



Kwila Insurance Corporation Ltd

P.O. Box 1457 Boroko, NCD Papua New Guinea

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B

APPLICATION FOR LIFE ASSURANCE

PERSONAL DETAILS (JUST SIGN , DO NOT COMPLETE)

NAME OF POLICY OWNER

HEIGHT CMS WEIGHT KGS I.D. NUMBER

EMPLOYER COMPANY OR DEPT. DIVISION/SECTION

POSTAL ADDRESS

OCCUPATION TELEPHONE:.....FAX:.....
JOB TITLE:

FORTNIGHTLY DEDUCTION - PREMIUM SAVINGS LOAN
FPDF CREDIT

LIFE COVER

LIFE INSURED MUST BE THE POLICY OWNER
 (Family Name) (First Names) Female Male DATE OF BIRTH Day Month Year Single Married

RELATIONSHIP TO LIFE INSURED
WIFE = W
SON = S
DAUGHTER = D
HUSBAND = H
Etc.

BENEFICIARIES LIFE INSURED OTHER (IF OTHER COMPLETE BELOW)

BENEFICIARIES NAMES Sex Day Month Year

BENEFICIARY ADDRESS

See attached information if beneficiary space is not enough.

GROUP EMPLOYER

EMPLOYEE FILE NO. Checked by:.....

AGENT NO. APPLICATION DATE

Please Turn Over

WITH RESPECT TO EACH OF THOSE TO BE INSURED:

	<u>YES</u>	<u>NO</u>	<u>DETAILS</u>
a Has any application for Life, Accident or Sickness insurance been declined, postponed, Modified or rated?	<input type="checkbox"/>	<input type="checkbox"/>	_____
b Are you now receiving or considering any medical attention or surgical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____
c Have you ever had Heart Trouble, high blood Pressure, Chest Pain, Albumin or Sugar in your Urine, Diabetes, Tuberculosis, Cancer, Tumors, Ulcers, Asthma, Mental or Nervous Disorder, Epilepsy, Rheumatic, Fever, Blood Vessel Disorder, Bowel Liver Gall-Bladder Renal Stone Problems or any Disorder of Genito-Urinary System or Severe Injury?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
d Are you now a member of any Military or Police Force?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
e Have you ever used habit forming Drugs Narcotics or Alcohol excessively or been treated for Alcoholism or drug Habits?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
f Have you any Physical Defects or Health impairments?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
g In past five years have you had any diagnostic test such as x-ray, electro-cardiogram, blood study, illness, operation, medical advice, Hospital treatment not mentioned above?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
h Female – Are you now pregnant or have you ever had disorder of the breast genital organs or complications of child birth?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
i Any other life insurance?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

IMPORTANT!

ABOVE QUESTIONS MUST BE ANSWERED TRUTHFULLY AND IN FULL. THE ANSWERS AFFECT THE DECISION WHETHER TO ACCEPT OR REJECT THE APPLICATION, IF UNTRUTHFUL OR INCOMPLETE ANSWERS ARE GIVEN IT MAY MEAN THE POLICY WILL BE INVALID.

COMMENTS:.....

I have read and understood all the statements and answers shown above, and to the best of my knowledge and belief, they are true and complete. I understand that the insurance applied for shall not become effective until this application is approved and the premium received by the company. I hereby authorize any doctor, hospital or clinic to provide information regarding my past medical history.

• PLEASE READ CAREFULLY

I UNDERSTAND, THAT IF THE POLICY ISSUED BY KWILA INSURANCE CORPORATION LTD, ARISING FROM THIS PROPOSAL, BE CANCELLED OR SURRENDERED FOR ANY REASON, INCLUDING MY FAILURE TO CONTINUE PAYING THE PREMIUM, I WILL BE REFUNDED THE BALANCE OF THE TOTAL PREMIUM PAID LESS THE COST OF LIFE COVER, OUTSTANDING LOANS, POLICY ADMINISTRATION AND THE AGENT’S COMMISSION FOR SELLING THE POLICY PLUS ANY FPDF BALANCE OR LOAN CREDIT BALANCE.

SIGNATRE
OF POLICY OWNER**DATE:**...../...../.....

Witness (Agent).....

Kwila Insurance - serving the PNG workforce since 1977