



## 2. Spouse

|   |                                   |                                  |                          |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
|---|-----------------------------------|----------------------------------|--------------------------|---------------------------------|----------------------------------|-----------------------------------|----------------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| <b>1. Personal particulars</b>                      |                                   |                                  |                          |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
| Title   | <input type="text"/>              |                                  |                          |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
| Surname   | <input type="text"/>              |                                  |                          |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
| First names   | <input type="text"/>              |                                  |                          |                                 |                                  | Maiden name                       | <input type="text"/>             |                      |                      |                      |                      |                      |
| Gender  | <input type="checkbox"/> Male     | <input type="checkbox"/> Female  | Marital status           | <input type="checkbox"/> Single | <input type="checkbox"/> Married | <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed | Date of marriage     | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Date of birth                                       | <input type="text"/>              | <input type="text"/>             | <input type="text"/>     | <input type="text"/>            | <input type="text"/>             | <input type="text"/>              | <input type="text"/>             | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Place of birth                                      | <input type="text"/>              |                                  |                          |                                 |                                  | Nationality                       | <input type="text"/>             |                      |                      |                      |                      |                      |
| <input type="checkbox"/> National identity document | <input type="checkbox"/> Passport | <input type="checkbox"/> PIN No. | No. <input type="text"/> |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
| Mandatory: Attach copy of Identification Document.  |                                   |                                  |                          |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
| <b>2. Personal particulars</b>                      |                                   |                                  |                          |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
| Title   | <input type="text"/>              |                                  |                          |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
| Surname   | <input type="text"/>              |                                  |                          |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
| First names   | <input type="text"/>              |                                  |                          |                                 |                                  | Maiden name                       | <input type="text"/>             |                      |                      |                      |                      |                      |
| Gender  | <input type="checkbox"/> Male     | <input type="checkbox"/> Female  | Marital status           | <input type="checkbox"/> Single | <input type="checkbox"/> Married | <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed | Date of marriage     | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Date of birth                                       | <input type="text"/>              | <input type="text"/>             | <input type="text"/>     | <input type="text"/>            | <input type="text"/>             | <input type="text"/>              | <input type="text"/>             | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Place of birth                                      | <input type="text"/>              |                                  |                          |                                 |                                  | Nationality                       | <input type="text"/>             |                      |                      |                      |                      |                      |
| <input type="checkbox"/> National identity document | <input type="checkbox"/> Passport | <input type="checkbox"/> PIN No. | No. <input type="text"/> |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
| Mandatory: Attach copy of Identification Document.  |                                   |                                  |                          |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
| <b>3. Personal particulars</b>                      |                                   |                                  |                          |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
| Title   | <input type="text"/>              |                                  |                          |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
| Surname   | <input type="text"/>              |                                  |                          |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
| First names   | <input type="text"/>              |                                  |                          |                                 |                                  | Maiden name                       | <input type="text"/>             |                      |                      |                      |                      |                      |
| Gender  | <input type="checkbox"/> Male     | <input type="checkbox"/> Female  | Marital status           | <input type="checkbox"/> Single | <input type="checkbox"/> Married | <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed | Date of marriage     | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Date of birth                                       | <input type="text"/>              | <input type="text"/>             | <input type="text"/>     | <input type="text"/>            | <input type="text"/>             | <input type="text"/>              | <input type="text"/>             | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Place of birth                                      | <input type="text"/>              |                                  |                          |                                 |                                  | Nationality                       | <input type="text"/>             |                      |                      |                      |                      |                      |
| <input type="checkbox"/> National identity document | <input type="checkbox"/> Passport | <input type="checkbox"/> PIN No. | No. <input type="text"/> |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
| Mandatory: Attach copy of Identification Document.  |                                   |                                  |                          |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
| <b>4. Personal particulars</b>                      |                                   |                                  |                          |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
| Title   | <input type="text"/>              |                                  |                          |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
| Surname   | <input type="text"/>              |                                  |                          |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
| First names   | <input type="text"/>              |                                  |                          |                                 |                                  | Maiden name                       | <input type="text"/>             |                      |                      |                      |                      |                      |
| Gender  | <input type="checkbox"/> Male     | <input type="checkbox"/> Female  | Marital status           | <input type="checkbox"/> Single | <input type="checkbox"/> Married | <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed | Date of marriage     | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Date of birth                                       | <input type="text"/>              | <input type="text"/>             | <input type="text"/>     | <input type="text"/>            | <input type="text"/>             | <input type="text"/>              | <input type="text"/>             | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Place of birth                                      | <input type="text"/>              |                                  |                          |                                 |                                  | Nationality                       | <input type="text"/>             |                      |                      |                      |                      |                      |
| <input type="checkbox"/> National identity document | <input type="checkbox"/> Passport | <input type="checkbox"/> PIN No. | No. <input type="text"/> |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |
| Mandatory: Attach copy of Identification Document.  |                                   |                                  |                          |                                 |                                  |                                   |                                  |                      |                      |                      |                      |                      |

