

MOONLIGHT PROVIDENT ASSOCIATES (PRIVATE) LIMITED t/a MOONLIGHT FUNERAL ASSURANCE **PROPOSAL FORM**

ROPOSAL NUMBER						
			Ema	il address:		
OME ADDRESS			TELEPH	HONE No. (HOME)		
USINESS ADDRESS			TELEPHO	ONE No. (WORK)	CELL	
Birth Particulars Place of Birth Day of Birth						
D No ROFESSION /OCCUPATION					MARITAL	
TATUS						Amount
TYPE OF POLICY		ASSURA	NCE PREMIUM			\$
SUM ASSURED	\$	POLICY				\$
TERM OF POLICY	· · · ·		ARY RIDERS			\$
STOP ORDER AUTHORITY		1)				\$
PAYMENT TERMS		2)				\$
		OTHERS				\$
				SPOUSE		
OTHER DEP	ENDANTS					
SURNAME	FIRST NAMES	D.O.B	I.D NUMBER	RELATIONSHIP	SUM ASSURED	
					\$	\$
					\$	\$
					\$	\$
					\$	\$
					\$	\$
		1			AL MONTHLY NTRIBUTION	\$

PERSONAL STATEMENT

- A . . Have any of the above proposed lives at any time suffered from or had symptoms of any of the following: State full details in the schedule below if the answer is "Yes" on any of the questions in the personal statement, give full details as well as the last experienced symptoms and the name of the attending doctor. (DELETE THE INAPPLICABLE)
- (1) Heart or circulation (e.g blood pressure, chest pains, heart murmur, palpitations, rheumatic fever or blood vessel disorders, stroke etc)? YES/NO R
 - (2) Lungs (e.g. persistent cough, shortness of breath, tuberculosis, asthma, bronchitis etc) ? YES/ No (3) Digestive system and liver (eg indigestion, ulcers, bleeding from the bowel, hepatitis etc)? YES/NO
 - (4) Kidneys, bladder or reproductive organ (e.g stones, infections, veneral diseases. AIDS, bilharzias and in the case of females, abnormal pregnancy etc)?
 - YES /NO
 - (5) Nervous System (e.g. concussion, unconciousness, paralysis, fits, blackouts, depressive or anxiety states, persistent headaches, etc)? YES / NO
 - (6) Eyes (exclusive errors of refraction) ears, nose, or throat (eg deafness, ear discharge, etc)?YES/NO

- (7) Skeleton, joints, muscles (eg accidental injury, rheumatism, arthritis, back or neck trouble, gout etc.)? YES/NO
 (8) Glands or blood (eg diabetes, thyroid, spleen, bleeding disorder or leukemia, etc.)? YES/NO
- (9) Any other prolonged illness or injury ? YES /NO
- If the answer to any of the above questions is "YES", give full details in the space below.

C. Have any of the proposed lives

(a) During the past three years consultant a doctor or visited any hospital or clinic in connection with health? YES /NO

(b) Received medical advice to reduce or stop smoking or drinking? YES/NO

(c) Any disability (eg blindness, deforming paralysis etc)? YES/NO

(d) Changed their occupation due to health reasons? YES/NO

D. Are the proposed lives now free from any disease or illness and in good health in every respect YES/NO? (if NO state details in schedule) N.B All material facts relating to the assessment and acceptance of the application must be disclosed. Any false health declaration may cause this contract to be null and void

	4.		
Question NO	Sate who was treated and give full details of the illness for which treated	Date	Duration of
B, C & D			Illness

Name of Dr or Hospital which administered Treatment, State Hosp. No	Have you completely recovered from sickness

Applicants over age 52 Years

If "yes" state details in the spaces provided.

During the last six years have been ill for more than one week at a time? YES/NO

Have you or any member of your family had Assurance before? YES/NO

Supplementary information

DECLARATION

Date

- a) I warrant that the information given in this application , whether in my handwriting or not, is true and complete.
 - b) I agree that any misstatement or omission herein may lead to this contract being declared null and void by the "Company" herein called "Moonlight Provident Associates (Pvt) Ltd
 - c) I confirm that I am fully aware that the representative referred to above is an independent contractor and that the company may not be held liable for any misrepresentations that might be made by such representative on its behalf.
 - d) I hereby grant my consent to the company obtaining and information concerning my (or my family's) state of health during or after our lifetime from any doctor, clinic or like institution.
 - e) The acceptance of Premium Deposit in respect of this proposal is subject to the condition that no risk is assumed by the company until this proposal is accepted by the Head Office of " Moonlight Provident Associates (Pvt) Ltd" If not accepted, money will be refunded upon production of relevant receipts. If the proposed is not yet 18 years. (A.N.B) the application must also be signed by a parent/ guardian.
 - (f) I have been made aware that the premium will escalate by the indicated percentage on each policy anniversary.

9	SIGNATURE OF PROPOSER
	SIGNATURE OF PARENT / GUARDIAN

I have read and understood all aspects of this proposal and statement and agree to all conditions contained herein.. REPRESENTATIVE 'S DECLARATION

a) Are there any circumstances known to you which may not have been divulged in the proposer's statement which may influence the risk of the proposed lives/? YES /NO.

b) Have you specifically drawn the proposer's attention to the above declaration and is he/she conversant with the contents? YES/NO

c)	Are any of t	ne proposed live	s excessively	overweight	? YES/NC

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d) Has the proposed to your knowledge ever had a Funeral Policy prior to this application? YES/NO

DATE	DATE
SIGNATURE OF REPRESENTATIVE	SIGNATURE OF NEW BUSINESS MANAGER
FOR HEAD OFFICE USE ONLY	

DATE	ACCEPTED pp"Moonlight Provident Associates
POLICY NUMBER	SIGNATURE

OTHER DETAILS
NOTES ON FOLLOW UP
AMMENDMENTS