



Fidelity Education Support Plan (FESP) Policy Application Form

* Means compulsory fields

* Part 1. Personal Details

Title: Date of Birth: (18 to 54 Yrs) Gender:
 First Name(s):
 Surname:
 Nationality: Other Nationality (if dual):
 Marital Status: Ghana Card No.:
 Type of ID: (NHIS **not** accepted)
 ID Number: ID Expiry Date:

Tax Compliance FATCA (complete if you are a permanent citizen of USA)

Are you a citizen of USA? Yes No
 Do you hold a resident Green Card? Yes No

Social Security Number:

EU Residence? Yes No

PEP STATUS: Are you a;

Politically Exposed Person (PEP)? Yes No

Family member or a known close associate of a PEP? Yes No

* Part 2. Contact Information

Primary Phone Number:
 WhatsApp Phone Number:
 Email:
 Residential Address:
 GPS Address:

* Part 3. Employment Information

Employer:
 Occupation:

* Part 4. Medical Information

4a) List diseases and disabilities that you have suffered in the last 10 years:

4b) List medications you are currently taking and their dosage:

4c) Please provide the details of your usual hospital:
 Hospital Name:
 Town:
 Region:

4d) Any close blood relative suffering from diabetes, heart disease, raised cholesterol, mental illness, any hereditary disease? Yes No

4e) How many cigarettes do you smoke per day?

4f) Do you take alcohol? Yes No Quantity per day:

* Part 5. Occupation

Do you in the course of your occupation perform duties that are not clerical or administrative, provide details:

* Part 6. Trustee Details

Trustee Name:
 Trustee Email Address:
 Trustee Date of Birth: Mobile No:
 Relationship to policyholder:

* Part 7. Beneficiary(ies) Details

Name	Date of Birth	Relationship	Share %

* Part 8. Payment Details

Premium Term: years Basic Premium (GHc):
 Premium (Lump Sum Payment on Death & TPD) (GHc):
 Policy Fee (GHc): Total Premium (GHc):
 Payment Frequency: Monthly Quarterly Bi-Annually Annually
 Inflation Protector: 10% 15% 20% 25% 30%

Declaration:

I, the life assured, declare that all the statement made in the declaration of health are true and complete and are in my own handwriting. I agree that this declaration of health shall be the basis of any insurance granted under the said policy and that if any material information is withheld, the insurance policy will be forfeited.

I hereby irrevocably authorize any doctor, hospital, medical institution or other professional person who may be in possession of, or hereafter acquire, any information concerning my health, including the results of any blood tests, to disclose, on request, such information to the company.

I agree that this authority shall remain in force after my death as well as prior there to.

*** Part 9. Bank Deduction**

Branch:

Account Type: Current Savings

Account Name:

Account Number:

I authorize the above amount and any further updates to be deducted from my bank account for the payment of this insurance policy.

* Signature: Date:

*** Part 10. Agreement and Authorization Relating to this Application**

By signing below, you agree that;

- This application and all other documents that we require form the basis of the insurance we issue for you. This includes any written statements and answers provided in this application and all other information given by you to any authorized person representing the company.
- You have read the statements and answers written in the application and confirm they are true and complete.
- You have **received, carefully read** and **accepted all** the Terms and Conditions under the policy.
- The terms and conditions of the policy have been explained to you in a language you understand.
- I agree that all communications from Prudential Life Insurance to me shall be via Email, from customerservice@prumail.com & bancassurance@prudential.com.gh.

* Signature: Date:

(By signing this Document, I agree that my personal information given to the Bank for my banking relationship can be shared with Prudential Life Insurance Company for the purpose of this transaction).

Also, please confirm if details for delivery mode has been provided.

*** Part 11. Sales Staff Information (For Bank's Use Only)**

Branch:

MIS Code:

Surname:

First Name(s):

Referrer's Name:

* Signature: Date:

*** Part 12. BSSM/BOS/DSE Team Leader/Supervisor's (For Bank's Use Only)**

Surname:

First Name(s):

* Signature: Date:

Addendum

*** Part 10. Financial Affordability**

Currency	(A) Average Monthly Income	(B) Average Monthly Expense	Affordability Per Month: 70% x Net Inflow (A - B)
GHC			

*Affordability for modal premiums = Number of Months x Affordability Per Month

NB: Requested policy premium amount must be less than or equal to Affordability Per Month