## 3. Children (Cover will cease when a child reaches 10)

|                                       |                                    |  |  |                               |                                 |                      |                      |                      |                      |                      |                      |                      |
|---------------------------------------|------------------------------------|--|--|-------------------------------|---------------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| 1. Surname                            | <input type="text"/>               |  |  |                               |                                 |                      |                      |                      |                      |                      |                      |                      |
| First names                           | <input type="text"/>               |  |  |                               |                                 |                      |                      |                      |                      |                      |                      |                      |
| Date of birth                         | <input type="text"/>               | <input type="text"/>                     | <input type="text"/>                           | <input type="text"/>          | <input type="text"/>            | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Place of birth                        | <input type="text"/>               |  |  |                               |                                 |                      |                      |                      |                      |                      |                      |                      |
| Relationship to policy/contract owner | <input type="checkbox"/> Own child | <input type="checkbox"/> Legally adopted | <input type="checkbox"/> Financially dependent | <input type="checkbox"/> Male | <input type="checkbox"/> Female |                      |                      |                      |                      |                      |                      |                      |
| 2. Surname                            | <input type="text"/>               |  |  |                               |                                 |                      |                      |                      |                      |                      |                      |                      |
| First names                           | <input type="text"/>               |  |  |                               |                                 |                      |                      |                      |                      |                      |                      |                      |
| Date of birth                         | <input type="text"/>               | <input type="text"/>                     | <input type="text"/>                           | <input type="text"/>          | <input type="text"/>            | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Place of birth                        | <input type="text"/>               |  |  |                               |                                 |                      |                      |                      |                      |                      |                      |                      |
| Relationship to policy/contract owner | <input type="checkbox"/> Own child | <input type="checkbox"/> Legally adopted | <input type="checkbox"/> Financially dependent | <input type="checkbox"/> Male | <input type="checkbox"/> Female |                      |                      |                      |                      |                      |                      |                      |
| 3. Surname                            | <input type="text"/>               |  |  |                               |                                 |                      |                      |                      |                      |                      |                      |                      |
| First names                           | <input type="text"/>               |  |  |                               |                                 |                      |                      |                      |                      |                      |                      |                      |
| Date of birth                         | <input type="text"/>               | <input type="text"/>                     | <input type="text"/>                           | <input type="text"/>          | <input type="text"/>            | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Place of birth                        | <input type="text"/>               |  |  |                               |                                 |                      |                      |                      |                      |                      |                      |                      |
| Relationship to policy/contract owner | <input type="checkbox"/> Own child | <input type="checkbox"/> Legally adopted | <input type="checkbox"/> Financially dependent | <input type="checkbox"/> Male | <input type="checkbox"/> Female |                      |                      |                      |                      |                      |                      |                      |
| 4. Surname                            | <input type="text"/>               |  |  |                               |                                 |                      |                      |                      |                      |                      |                      |                      |
| First names                           | <input type="text"/>               |  |  |                               |                                 |                      |                      |                      |                      |                      |                      |                      |
| Date of birth                         | <input type="text"/>               | <input type="text"/>                     | <input type="text"/>                           | <input type="text"/>          | <input type="text"/>            | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Place of birth                        | <input type="text"/>               |  |  |                               |                                 |                      |                      |                      |                      |                      |                      |                      |
| Relationship to policy/contract owner | <input type="checkbox"/> Own child | <input type="checkbox"/> Legally adopted | <input type="checkbox"/> Financially dependent | <input type="checkbox"/> Male | <input type="checkbox"/> Female |                      |                      |                      |                      |                      |                      |                      |



