OLD MUTUAL

Life & Pensions

Insurance contract underwritten by Old Mutual

PROPOSAL FORM

Proposal /contract number

Please complete in BLOCK LETTERS using black or blue ink.

Statements in this application form must be complete and accurate. All questions must be fully answered, unless otherwise specified.

Print in BLOCK LETTERS or by marking a box [x] where appropriate, using black or blue ink only. Please write within the margins of the character box to enable speedy processing.

FOR OFFICE USE ONLY
This application form has been checked for complete-ness and accuracy

Name of Initiator Of request

Telephone number

Email address of initiator Of request

Old Mutual Service details (for clients)

Fax number	+265 (0) 1 822 649
Telephone number	+265 (0) 1 820 677
Address	Old Mutual Building 30 Glyn Jones Road, Blantyre, Malawi. P.O Box 393, Blantyre, Malawi
Servicing hours	07:30 to 12.00 13:15 to 16:30 Monday to Friday

(Please tick where applicable)
New application
Additional component on contract number

1.PROPOSER'S DETAILS (Complete this section if the Proposer is not the Life to be assured. Do not complete for regular premium retirement and single premium retirement benefits)

Surname _____ First names _____ Other initials _____

Title _____ Date of birth _____ Age next birthday _____

Sex _____ Identification medium: Proof of age affidavit ☐ Birth Certificate ☐ Passport ☐

ID number _____

Maiden and /or previous surnames (if applicable) _____ Marital status _____

Email _____ Postal Address _____

Telephone (W) _____

Telephone (H) _____

Mobile number _____ Main occupation _____

Industry employed _____

Proposer's insurable interest in the Life to be assured _____

2.PREMIUM OPTIONS

Premium frequency Monthly ☐ Yearly ☐ single ☐

Payment method Cheque ☐ Debit order ☐

Complete this section only if the Proposer is not a premium payer. Note that the Proposer is still responsible for the premium payments. Premium protection benefits will be based on the premium payer

Surname _____ First names _____ Other initials _____

Title _____ Date of birth _____ Age next birthday _____

Sex _____ Identification medium _____ Proof of age affidavit _____

Birth Certificate _____ Passport _____ ID number _____

Maiden and /or previous surnames (if applicable) _____ Marital status _____

Email _____ Postal Address _____

Telephone (W) _____ _____

Telephone (H) _____

Mobile number _____ Main occupation _____

Industry employed _____

3.COMPULSORY COVER AND PREMIUM INCREASE OPTIONS (For retirement and Savings Benefits the increases will be on premiums)

Please select the annual regular increase option(Please note that the option may only be reduced in an increase higher than CPI has been selected. It may be removed but will not be reinstated once removed

- ☐ CPI Only
- ☐ CPI +1
- ☐ CPI +2
- ☐ CPI +3
- ☐ CPI +4
- ☐ CPI +5
- ☐ CPI +6
- ☐ CPI +7
- ☐ CPI +8
- ☐ CPI +9
- ☐ CPI +10
- ☐ CPI +11
- ☐ CPI +12
- ☐ CPI +13
- ☐ CPI +14
- ☐ CPI +15
- ☐ CPI +16
- ☐ CPI +17
- ☐ CPI +18
- ☐ CPI +19
- ☐ CPI +20

4.PERSONAL FINANCIAL PLANNING CONTRACT

CODE	PRODUCT NAME	SUM ASSURED	PREMIUM	TERM	TICK AS REQUIRED
610	Regular Premium Death Benefit-Term				
620	Regular Premium Death Benefit-Whole Life				
630	Regular Premium Savings Benefit				
640	Accidental Death Benefit				
641	Accidental Disability Benefit				
642	Severe Premium Benefit				
643	Physical Impairment Benefit				
631	Single Premium Savings Benefit				
690	Premium Protection on Death Rider				
691	Premium Protection on Disability Rider				

5. PERSONAL RETIREMENT PLANNING CONTRACT

CODE	PRODUCT NAME	SUM ASSURED	PREMIUM	TERM	TICK AS REQUIRED
710	Regular Premium Retirement Benefit				
711	Single Premium Retirement Benefit				
691	Premium Protection on Disability Rider				

6. LIFE ASSURED UNDERWRITING

LIFE ASSURED UNDERWRITING

6(a) MEDICAL HISTORY **YES NO**

Where any question is answered "YES", please give full and accurate details below, stating nature of complaint/ symptom(s), dates, medical doctor and when test symptom(s) were experienced.

