Tatil
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POLICY NO.

TATIL LIFE
Guaranteed Protection

LIFE POLICY APPLICATION - PART 1
(FOR ADULTS AGE 16 AND OVER)

1. OWNER (Print full name): ..... PREVIOUS NAMES: .....

MAILING ADDRESS: .....

RESIDENCE ADDRESS: ..... PHONE/E-MAIL: .....

2. PROPOSED INSURED:- Same as Owner ☐ or ..... PREVIOUS NAMES: .....

RESIDENCE ADDRESS: ..... PHONE: .....

3. BENEFICIARY: .....

.....

4. TRUSTEES under the Married Persons Act. OWNER AND .....

5. DETAILS OF BENEFICIARIES AND TRUSTEES

FULL NAME	DATE OF BIRTH	ADDRESS

EFFECTIVE DATE:

6. **COVERAGE REQUESTED**

BASIC PLAN ..... ☐ PAR ☐ NON PAR SUM INSURED $ .....

☐ TOTAL DISABILITY WAIVER ☐ ACCIDENTAL DEATH $ .....

DISABILITY INCOME RIDER:

☐ MONTHLY INCOME $ ..... ☐ ACCIDENTAL DEATH AND DISMEMBERMENT $ .....

☐ ..... ☐ LIFESPAN @60 ☐ @65 ☐ @70 ☐ $ .....

☐ ..... ☐ SMOKER ☐ NON-SMOKER

7.

PREMIUM PAID	FREQUENCY	METHOD OF PAYMENT (IF MONTHLY)
$	☐ Y ☐ H ☐ Q ☐ M	☐ SALARY ☐ BANK ☐ POST DATED CHEQUES

QUESTIONS 8 - 13 APPLY TO THE PROPOSED INSURED

8.

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

COUNTRY OF BIRTH	DATE OF BIRTH			AGE NEXT BIRTHDAY	
	Day:	Month:	Year:		☐ MALE ☐ FEMALE

9. OCCUPATION

JOB TITLE AND EXACT DUTIES: _____

HOW LONG EMPLOYED? _____ ANY CHANGE IN OCCUPATION CONTEMPLATED? ☐ NO ☐ YES - Details _____

EMPLOYER'S NAME AND ADDRESS: _____

YOUR OFFICE ADDRESS, IF DIFFERENT: _____

PART-TIME OCCUPATION: ☐ NO ☐ YES - Details _____

10. OTHER LIFE OR CRITICAL ILLNESS OR HEALTH INSURANCE IN FORCE:

Year Issued	Company	SUM INSURED			ACCIDENT BENEFITS		
		Life Insurance	Critical Illness	Health	AD	AD & D	Accident Indemnity

	YES	NO	IF YES, STATE PARTICULARS
11. HAVE YOU: (A) ANY APPLICATION FOR INSURANCE PENDING WITH THIS OR ANOTHER COMPANY?	—	—	
(B) ANY INTENTION OF REPLACING EXISTING INSURANCE WITH THIS POLICY?	—		
(C) EVER LAPSED OR SURRENDERED A POLICY IN THIS COMPANY?	—	—	
(D) EVER HAD AN APPLICATION FOR INSURANCE, CHANGE OR REINSTATEMENT DECLINED, POSTPONED, RATED OR MODIFIED IN ANY WAY?	—	—	
(E) EVER APPLIED FOR OR RECEIVED A DISABILITY BENEFIT, PENSION OR COMPENSATION FOR ACCIDENT, ILLNESS OR INJURY?	—	—	
(F) ANY INTENTION OF CHANGING YOUR COUNTRY OF RESIDENCE?	—	—	
(G) EVER USED OR TRAVELLED ON A MOTORCYCLE?	—	—	
(H) (i) EVER ENGAGED IN SCUBA DIVING, AUTOMOBILE OR MOTOR CYCLE RACING, BOXING, WRESTLING OR OTHER HAZARDOUS SPORTS?	—	—	
(ii) ANY INTENTION OF DOING SO IN THE FUTURE?	—	—	
(I) (i) EVER FLOWN OTHER THAN AS A FARE PAYING PASSENGER ON A REGULAR SCHEDULED AIRLINE?	—		
(ii) ANY INTENTION OF DOING SO IN THE FUTURE?	—	—	

	YES	NO	IF YES, STATE PARTICULARS
12. (B) HAS ANY ILLNESS CAUSED YOU TO BE ABSENT FROM WORK FOR LONGER THAN TWO WEEKS AT A TIME DURING THE PAST 3 YEARS?	☐	☐	
13. HAVE YOU:			
(A)(i) EVER USED MARIJUANA, COCAINE, AMPHETAMINES, BARBITURATES, HALLUCINOGENIC AGENTS, HEROIN. (OR OTHER DERIVATIVES OF OPIUM) OTHER THAN ON A PRESCRIPTION BASIS?	☐	☐	
(ii) EVER BEEN TREATED OR COUNSELLED FOR USE OF ALCOHOL OR DRUGS?	☐	☐	
(B) HAVE YOU EVER SMOKED?	☐	☐	
IF YES STATE WHEN STARTED?			
(i) IN THE PAST 12 MONTHS HAVE YOU SMOKED CIGARETTES, CIGARS, PIPE OR USED ANY FORM OF TOBACCO, OR NICOTINE PRODUCT? IF YES, PLEASE GIVE DETAILS:	☐	☐	
(a) TYPE OF TOBACCO?			
(b) AMOUNT USED DAILY?			
(ii) NO. OF CIGARETTES SMOKED PER DAY?			
(iii) NO. OF CIGARS SMOKED PER DAY?			
(iv) HOW OFTEN YOU SMOKE A PIPE PER DAY?			
(v) IF YOU STOPPED SMOKING, STATE THE NUMBER OF YEARS SINCE YOU STOPPED ..... REASON?			
(C) HOW OFTEN DO YOU CONSUME ALCOHOLIC BEVERAGES? HOW MANY DRINKS ARE CONSUMED ON EACH OCCASION? ☐ DAILY ..... drinks ☐ MONTHLY ..... drinks ☐ WEEKLY ..... drinks ☐ NOT AT ALL ☐ OTHER (Details)			
	YES	NO	
(D) WITHIN THE PAST 5 YEARS HAVE YOU BEEN CHARGED WITH OR CONVICTED OF A CRIMINAL OFFRNCE AS A RESULT OF A MOTOR VEHICULAR ACCIDENT?	☐	☐	
(E) DO YOU HAVE ANY MOTOR VEHICULAR ACCIDENT CASE PENDING?	☐	☐	