## 4. Parents and Parents-in-Law

|  |  |        |  |                     |  |             |  |                |  |      |  |
|--|--|--------|--|---------------------|--|-------------|--|----------------|--|------|--|
| <b>Father</b>  |  |        |  |                     |  |             |  |                |  |      |  |
| Surname  |  |        |  |                     |  | First names |  |                |  |      |  |
| Date of birth  |  |        |  | Tax/ID/Passport no. |  |             |  | Place of birth |  |      |  |
| Postal address:  |  | PO Box |  |                     |  | Town        |  |                |  | Code |  |
| Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed |  |        |  |                     |  |             |  |                |  |      |  |
| <b>Mother</b>  |  |        |  |                     |  |             |  |                |  |      |  |
| Surname  |  |        |  |                     |  | First names |  |                |  |      |  |
| Maiden name  |  |        |  |                     |  |             |  |                |  |      |  |
| Date of birth  |  |        |  | Tax/ID/Passport no. |  |             |  | Place of birth |  |      |  |
| Postal address:  |  | PO Box |  |                     |  | Town        |  |                |  | Code |  |
| Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed |  |        |  |                     |  |             |  |                |  |      |  |
| <b>Father-in-Law</b>   |  |        |  |                     |  |             |  |                |  |      |  |
| Surname  |  |        |  |                     |  | First names |  |                |  |      |  |
| Date of birth  |  |        |  | Tax/ID/Passport no. |  |             |  | Place of birth |  |      |  |
| Postal address:  |  | PO Box |  |                     |  | Town        |  |                |  | Code |  |
| Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed |  |        |  |                     |  |             |  |                |  |      |  |
| <b>Mother-in-Law</b>   |  |        |  |                     |  |             |  |                |  |      |  |
| Surname  |  |        |  |                     |  | First names |  |                |  |      |  |
| Maiden name  |  |        |  |                     |  |             |  |                |  |      |  |
| Date of birth  |  |        |  | Tax/ID/Passport no. |  |             |  | Place of birth |  |      |  |
| Postal address:  |  | PO Box |  |                     |  | Town        |  |                |  | Code |  |
| Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed |  |        |  |                     |  |             |  |                |  |      |  |

## 5. Extended family

|                                |  |  |  |                |  |             |  |  |  |  |  |   |  |                               |                                 |                              |                                 |
|--------------------------------|--|--|--|----------------|--|-------------|--|--|--|--|--|---|--|-------------------------------|---------------------------------|------------------------------|---------------------------------|
| Surname                        |  |  |  |                |  | First names |  |  |  |  |  | Other initials                          |  |                               |                                 |                              |                                 |
| Date of birth                  |  |  |  | Place of birth |  |             |  |  |  |  |  |   |  |                               |                                 |                              |                                 |
| Relationship to contract owner |  |  |  |                |  |             |  |  |  |  |  | aunt, uncle, cousin, niece, nephew etc. |  | <input type="checkbox"/> Male | <input type="checkbox"/> Female | <input type="checkbox"/> Add | <input type="checkbox"/> Delete |
| Surname                        |  |  |  |                |  | First names |  |  |  |  |  | Other initials                          |  |                               |                                 |                              |                                 |
| Date of birth                  |  |  |  | Place of birth |  |             |  |  |  |  |  |   |  |                               |                                 |                              |                                 |
| Relationship to contract owner |  |  |  |                |  |             |  |  |  |  |  | aunt, uncle, cousin, niece, nephew etc. |  | <input type="checkbox"/> Male | <input type="checkbox"/> Female | <input type="checkbox"/> Add | <input type="checkbox"/> Delete |
| Surname                        |  |  |  |                |  | First names |  |  |  |  |  | Other initials                          |  |                               |                                 |                              |                                 |
| Date of birth                  |  |  |  | Place of birth |  |             |  |  |  |  |  |   |  |                               |                                 |                              |                                 |
| Relationship to contract owner |  |  |  |                |  |             |  |  |  |  |  | aunt, uncle, cousin, niece, nephew etc. |  | <input type="checkbox"/> Male | <input type="checkbox"/> Female | <input type="checkbox"/> Add | <input type="checkbox"/> Delete |
| Surname                        |  |  |  |                |  | First names |  |  |  |  |  | Other initials                          |  |                               |                                 |                              |                                 |
| Date of birth                  |  |  |  | Place of birth |  |             |  |  |  |  |  |   |  |                               |                                 |                              |                                 |
| Relationship to contract owner |  |  |  |                |  |             |  |  |  |  |  | aunt, uncle, cousin, niece, nephew etc. |  | <input type="checkbox"/> Male | <input type="checkbox"/> Female | <input type="checkbox"/> Add | <input type="checkbox"/> Delete |
| Surname                        |  |  |  |                |  | First names |  |  |  |  |  | Other initials                          |  |                               |                                 |                              |                                 |
| Date of birth                  |  |  |  | Place of birth |  |             |  |  |  |  |  |   |  |                               |                                 |                              |                                 |
| Relationship to contract owner |  |  |  |                |  |             |  |  |  |  |  | aunt, uncle, cousin, niece, nephew etc. |  | <input type="checkbox"/> Male | <input type="checkbox"/> Female | <input type="checkbox"/> Add | <input type="checkbox"/> Delete |



