

H. Declaration by Funeral Parlor/Agent

I declare and warrant that the information contained in this Proposal Form is complete, true and unaltered as provided by the applicant.

Surname Forenames

Title Initials ID Number

Signed at on this day of 20

Signature

Additional information by Funeral Parlor, if any

I. For Official Use Only

I declare and warrant that the information contained in this Proposal Form is complete, true, and unaltered as Provided by the applicant.

Name of Officer

Signature of Officer Date

This application has been approved Yes No.

Authorised by

Signature of Officer Date



THANDIZO PLUS POLICY PROPOSAL FORM

A. General Information of Principal Life Insured

Surname: Forenames:

Title: Date of Birth (CCYYMMDD): Gender:

ID Number:

Type of ID e.g. Passport, National Identity Card, Driving Licence etc

B. Employment Information

Present Occupation: Company Name:

Physical Address:

Telephone Number: E-mail:

C. Residential Information

Residential Address: City/Township:

Postal Address: Telephone Number:

Other E-mail Address:

D. Funeral Benefit Options

Please tick the option chosen:

	OPTION	Main Member	Spouse	Children Parents & Dependents	Monthly Premium	Additional Premium per each Parent and Dependant
<input type="checkbox"/>	Option 1	2,500,000.00	2,500,000.00	1,000,000.00	15,125.00	800.00
<input type="checkbox"/>	Option 2	2,000,000.00	2,000,000.00	1,000,000.00	12,100.00	800.00
<input type="checkbox"/>	Option 3	1,000,000.00	1,000,000.00	500,000.00	6,050.00	500.00
<input type="checkbox"/>	Option 4	500,000.00	500,000.00	300,000.00	3,025.00	320.00
<input type="checkbox"/>	Option 5	300,000.00	300,000.00	300,000.00	2,205.00	320.00

Total Monthly Premium (MWK):

**Please note that the monthly premium on the above table is for main
Members, Spouse and Biological children (Maximum 4)**

E. Next of Kin Information

Please nominate the members of your immediate family who will be the next of kin under this policy in the event of a claim on the life of principal Life Insured.

Full Name	Date of Birth (CCYYMMDD)	Relationship to Principal Life	Contact Details
1.			
2.			

F. Dependant Information

Please complete this section if you wish to extend cover to other members of your family. Dependants included in this policy will be covered under the following categories as defined in the policy document: SP - Spouse; BC - Young Biological Child; DC - Young Dependent Child; DA - Dependent Adult

Please list the dependants included in this policy in the grid below:

1. Full Name	Date of Birth (CCYYMMDD)
ID Number (Indicate type of identification)	Gender (M/F)
Relationship to Principal Life (SP/BC/DC/DA)	
Benefit (MWK)	Monthly Premium (MWK)
2. Full Name	Date of Birth (CCYYMMDD)
ID Number (Indicate type of identification)	Gender (M/F)
Relationship to Principal Life (SP/BC/DC/DA)	
Benefit (MWK)	Monthly Premium (MWK)
3. Full Name	Date of Birth (CCYYMMDD)
ID Number (Indicate type of identification)	Gender (M/F)
Relationship to Principal Life (SP/BC/DC/DA)	
Benefit (MWK)	Monthly Premium (MWK)
4. Full Name	Date of Birth (CCYYMMDD)
ID Number (Indicate type of identification)	Gender (M/F)
Relationship to Principal Life (SP/BC/DC/DA)	
Benefit (MWK)	Monthly Premium (MWK)
5. Full Name	Date of Birth (CCYYMMDD)
ID Number (Indicate type of identification)	Gender (M/F)
Relationship to Principal Life (SP/BC/DC/DA)	
Benefit (MWK)	Monthly Premium (MWK)
6. Full Name	Date of Birth (CCYYMMDD)
ID Number (Indicate type of identification)	Gender (M/F)
Relationship to Principal Life (SP/BC/DC/DA)	
Benefit (MWK)	Monthly Premium (MWK)
7. Full Name	Date of Birth (CCYYMMDD)
ID Number (Indicate type of identification)	Gender (M/F)
Relationship to Principal Life (SP/BC/DC/DA)	
Benefit (MWK)	Monthly Premium (MWK)

F. Dependant Information

SP - Spouse; BC - Young Biological Child; DC - Young Dependant Child; DA - Dependant Adult

8. Full Name	Date of Birth (CCYYMMDD)
ID Number (Indicate type of identification)	Gender (M/F)
Relationship to Principal Life (SP/BC/DC/DA)	
Benefit (MWK)	Monthly Premium (MWK)
9. Full Name	Date of Birth (CCYYMMDD)
ID Number (Indicate type of identification)	Gender (M/F)
Relationship to Principal Life (SP/BC/DC/DA)	
Benefit (MWK)	Monthly Premium (MWK)
10. Full Name	Date of Birth (CCYYMMDD)
ID Number (Indicate type of identification)	Gender (M/F)
Relationship to Principal Life (SP/BC/DC/DA)	
Benefit (MWK)	Monthly Premium (MWK)
11. Full Name	Date of Birth (CCYYMMDD)
ID Number (Indicate type of identification)	Gender (M/F)
Relationship to Principal Life (SP/BC/DC/DA)	
Benefit (MWK)	Monthly Premium (MWK)
12. Full Name	Date of Birth (CCYYMMDD)
ID Number (Indicate type of identification)	Gender (M/F)
Relationship to Principal Life (SP/BC/DC/DA)	
Benefit (MWK)	Monthly Premium (MWK)
13. Full Name	Date of Birth (CCYYMMDD)
ID Number (Indicate type of identification)	Gender (M/F)
Relationship to Principal Life (SP/BC/DC/DA)	
Benefit (MWK)	Monthly Premium (MWK)

According to your knowledge, does any of the people proposed to be covered, including yourself, have any existing medical condition? ☐ YES ☐ NO *If yes, specify the person(s) and type of illness below*

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Payment shall be by cash at Smile Life Insurance offices or by direct bank deposit at our bank as advised. In the event of the death of the Policyholder, the only claim option will be that chosen by him/her at policy inception. i.e. it will not be changed by next of kin beneficiary.

G. Declaration by Applicant

Do you understand that the information you have provided in this proposal form is warranted to be true and complete and that consequently any misstatement or concealment of fact shall invalidate any contract of assurance based thereon?

Yes ☐ No ☐

I declare and warrant that this Proposal Form is complete and true, and also that I understand and agree that this Proposal Form and other documents relative thereto, shall be the basis of the proposed contract of assurance.

Signed at on this day of 20

Signature of Account Holder

Additional Information by Applicant, If any