14. DECLARATION

I hereby certify that to the best of my knowledge and belief all statements and answers contained in Parts 1 and 2 of this application are full, complete and true, and expressly agree as follows:

a. The application and the statements and answers in any declaration of insurability or questionnaire completed in connection with this application shall be the basis of the policy contract.

b. All material facts which the company would consider likely to influence the acceptance of the application have been disclosed and failure of the policyowner or proposed insured to disclose any material fact may result in the avoidance of the contract.

c. Any fact about which teh policyowner or proposed insured is doubtful whether it is material should be disclosed.

d. The policy applied for shall not take effect until it has been delivered and the first premium paid, no material change having taken place in the health of the owner or the proposed insured between the date of the application and delivery of the policy.

e. Acceptance by me of any policy issued on this appication shall constitute approval by me of the provisions of the policy.

f. If the policy as applied for or as amended in accordance with my signed agreement has been issued but not accepted by me, the company may deduct all its costs incidental to the issuingfrom any moneys that might be refundable to me in the circumstances.

g. No agent has the power on behalf of the company to modify any application for insurance or the policy, or to bind the company by making any promise or representation or by giving or receving any information.

h. The right to change the beneficiary, to assign the policy, and to secure loans and guaranteed values without the consent of the beneficiary is reserved to the owner, subject, however, to any statutory restrictions.

i. The Auromatic Premium Loan provision shall be operative if that provision is available under the policy.

.....
Date

.....
Signature of Proposed Insured

.....
Signature of Witness

.....
Signature of Owner

AGENT'S REPORT

15. PREMIUM CALCULATION **Planned Periodic Premium: $** .....

(for Cashbuilder, show minimum modal premium only).

(1)	(2)	(3)	(4)	(5)
ANB:	PREMIUM		DISABILITY WAIVER	
SEX:	Annual	Modal	Annual	Modal
Basic Plan				
Sum Insured	$	$		
Policy Fee	$	$		
Riders/Benefits	$	$		
	$	$		
	$	$		
	$	$		
SUB TOTAL	.....	.....	.....	.....
TOTAL	cols. (2) + (4) $	cols. (3) + (5) $		

	GIVE FULL DETAILS
16. (A) HOW LONG AND HOW WELL HAVE YOU KNOWN THE PROPOSED INSURED? STATE RELATIONSHIP, IF ANY.	
(B) IF THE PROPOSED INSURED IS A DEPENDENT SPOUSE GIVE OTHER SPOUSE'S NAME, OCCUPATION AND AMOUNT OF INSURANCE IN FORCE.	
(C) REASON FOR INSURANCE	
(D) OWNER'S ANNUAL INCOME (SHOW EMPLOYMENT AND OTHER SOURCES SEPARATELY) AND NET WORTH.	

	YES	NO	GIVE FULL DETAILS
17. (A) ARE YOU AWARE OF ANYTHING CONCERNING THE PAST OR PRESENT HEALTH, HABITS, CHARACTER OR OCCUPATION OF THE PROPOSED INSURED WHICH MIGHT AFFECT HIS OR HER INSURABILITY?	☐	☐	
(B) WAS AN AUTHORIZED EXAMINER USED? IF NOT, EXPLAIN	☐	☐	
(C) HAS THERE BEEN OR WILL THERE BE ANY CHANGE IN EXISTING INSURANCE OR ANNUITY OR WILL PREMIUMS FOR THIS POLICY BE PAID BY A POLICY LOAN?		☐	

18. (A) HOW WAS BUSINESS OBTAINED? ☐ REFERRED LEAD ☐ COLD CALL ☐ APPLICANT'S REQUEST ☐ AGENT'S INITIATIVE

(B) ADDITIONAL INFORMATION WHICH MAY HELP IN UNDERWRITING THIS RISK

.....

.....

.....

COMPLETE IF THIS IS A THIRD PARTY APPLICATION

19. (a) PURPOSE OF INSURANCE: ☐ BUSINESS ☐ STOCK RETIREMENT ☐ KEY MAN ☐ STOCK PURCHASE ☐ PARTNERSHIP ☐ OTHER (EXPLAIN) .....

(b) HOW MUCH BUSINESS INSURANCE IS IN FORCE

(i) ON THE PROPOSED INSURED $

(ii) ON OTHER MEMBERS OF THE FIRM (GIVE NAMES)

..... $ .....

..... $ .....

..... $ .....

I hereby certify that I solicited and secured this application, and I know of nothing against the risk which is not fully disclosed in these papers, and I unreservedly recommend him/her for life insurance.

Date: ..... Agent's Signature: ..... Unit/Agent No.: .....