## 6. Method of Premium Payment

Please indicate method of payment:

Salary deduction  (Please complete salary deduction form)      Cash   
 Bank debit order  (Please complete relevant bankers order form)      M-Pesa\*   
 Standing order  (Please complete relevant standing order form)

\*Metropolitan Life Insurance Kenya Ltd (hereafter referred to as Metropolitan) and its associates, officers, employees or agents shall under no circumstances be liable or responsible for any loss, damage, liability, cost or expense incurred or suffered by the Contact Owner, Insured Life or Premium Payer for any failure on the part of the collection agent so instructed by Metropolitan, to remit premiums due in terms of this contract to Metropolitan.

**Salary deduction** (latest salary slip compulsory, please complete salary deduction form)

I hereby authorise my Employer mentioned below to deduct the premium for this contract and to remit it to Metropolitan. This authorisation must be kept in force until such time as I cancel this authority or submit a replacement authority in writing.

Name of employer  Employee's ref. number   
 Date of first deduction           Date employment started             
 y y y y m m d d      y y y y m m d d  
 Employment terms  Temporary  Permanent  Contract      Job title   
 Signature of premium payer  Date            
 y y y y m m d d

**Bank details** (the bankers order/standing order form should also be completed)

Bank account information  
 Bank  Branch name   
 Account type  Current  Savings      Other   
 Account holder  Account no.                       
 Date            
 Signature of account holder      y y y y m m d d

**Cash deposit(s) NOTE: We do not receive cash in the office**

Kindly pay your initial premiums via:

1. Initial premium can be deposited at Equity Bank, Moi Avenue branch, A/C No **047 029 313 9292**.
2. Deposit in Cooperative Bank, Aga Khan Walk branch, account number **011363 057 046 00** (account name Metropolitan Life Insurance). Attach deposit slip to the application form.
3. M-PESA paybill no. **808900** (indicate ID as account number and M-PESA code on the application form).

## 7. Contract Details

| Payment frequency                      | Level of cover                           | AIM (Tick one)               | Rider benefits   | Premium                  |
|--|--|------------------------------|--|--------------------------|
| (cannot be changed after policy issue) | <input type="checkbox"/> Copper          | <input type="checkbox"/> 0%  | <input type="checkbox"/> Death Premium Waiver Benefit      | KSh <input type="text"/> |
| <input type="checkbox"/> Monthly       | <input type="checkbox"/> Bronze          | <input type="checkbox"/> 5%  | <input type="checkbox"/> Disability Premium Waiver Benefit | KSh <input type="text"/> |
| <input type="checkbox"/> Quarterly     | <input type="checkbox"/> Silver          | <input type="checkbox"/> 10% | <input type="checkbox"/> Cash Withdrawal Benefit           | KSh <input type="text"/> |
| <input type="checkbox"/> Half-yearly   | <input type="checkbox"/> Gold            | <input type="checkbox"/> 15% |  |                          |
| <input type="checkbox"/> Annually      | <input type="checkbox"/> Platinum        |                              | <b>Total rider benefits premium (B)</b>                    | KSh <input type="text"/> |
| <b>Number of:</b>                      |  |                              |  |                          |
| <input type="checkbox"/> Spouses       | <input type="checkbox"/> Extended family |                              |  |                          |
| <input type="checkbox"/> Children      | <input type="checkbox"/> Parents         |                              |  |                          |
| <b>Total funeral premium (A)</b>       | KSh <input type="text"/>                 |                              |  |                          |
| <b>Total premium (A + B)</b>           | KSh <input type="text"/>                 |                              |  |                          |



