

## Application Form Sections C & N

To be attached to and form part of Application Form dated:

For: Plan Type:

Applied for by: Policy Owner:

I.D. Card No. /  
Company Registration No.  
(if applicable)

### Section C – Details of the Person to be Covered

This section is to be completed and attached to the Application Form if the person to be covered is a Third Party

It is not advisable to select more than one person to be covered if the person covered is a child under the age of 18 years and the title to the plan is intended to be transferred to the child after the age of 18 years.

	First Person Covered	Second Person Covered
First Name/s	<input type="text"/>	<input type="text"/>
Surname / Title	<input type="text"/>	<input type="text"/>
Maiden Name	<input type="text"/>	<input type="text"/>
Marital Status / Gender	<input type="text"/>	<input type="text"/>
	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
I.D. Card / Passport No	<input type="text"/>	<input type="text"/>

Please provide a true authenticated photocopy of your I.D. card / Passport

Date of Birth / Country of Birth	<input type="text"/>	<input type="text"/>
Address	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	Postcode <input type="text"/>	Postcode <input type="text"/>
Telephone (Home)	<input type="text"/>	<input type="text"/>
Telephone (Mobile)	<input type="text"/>	<input type="text"/>
Telephone (Work)	<input type="text"/>	<input type="text"/>
E-mail	<input type="text"/>	<input type="text"/>
Country of Residence	<input type="text"/>	<input type="text"/>
Country of Employment	<input type="text"/>	<input type="text"/>

## Section N - Lifestyle and Medical Questionnaire

This section is to be completed and attached to the Application Form if:

- (a) the Death Benefit IS NOT the Minimum Sum Insured OR  
 (c) the application INCLUDES the Waiver of Premium Benefit.

(b) the Guaranteed Insurability Option IS REQUIRED (where it is available), OR

	First Person Covered	Second Person Covered
1) Occupation (Exact Nature of work/ part time work)	<input type="text"/>	<input type="text"/>
2) Height	<input type="text"/> cms <input type="text"/> ft <input type="text"/> inches	<input type="text"/> cms <input type="text"/> ft <input type="text"/> inches
3) Weight	<input type="text"/> kgs <input type="text"/> lbs <input type="text"/> oz	<input type="text"/> kgs <input type="text"/> lbs <input type="text"/> oz
4a) Name & Address of your usual doctor	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Postcode	Postcode

4b) Has this doctor been your usual doctor for less than 1 year? YES  NO  YES  NO

If your answer to question 4b is YES, please provide us with details in the space provided below.

	First Person Covered	Second Person Covered
Name & Address of your previous doctor	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Postcode	Postcode

5a) Do you smoke or have you done so in the past 2 years? YES  NO  YES  NO   
 We may ask you to undergo a simple test to confirm your answer to this question.

If your answer to question 5a is YES, please provide us with details in the space provided below.

Type	Amount	Frequency (Daily/Monthly)	Type	Amount	Frequency (Daily/Monthly)
<input type="checkbox"/> Cigarettes	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Cigarettes	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Cigars	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Cigars	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Pipe	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Pipe	<input type="text"/>	<input type="text"/>

5b) Have you ever smoked? YES  NO  YES  NO

If your answer to question 5b is YES, please reply to questions (5bi) and (5bii).

5b i) How many did you smoke?

<input type="checkbox"/> Cigarettes	Less than 20 / day <input type="checkbox"/>	<input type="checkbox"/> Less than 20 / day <input type="checkbox"/>
<input type="checkbox"/> Cigars	20-40 / day <input type="checkbox"/>	<input type="checkbox"/> 20-40 / day <input type="checkbox"/>
<input type="checkbox"/> Pipe	40+ / day <input type="checkbox"/>	<input type="checkbox"/> 40+ / day <input type="checkbox"/>

5b ii) When did you stop smoking?

<input type="checkbox"/> 6 months to 2 years ago <input type="checkbox"/>	<input type="checkbox"/> 6 months to 2 years ago <input type="checkbox"/>
<input type="checkbox"/> between 2 and 5 years ago <input type="checkbox"/>	<input type="checkbox"/> between 2 and 5 years ago <input type="checkbox"/>
<input type="checkbox"/> more than 5 years ago <input type="checkbox"/>	<input type="checkbox"/> more than 5 years ago <input type="checkbox"/>

6a) Do you drink alcohol? YES  NO  YES  NO

If your answer to question 6a is YES, please provide us with details in the space provided below.

	Type	Amount	Frequency (Daily/Monthly)	Type	Amount	Frequency (Daily/Monthly)
1 Unit = 1 glass Wine 1 Unit = 1/2 pint Beer 1 Unit = 1 measure Spirits	<input type="checkbox"/> Wine	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Wine	<input type="text"/>	<input type="text"/>
	<input type="checkbox"/> Beer	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Beer	<input type="text"/>	<input type="text"/>
	<input type="checkbox"/> Spirits	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Spirits	<input type="text"/>	<input type="text"/>

6b) Have you ever been advised to reduce or give up drinking alcohol? YES  NO  YES  NO