1. Any disorder of the heart, blood vessels or circulatory system, e.g. high blood pressure, chest pain, heart murmur, coronary artery disease, shortness of breath or palpitations?
2. Any respiratory or lung trouble, e.g. asthma, bronchitis, persistent cough, tuberculosis?
3. Any disorder of the digestive system, gall bladder or liver, e.g. hepatitis B, actual or suspected gastric or duodenal ulcer, recurrent Indigestion, persistent diarrhoea or hiatus hernia?
4. Any disease or disorder of the kidney, bladder or reproductive organs e.g. albumin in urine, stones,prostatis, venereal diseases or Gynecology related symptoms or conditions (i.e. problems with the female organs)?
5. Any nervous or mental complaint, e.g. epilepsy, blackouts, loss of consciousness, paralysis, anxiety state or depression
6. Any ear, eye, nose or throat disorder, e.g. ear discharge, swollen glands, persistent mouth sores, defective vision, cataracts or any hereditary eye disease ?
7. Any disorder or disease of muscles, bones, joints, limbs, spine, e.g. rheumatism, arthritis, gout, slipped disc or other back trouble?
8. Diabetes, sugar in urine, thyroid, or other glandular or blood disorder
9. Cancer, growth or tumour of any kind, or skin disorders
10. Any other disease, symptoms, physical abnormality, congenital pr otherwise, requiring consultation with medical practitioner (excluding colds, influenza and general children's ailments)
11. Are there any other health factors (past or present) which may influence the risk attached to this contract, or has any proposal for life, sickness, accident or disability insurance on your life ever been declined, deferred, withdrawn or accepted on special terms or at special rates? (Where proposal has been declined, deferred, withdrawn or accepted on special terms/rates, please state name of insurer and date of occurrence in "DETAILS" below.)
12. State initials, surname and address of the medical doctor that you usually consult, or name and address of your clinic/hospital
13. For how long have you been consulting this doctor/clinic/hospital?
14. Height (without shoes) _____ Mass (clothed) _____

    Has your mass changed by more than 5 kilograms in the past year? YES _____ NO _____
15. (a) What type and quantity of alcoholic liquor do you consume

    Type _____ Qty (weekly average) _____

    (b) Have you consumed more in the past or have you ever received medical advice to reduce or discontinue your consumption? If yes state full details below and complete the Habits questionnaire

    YES ☐ NO ☐ If YES state the full details below

16. Family History	Ages if alive	If alive, give a brief description of present state of health	If deceased give the cause of death	Age at death
Father				
Mother				
Brothers				
Sisters				
Spouse				

7a.DETAILS: If insufficient space below, please attach a separate sheet duly signed and dated

Question number	Full details-nature of complaint/symptom(s), dates, medical doctor and when last symptom(s) were experienced

7b AIDS DECLARATION

1. have you, or to your knowledge, your spouse or any sexual partner ever been tested for or received or do you expect to receive medical advice, personal counseling or treatment in connection with HIV(human Immunodeficiency Virus), AIDS, an AIDS-related condition, any infection by one of the AIDS viruses or any sexually transmitted disease, including hepatitis B

YES ☐ NO ☐

Duration of symptoms

(state months or years)

(Please disclose the results of all previous HIV tests, including those that were negative, in order to avoid cover being declined)

	Last attending doctor/clinic/hospital	Last date of attendance
Name		
Address		

2. For this application to be considered, an **HIV TEST IS COMPULSORY**
3. Please insert the name and address of the doctor, hospital or clinic to which OLD MUTUAL may advise a positive HIV test results

Name	
Address	

NOTE: A positive HIV Test result may only be notified to a doctor, hospital or clinic of your choice. For the HIV test to be taken, a PATHOLOGY REQUEST FORM must be completed. The Life assured must submit this pathology request form, and provide satisfactory photographic identification (e.g. Identity card, passport from country of origin) to the pathology laboratory or Doctor on Old Mutual's approved list of doctors and clinics for the HIV Test

8. **DECLARATION.**

I, the applicant understand that an HIV test is a requirement to proceed with this application.
I understand that the result of such a test may have serious consequences. I acknowledge that I am aware of the necessity to be fully informed and counseled prior to the test. I undertake not to have this test taken until I have satisfied myself that I am properly informed and counseled. I further acknowledge and understand that OLD MUTUAL and its directors, agents and employees are not liable for any infringement of my rights, or damages caused by any person in connection with, or arising from, such test. Should the HIV test prove positive, I require OLD MUTUAL to convey the results to the doctor, hospital or clinic that I have specified in question 3 above.

