

Wapic eTERM PROTECTION PLAN PROPOSAL FORM

Affix a recent passport photograph here

GUIDELINE TO FILL THE FORM

1. An individual who assists an applicant to complete this proposal form for insurance shall be deemed to have done so as the agent of the applicant
2. All details are mandatory, except they are not applicable. Please ensure regularity of your signature in all correspondences.
3. Please attach: (i) Recent passport photograph (ii) Means of identification: Nigerian Driver's License, National ID card, International Passport, Voters Registration Card (iii) Evidence of utility bill payment:PHCN, Water Rates etc
4. Please note the liability of the Company does not commence until this proposal has been accepted by Wapic and the premium paid.
5. We do not accept responsibility for any cash payment to our representatives/agents.

SECTION A: POLICYHOLDER'S DETAILS

Name: S U R N A M E M I D D L E N A M E F I R S T N A M E

Title: Mr Mrs Miss Others Marital Status: Single Married Divorced Widow DOB: D D M M Y Y Y Y

E-mail:

Address: T O W N C I T Y

State: S T A T E C O U N T R Y Nationality: State of origin:

Telephone: Alt. Tel: P.O. Box:

Linked In ID: Facebook ID:

Occupation: Are you Self Employed? Y N If yes Pls. Indicate: Partnership Professional Sole-Owner

If "No", Employer: Job Title: BVN:

Annual Income Band: Over N15m N10.1 - N15m N7.6 - N10m N5.1 - N7.5m N2.6 - N5m N1 - N2.5m Below N1m

Means of Identification: National ID Card Int'l Passport Driver's License Voter's Card Others Pls Specify Non Nigerian Resident Permit

SECTION B: INSURANCE DETAILS

Start Date: D D M M Y Y Y Y Annual Premium(N): Duration (Yrs):

Table Of Benefits:	Death Benefit	Permanent Disability Benefit	Accidental Medical Expenses	Premium	Death Benefit	Permanent Disability Benefit	Accidental Medical Expenses	Premium	Death Benefit	Permanent Disability Benefit	Accidental Medical Expenses	Premium
100,000.00	100,000.00	10,000.00	1,000.00	600,000.00	600,000.00	30,000.00	6,000.00	2,000,000.00	2,000,000.00	100,000.00	20,000.00	
200,000.00	200,000.00	10,000.00	2,000.00	700,000.00	700,000.00	35,000.00	7,000.00	5,000,000.00	5,000,000.00	150,000.00	50,000.00	
300,000.00	300,000.00	15,000.00	3,000.00	800,000.00	800,000.00	40,000.00	8,000.00	7,500,000.00	7,500,000.00	200,000.00	75,000.00	
400,000.00	400,000.00	20,000.00	4,000.00	900,000.00	900,000.00	45,000.00	9,000.00	10,000,000.00	10,000,000.00	250,000.00	100,000.00	
500,000.00	500,000.00	25,000.00	5,000.00	1,000,000.00	1,000,000.00	50,000.00	10,000.00					

Method of Payment: Cheque Transfer Direct Debit Do you have insurance with Wapic? Y N If 'Yes' Please Give Details

Please state sum assured currently in force on your life Please state the Insurance Company

Has any proposal on your life ever been declined, postponed, deferred, withdrawn or accepted on special terms? Y N If 'Yes' give details

Wapic Account details: **Access Bank Plc, Account No.: 0056068658**

SECTION C: BENEFICIARIES DETAILS

	FULL NAME	DATE OF BIRTH	AGE (YRS)	RELATIONSHIP	PHONE NUMBER	(%)
PRIMARY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
CONTINGENT	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

SECTION D: MEDICAL DECLARATION

Do you have any existing medical condition / Illness? Y N If 'Yes' Please Give Details

Height (ft/inches): Weight (kg):

SECTION E: DECLARATION

I, _____, the Life assured, do hereby declare that I have personally checked all the information as given out in this form and confirm that all the answers are true and that I have not concealed or withheld anything with which the assurer should be acquainted with in order to assess my eligibility for assurance. I further declare that the meaning and consequences of all the terms and conditions have been explained to me and that I am fully aware and understand same.

I irrevocably authorize and request any Doctor or other person(s) who may be in possession of, or hereafter acquire, any information concerning my health up to the present time to disclose such information to the assurer. I agree that this authority and request shall remain in force after my demise as well as prior thereto.

Date: D D M M Y Y Y Y Signature of the Assured

Witness: Name Date: D D M M Y Y Y Y Signature of the Witness

Policy Document Delivery Address: Tick if document should be delivered to address above If otherwise, pls. specify

SECTION F: FOR OFFICIAL USE ONLY

Staff / Agency Code Branch / Team MIS Code

Policy Number Date: D D M M Y Y Y Y Signature of Sales Person