and I hereby authorise the application to be sent to New Business Solutions for underwriting.

Name:

Signature/RTP:

Date:

**2. NEW BUSINESS SOLUTIONS**

Received By:  Date Received:

Assessed By:  Date Assessed:

Rejected/Deferred  Reason

## PREMIUM DEDUCTION MANDATE

Policy Number:  Commencement Date:

### A PREMIUM PAYER

Title:  Surname:   
First Name:   
Date of Birth:         Mobile No.:   
TIN Number:

### B POLICY DETAILS

Product Name:   
Premium Amount GHS:  Date of First Deduction:          
Frequency: Monthly  Quarterly  Semi-Annual  Annually

#### Automatic Inflation Management (Annual Premium Increase):

Premium Increase	10%	20%	30%	40%
Tick Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### C DEBIT ORDER DEDUCTION:

Account Name:   
Bank Name:  Branch:   
Account Number:  Account Type:   
Please, add a photocopy of your cheque leaflet

I the undersigned authorize Metropolitan Life Insurance Ghana Ltd. to withdraw the amount stated below and if selected, increased yearly as per the Automatic Inflation Management rate from my account as premium for my policy(ies). This request should be done between the 20th of the current month to 15th of the following commencement date stated above continuing till the end of the policy term.

I understand that the withdrawals hereby authorized shall be processed by electronic funds transfer and that details of each withdrawal shall be printed on my bank statement. I also understand that if any Direct Debit Instruction is paid which breaches the terms of this authority, Metropolitan Life shall not be liable in any way or manner whatsoever, whether under contract, tort or negligence and that our recourse shall be limited to Metropolitan Life Insurance Ghana Ltd.

I shall not be entitled to any refund of amounts which may have already been withdrawn while this Authority was in force if such amounts were legally owed to Metropolitan Life Insurance Ghana Ltd.

This Authority remains in force until I give Metropolitan Life Insurance Ghana a written notice of cancellation.

Applicant Signature:  Premium: GHS   
Date:

### D PAYPOINT (SOURCE) DEDUCTION:

Name of Staff:   
Company Name:   
Department:  Staff ID:   
Please, add a photocopy of your latest payslip

I the undersigned authorize you to deduct the stated amount from my salary and transmit same to Metropolitan Life Insurance Ghana Ltd. I understand that the withdrawals hereby authorized shall be printed on my pay slip. I also understand that if any wrongful deduction is made which breaches the terms of this contract, Metropolitan Life Insurance Ghana Ltd. will not be liable in any way or manner whatsoever whether under contract, tort or negligence and that our recourse shall be limited to Metropolitan Life Insurance Ghana Ltd.

I shall not be entitled to any refund of amounts which may have already been deducted while this authority was in force if such amounts were legally owing to Metropolitan Life Insurance Ghana Ltd.

This authorization shall be effective until my employment is terminated or written notice by me to cancel this mandate stating when such cancellation shall be effective or until termination of this premium payment by Metropolitan Life Insurance Ghana Ltd.

Applicant Signature:  Premium: GHS   
Date:

### E MOBILE MONEY DEDUCTION:

Service Provider: MTN  Airtel Tigo  Vodafone   
Mobile/Momo Number:

Premium: GHS  I hereby authorise deductions of premiums from my mobile money wallet with details above.

Date:         Applicant Signature/RTP:

## PREMIUM DEDUCTION MANDATE

Policy Number:  Commencement Date:

### A PREMIUM PAYER

Title:  Surname:   
First Name:   
Date of Birth:         Mobile No.:   
TIN Number:

### B POLICY DETAILS

Product Name:   
Premium Amount GHS:  Date of First Deduction:          
Frequency: Monthly  Quarterly  Semi-Annual  Annually

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Applicant Signature:  Premium: GHS   
Date:

### E MOBILE MONEY DEDUCTION:

Service Provider: MTN  Airtel Tigo  Vodafone   
Mobile/Momo Number:

Premium: GHS  I hereby authorise deductions of premiums from my mobile money wallet with details above.

Date:         Applicant Signature/RTP: