



# EDUCATION PLAN - PROPOSAL FORM

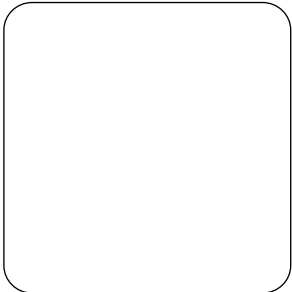
Important Notice: Kindly complete the proposal form carefully in your own handwriting. If our Living Benefits Advisors or any other person assists you to complete this proposal form, such person is deemed to have done so as your Agent.

Note also that ARM Life does not accept cash payments.

The minimum age at entry for this product is 18 years and maximum age at entry is 55 years

Proposal Number: \_\_\_\_\_ Customer's ID: \_\_\_\_\_

Adviser's Name: \_\_\_\_\_ Adviser's Code: \_\_\_\_\_



Please affix a passport photograph and attach a means of identification i.e. copy of international passport, Drivers' License, National I.D Card or Voters card.

## PERSONAL DATA

Title \_\_\_\_\_ Surname \_\_\_\_\_

Others Name(s) \_\_\_\_\_

Date of Birth       Gender: Male  Female   
(dd-mm-yy)

Occupation/Profession \_\_\_\_\_ Place of Birth \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile \_\_\_\_\_

E-mail \_\_\_\_\_ Fax: \_\_\_\_\_

Marital Status  
 Single  Married  Divorced/Separated  Widowed

Mother's Maiden Name \_\_\_\_\_

Communication/Postal Address:  Current Residence  Permanent Residence  Office

Current Residential Address  
(Please attach a copy of your utility bill e. g PHCN, waste disposal bill etc as proof of address)  
\_\_\_\_\_  
\_\_\_\_\_

Permanent Residential Address  
\_\_\_\_\_  
\_\_\_\_\_

Name of Employer/Company/Business \_\_\_\_\_

Address \_\_\_\_\_

Telephone Numbers \_\_\_\_\_

Sum Assured (Maximum: Four (4) times annual contribution)

Minimum: ₦500,000  Others: ₦.....

Annual Sum Assured Escalation  10%  15%  20%

Proposed Tenure:  5 years (minimum)  Others \*(Please specify).....  
\*(maximum tenure permissible is 20 years)

Annual Contribution:  ₦60,000 (minimum)  Others ₦.....

Contribution Payment Pattern:  Monthly  Quarterly  Bi-annually  Annually

Mode of Contribution Payment:  Direct Debit (please complete mandate form)  Cheque  Others.....

Date(dd-mm-yy)

### ID document submitted

Driver's License  Voters' card  
 National ID card  International Passport

ID Number

### FOR OFFICE USE ONLY

Branch \_\_\_\_\_

Account Officer \_\_\_\_\_

Relationship Manager \_\_\_\_\_

Signature Verification \_\_\_\_\_

### ACCOUNT OFFICER

Name \_\_\_\_\_

Code \_\_\_\_\_

Tel: \_\_\_\_\_

Branch Code \_\_\_\_\_

Signature \_\_\_\_\_

Initial Contribution

Initial Payment Details

Account Name: \_\_\_\_\_

Account Number \_\_\_\_\_

Bank: \_\_\_\_\_

Cheque No.(if applicable): \_\_\_\_\_

Sum Assured Benefit Payment:

- Lump Sum
- Family income Benefit (in (3) three equal instalment)
- Frequency of Payment:  Monthly  Quarterly  Bi-Annually  Annually

Appointment of Asset Management Company or Trustee\*

- ARM Trustees
- Others: \_\_\_\_\_

\* The Policyholder/Beneficiary/Legal Guardian to complete account opening formalities relating to Asset Management Company /Trustees at the time of maturity.

What is your income per annum :

- Below N1m  N1m-N2m  N2m- N5m  N5m- N10m  AboveN10m

GENERAL

Has any proposal on your Life been made before to ARM Life Plc or any other Insurance company?

Yes/No If yes please complete the following and attach additional sheet if space below is inadequate.

Name of Insurance Company	Sum Assured	Type of Policy	Annual Premium

Physical Description (of life to be insured): Height.....Weight.....(in kg)

Declaration of Good Health of life to be insured

- a) Are you in good health? Yes  No  (ii) any bodily infirmity? Yes  No
- b) Have you ever had heart condition, a stroke, hypertension, Paralysis, Cancer, Diabetes, Kidney failure, Liver failure, Mental illness, HIV infection or AIDS? Yes  No
- c) Do you currently have, or are you receiving treatment for any symptoms, medical conditions or disabilities? Yes  No
- d) Have you been absent from work due to illness or injury for a continuous period of more than 10days during the last one year? Yes  No
- e) Are you currently pregnant ( applicable for female life only)? Yes  No

Please state any material fact, substance or information regarding your health and way of living:

.....  
.....

• Name of Next of Kin ..... Telephone No: .....

• Address of Next of Kin .....

.....

**BENEFICIARIES:**

**(i) Sum Assured Beneficiaries (Spouse, Children or Relatives)**

S/n	Name of Beneficiaries	Date of Birth	Address	Relationship	Proportion of Benefit %
1					
2					
3					
4					

**NOTE:**  
Where beneficiary is a Minor (less than Age 18 on last birthday), please provide details of Guardian/Legal Representative.

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone No. \_\_\_\_\_ E-mail \_\_\_\_\_

**(ii) Maturity Benefit Beneficiaries (Children)**

S/n	Name of Beneficiaries	Date of Birth	Address	Relationship	Proportion of Benefit %
1					
2					
3					
4					

**NOTE:**  
Where beneficiary is a Minor (less than Age 18 on last birthday), please provide details of Guardian/Legal Representative.

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone No. \_\_\_\_\_ E-mail \_\_\_\_\_

**DECLARATION**

I, .....the Life assured declare that the information above has been provided by me and is true to the best of my knowledge and belief. ARM Life Plc has my permission to obtain any other information about my state of health/medical records prior and subsequent to the proposed Life Assurance contract from any source and to rely on the information obtained for the purpose of this proposal and in fulfillment of my obligations under the proposed Life insurance contract.

I affirm that this Declaration together with every other information shall be the basis of my insurance contract with ARM Life Plc.

Signature of Proposer.....Date .....

**For Office Use Only**

Sales Representative Name \_\_\_\_\_

Sales Representative Code \_\_\_\_\_ Telephone (Mobile) \_\_\_\_\_

Branch Code \_\_\_\_\_ Signature \_\_\_\_\_