SIGNATURE OF THE APPLICANT

DATE

7c. SMOKING DETAILS OF THE PROPOSER-This must be completed if a Premium Protection benefit is being applied for.

Non smoker

- ☐ Never smoked
- ☐ Ex-smoker
- ☐ Last smoked: 0.5 years ago
- ☐ Last smoked: 5+ years ago

Smoker

What do you smoke?

- Cigarettes ☐
- Cigars ☐
- Pipe ☐
- How many per day? ☐

9. **OCCUPATION AND ACTIVITIES OF THE LIFE ASSURED-Must be answered by the Life assured for any amount of Life or Disability cover**.

1. Details of occupation (To be given in full, stating your activities and any circumstances that may affect the risk of premature death or disability)

2. Employer

Years of service

3. Do you intend changing your occupation or country of residence (Temporarily or permanently)?

4. Are you currently practicing all the normal duties and activities of your occupation?

5. Please supply details of all your education qualifications

Education qualification	Year obtained	Name of institution where qualification obtained

6. If you are a member of a professional body, please supply the following;

Name of professional body

Qualification required for admittance

7. Applicable to trainee professionals (Including those in articles) who have a three– year (or longer) recognized University degree.

When will you become a member of a recognized professional body

8. Monthly income

	Amount	Source
Salary	MK	
Commission	MK	
Other (State nature)	MK	

9. Have you ever been declared insolvent? If YES please specify full details YES ☐ NO ☐

10. Hazardous activities

Have you during the past 5 years engaged in, or do you intend engaging in, any of the following activities (whether by occupa tion, hoppy, sport or past time), the Liquor trade, mining, diving, racing, hunting, aviation, parachuting, parasailing, hang-gliding, ballooning, climbing, working with machinery or electricity, or are exposed to chemicals, radiation, X-Ray, inflammable materials or liquids, or any other potentially hazardous activity. If YES, please specify full details.

YES ☐ NO ☐

Cover required ☐ Specific Activity _____ Not required ☐

10. EXISTING ASSURANCE OF THE PROPOSER/PREMIUM PAYER-Must always be completed for any amount of Life or Disability cover.

1. Do you have or are you currently applying for any assurance with OLD MUTUAL, or other life assurer (including additions to existing contracts and reinstatement of lapsed contracts)? If YES please complete the following;

YES ☐ NO ☐

Type of Assurance	Issued OLD MUTUAL Last 24 months Sum assured	Total all Life Assurers (Last 24 months) Sum assured	Current Pending Sum Assured	Name of Life Assured
Life Cover	MK	MK	MK	

	Total OLD MUTUAL Less than 24 months Sum insured	Other Life assurers Sum assured	Current Pending Sum assured	Name of Life Assured
Severe illness Benefit	MK	MK	MK	
Physical Impairment Benefit	MK	MK	MK	

	Total OLD MUTUAL (Excluding this process)	Current Pending with OLD MUTUAL
Premium Protection (Yearly premium benefit)	MK pa	MK pa

2. Have you ever claimed compensation against a sickness, disability or accident contract or had any of the above cover ever been affected on your life on special terms or at special premium rates, or has any application for any of the above on your life ever been declined, deferred or withdrawn? If YES please state name of insurer/society/fund, date and reasons in DETAILS below

YES ☐ NO ☐

DETAILS: If insufficient space below, please attach a separate sheet duly signed and dated by premium payer

11. ASSURANCE REPLACEMENT (Must always be answered by proposer)

Is this proposal to replace, wholly or partly, your existing assurance with OLD MUTUAL or with any other assurer immediately, or to replace an assurance discontinued during the past 6 months, or to replace an assurance that will be discontinued within the next 6 months, either on the Life to be Assured or owned by proposer?

YES ☐ NO ☐

Name of Assurer(s)	Policy number(s)

Note: the replacement of any assurance is usually disadvantageous because initial costs charged to the policy will be duplicated.

12. DECLARATIONS

12a GENERAL DECLARATIONS (Must be signed by the Life to be Assured and Proposer if other than the Life to be Assured)

1. I warrant that all the information given in this proposal, and in all documents which have been or will be signed by me in connection with the proposed assurance, whether in my handwriting or not, is true and complete.

2. I agree that the statements in this proposal and the documents stated above shall be the basis of the proposed contract, that any misstatement or omission therein may lead to any contract made being declared void by OLD MUTUAL, and that all monies paid in respect thereof shall be forfeited.