## 8.1 Insurability questions (Always complete)

| The following questions must be answered by the Main Life Insured on behalf of him/herself, spouse, children, parents and/or extended family:  | Main Life Insured        |                          | Spouse                   |                          | Children                 |                          | Parents/ Extended Family |                          |   |                      |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---|----------------------|
|  | Yes                      | No                       | Yes                      | No                       | Yes                      | No                       | Yes                      | No                       |   |                      |
| 1. Has any of the insured lives suffered continually from persistent night sweats, persistent diarrhoea, swollen glands, persistent cough, purplish skin blemishes, persistent mouth sores or unexplained weight loss during the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |                      |
| 2. Has any life insurer ever declined, postponed, withdrawn or loaded insurance applied for by any of the insured lives?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |                      |
| 3. Has any of the insured lives ever suffered from any form of disability or heart attack or heart disease, or diabetes mellitus, stroke, cancer, hypertension or kidney disease?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |                      |
| 4. Apart from minor ailments such as colds or flu, has any of the insured lives received any treatment from any medical practitioner during the past 6 months?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |                      |
| 5. Has any of the insured lives been hospitalised or undergone hospital treatment, or specialist examination during the past five years?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |                      |
| 6. Has any of the insured lives taken any medication or drugs for health reasons during the past 5 years?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |                      |
| <b>Questions 7 to 9 relate only to the Main Life Insured.</b>  |                          |                          |                          |                          |                          |                          |                          |                          |   |                      |
|  | Yes                      |                          | No                       |                          |                          |                          |                          |                          |   |                      |
| 7. Does the Main Life Insured consume alcohol?   | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |                          |                          |                          |   |                      |
| 8. Does the Main Life Insured smoke?   | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |                          |                          |                          |   |                      |
| 9. Height <input type="text"/> <input type="text"/> <input type="text"/> feet      Weight <input type="text"/> <input type="text"/> <input type="text"/> kilograms   |                          |                          |                          |                          |                          |                          |                          |                          |   |                      |
| <b>FURTHER PARTICULARS</b>   |                          |                          |                          |                          |                          |                          |                          |                          |   |                      |
| If the answer to any of the questions, except 7 to 9 is "yes", please give full particulars below:   |                          |                          |                          |                          |                          |                          |                          |                          |   |                      |
| Where applicable, include the name of the insured life, when last symptoms occurred (month and year), as well as names and addresses of doctors, hospitals or institutions.  |                          |                          |                          |                          |                          |                          |                          |                          |   |                      |
| Question   | Name                     | Date of Birth            |                          |                          |                          |                          |                          | Particulars              |   |                      |
| <input type="text"/>   | <input type="text"/>     | Y                        | Y                        | Y                        | Y                        | M                        | M                        | D                        | D | <input type="text"/> |
| <input type="text"/>   | <input type="text"/>     | Y                        | Y                        | Y                        | Y                        | M                        | M                        | D                        | D | <input type="text"/> |
| <input type="text"/>   | <input type="text"/>     | Y                        | Y                        | Y                        | Y                        | M                        | M                        | D                        | D | <input type="text"/> |
| <input type="text"/>   | <input type="text"/>     | Y                        | Y                        | Y                        | Y                        | M                        | M                        | D                        | D | <input type="text"/> |
| <input type="text"/>   | <input type="text"/>     | Y                        | Y                        | Y                        | Y                        | M                        | M                        | D                        | D | <input type="text"/> |
| <input type="text"/>   | <input type="text"/>     | Y                        | Y                        | Y                        | Y                        | M                        | M                        | D                        | D | <input type="text"/> |