3. I agree that no statement, whether made by myself or by the person canvassing for or handling this proposal or by any other person, shall be binding upon OLD MUTUAL unless the same be reduced to writing, submitted to the head office of OLD MUTUAL and made part of the contract.

4. I also agree that should this proposal be accepted by OLD MUTUAL it will be conditional upon there having been no material alteration to the facts on which the acceptance was based and no illness or injury suffered by the Life to be Assured or Proposer (if applicable) between the date of this proposal and the date of payment of the full amount due in respect of the premium or the date of OLD MUTUAL's unconditional acceptance of the risk, whichever shall be later.

5. I am aware and accept that any disability and/or debility assurance benefits due under this contract will be reduced if they exceed the maximum benefits allowed (at the time of disablement) as set out by OLD MUTUAL.

6 I agree that OLD MUTUAL will not incur any obligation before unconditional acceptance thereof has been communicated in writing and the first premium has been paid.

7. Accepting that I am thereby curtailing my right of privacy, but to facilitate the assessment of the risks, and the consideration of any claim for benefits, under a policy related to this or any other proposal for insurance made by me, or in respect of me as life assured, I irrevocably authorize OLD MUTUAL;
   (a) To obtain from any person, whom I hereby so authorize and request to give, any information which OLD MUTUAL deems necessary, and
   (b) To share with other insurers that information and any information contained in this proposal or in any related policy or other documents, either directly or through a database operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as may from time to time be decided by OLD MUTUAL or by the operators of such a database. I give this authorization in respect of myself and in respect of those additional assured lives under this proposal whom I am legally entitled to represent.

8. I/WE, THE UNDERSIGNED LIFE TO BE ASSURED (AND PROPOSER IF OTHER THAN THE LIFE TO BE ASSURED), CONFIRM THAT I/WE HAVE READ THIS DECLARATION AND UNDERSTAND ITS IMPLICATIONS.

DATED AT _____ ON _____

SIGNATURE of LIFE TO BE ASSURED

SIGNATURE OF PROPOSER (If other than Life to be Assured)

SIGNATURE OF LEGAL REPRESANTATIVE OF LIFE TO BE ASSURED (Where required)

RELATIONSHIP OF PROPOSER TO LIFE TO BE ASSURED

SIGNATURE OF LEGAL REPRESENTATIVE OF PROPOSER

11b. Investment declaration (Must be signed by the proposer)

1. I understand that my Savings or Retirement premiums, net of expense charges, will purchase units in the Old Mutual Investor Fund, which is a medium to long term investment.
2. I understand that the value of units may go down as well as up and past performance is not necessarily a guide to the future.
3. I, THE UNDERSIGNED PROPOSER CONFIRM THAT I HAVE READ THIS DECLARATION AND UNDERSTAND ITS IMPLICATIONS.

DATED AT _____ ON _____

SIGNATURE OF PROPOSER _____

12 INFORMATION SUPPLIED BY SALES AGENT

Name(s) of introducer(s)	Sales centre (Code)	Intermediary (Code)	commission (%)	Figures

PRESENTER(s) AND SELLER(S) OF THIS CONTRACT

Surname	Date of birth	External reference number (Broker's proposal number)

Are you Registered with the Malawi Registrar of Insurance to Market and sell life insurance? YES ☐ NO ☐

Registration number _____

I DECLARE THAT I HAVE FULLY EXPLAINED THE MEANING OF ASSURANCE REPLACEMENT (SECTION 11), AND THE EFFECT OF SUCH (Important note added to Replacement section) TO THE PROPOSER

INTRODUCER SIGNATURE _____

OYP (NB clerk use)	Commission (Introducer use)	NB Clerk (Please print initials and surname)

INTERNAL USE ONLY-ATTACHED DOCUMENTATION Please indicate which documents have attached to this proposal submission

	YES	NO
1. New Business work sheet		
2. Current OLD MUTUAL portfolio		
3. Manual quote		
4. Policy delivery slip		
5. Beneficiary Appointment Form		
6. Medical Reports		
7. Cession Form		
8. Proof of Age		
9. Debit Order Form		
10. Receipt (Cheque payments)		
11. Specimen Cheque		
12. Occupation/Activity Questionnaire		
13. Financial Questionnaire (Statement of Assets and Liabilities)		

NB CLERK (Print initials and Surname)

DATE

CLERK STAMP