## 8.2 Insurability questions (Complete only if a Premium Waiver Benefit is added and the Main Life Insured is not the Premium Payer)

|  |  |                          |                          |
|--|--|--------------------------|--------------------------|
| 1.   | Is the Premium Payer currently engaged in any of the following:  | Yes                      | No                       |
|  | 1.1 Flying other than as a fare-paying passenger of a recognised airline on a scheduled route?   | <input type="checkbox"/> | <input type="checkbox"/> |
|  | 1.2 Any hazardous sport, pursuit or occupation such as boxing, diving, motor-racing, hang gliding or handling of explosives?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.   | Has any application for insurance in respect of the Premium Payer ever been declined, postponed, withdrawn or accepted on special terms by any life insurer?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.   | Has there been any application for insurance, or application for reinstatement of a lapsed contract, in respect of the Premium Payer with Metropolitan or any other life insurer during the past 12 months? If "yes", please furnish the name of the insurer, entry/amended date and sum insured in section below. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.   | Does the Premium Payer consume alcohol?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5.   | Does the Premium Payer smoke?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6.   | Height <input type="text"/> <input type="text"/> <input type="text"/> feet      Weight <input type="text"/> <input type="text"/> <input type="text"/> kilograms  |                          |                          |
| 7.   | Is the Premium Payer on any permanent medication or has he/she seen a medical practitioner, gone to a medical facility or institution regarding health problems or habits affecting his/her health, either physically or mentally during the past 5 years (excluding minor ailments and surgery)?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8.   | Is the Premium Payer suffering from any illness, deformity or disability of whatever nature or is the Life Insured/Premium Payer in poor physical or mental health?  | <input type="checkbox"/> | <input type="checkbox"/> |
| If the answers to the above questions, except for questions 4 to 6 are "yes", please complete below: |  |                          |                          |
| Question   | Particulars  |                          |                          |
| <input type="text"/>   | <input type="text"/>   |                          |                          |
| <input type="text"/>   | <input type="text"/>   |                          |                          |

(continued overleaf)





## 12. Information to be completed by Intermediary

|   |  |
|---|--|
| <b>Intermediary:</b><br>Name <input style="width: 90%;" type="text"/><br>Level code <input type="text" value="0"/> <input type="text" value="0"/> <input type="text" value="K"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/><br><br><div style="border: 1px solid black; height: 20px; width: 100%;"></div><br>Signature<br>Date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/><br>y y y y m m d d | <b>Sales manager/Broker consultant:</b><br>Name <input style="width: 90%;" type="text"/><br>Level code <input type="text" value="0"/> <input type="text" value="0"/> <input type="text" value="K"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/><br><br><div style="border: 1px solid black; height: 20px; width: 100%;"></div><br>Signature<br>Date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/><br>y y y y m m d d |
|---|--|

## 13. Agent Disclosure checklist

The contract owner has the right to the following information. Kindly confirm that this has been provided.

**AGENT STATUS** (indicate with a tick in the yes or no box)

|   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 13.1 Have you provided the following information to the contract owner:                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| a) Your full name and title?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Office details (physical and postal address)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Telephone and email contact details?   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>ADVICE</b>   |                          |                          |
| 13.2 a) Have you taken the circumstances of the contract owner into account to satisfy their financial needs? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Have you done a sufficient needs analysis?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13.3 Have you disclosed the following information to the contract owner:                                      |                          |                          |
| a) Name and type of policy?   | <input type="checkbox"/> | <input type="checkbox"/> |
| b) The premium?   | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Type, extent and limitations of benefits?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d) That commission is payable on this policy and answered any commission related questions?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| e) The 30-day cooling off period?   | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Claims notification procedure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Cancellation procedure and surrender?  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>APPLICATION STAGE</b>  |                          |                          |
| 13.4 Is the contract owner satisfied with the advice and disclosure that you have given?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 13.5 Has the policyholder completed and signed the application form?  | <input type="checkbox"/> | <input type="checkbox"/> |

|  |  |
|--|--|
| <div style="border: 1px solid black; height: 25px; width: 90%; margin: 0 auto;"></div> Signature of Policy Owner<br><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/><br>y y y y m m d d | <div style="border: 1px solid black; height: 25px; width: 90%; margin: 0 auto;"></div> Signature of Intermediary<br><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/><br>y y y y m m d d |
|--|--|

## FOR OFFICE USE ONLY

|  |   |
|--|---|
| <p><b><u>AUTHORISATION AND CHECK BY MANAGER</u></b></p> <p>Accept Application which is:</p> <p><input type="checkbox"/> Complete    <input type="checkbox"/> Not able to be spot checked    <input type="checkbox"/> Spot checked</p> <p>Signature <input style="width: 80%;" type="text"/></p> <p>Date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/><br/>                   y y y y m m d d</p> | <p><b><u>NEW BUSINESS</u></b></p> <p><b><u>UNDERWRITER'S COMMENTS</u></b></p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div> |
|--|---|