

MY SAVINGS PLAN

(Proposal & KYC form)

Proposal
Number:



Passport
Photograph

IMPORTANT INFORMATION:

1. An agent who assists an applicant to complete an application or proposal form for Insurance shall be deemed to have done so as the agent of the applicant in accordance with section 54(2), Insurance Act, 2003.
2. The liability of the company does not commence until this application is accepted and the premium is paid in accordance with section 50(1) of the Insurance Act, 2003.
3. All premium payments MUST be made directly to Prudential Zenith Life Insurance and not any representative of the company nor a third party.

PLEASE COMPLETE IN BLOCK LETTERS

Section 1. Details of Policy Owner

FIRST NAME

MIDDLE NAME

SURNAME TITLE

DATE OF BIRTH AGE

CONTACT DETAILS

MOBILE NO. +

ALTERNATIVE NO. +

EMAIL ADDRESS

COUNTRY

STATE

L.G.A

MOTHER'S MAIDEN NAME

POSTAL ADDRESS

CODE

GENDER (please tick) MALE FEMALE MARITAL STATUS (please circle) Single Married

BVN

NATIONALITY

Please state any nationality (other than Nigerian) that you hold

RESIDENTIAL ADDRESS Same as above

ADDRESS

(Number, Street & Location)

STATE & COUNTRY

EMPLOYMENT DETAILS (if employed)

EMPLOYER

ADDRESS

(Number, Street & Location)

STATE & COUNTRY

OCCUPATION

EMPLOYEE STATUS TEMPORARY PERMANENT CONTRACT

ID TYPE (please tick)

- NATIONAL ID CARD
- DRIVING LICENSE
- VOTERS CARD
- INTERNATIONAL PASSPORT

ID NO

ISSUING AUTHORITY

COUNTRY OF ISSUE

DATE OF ISSUE

DATE OF EXPIRY

RESIDENCE PERMIT

Note: The policy terms and conditions have been attached to this form, these are an essential part of your contract of insurance with us. Please request for a copy if you do not receive them.

TELEPHONE NO. +

EMAIL ADDRESS

EMPLOYEE NO. EMPLOYMENT DATE

IS YOUR EMPLOYER : GOVERNMENT
 PRIVATE

SALARY LEVEL (PER MONTH) N 18,000 - 49,999 N 50,000 - 99,999 N 200,000 - 499,999 N 500,000 AND ABOVE

BUSINESS DETAILS (if self-employed)

BUSINESS NAME

NATURE OF BUSINESS

INCOME LEVEL (PER MONTH) N 18,000 - 99,999 N 100,000 - 399,999 N 400,000 - 999,999 N 1,000,000 AND ABOVE

Section 2. Details of Premium Payment

REGULAR PREMIUM ANNUALLY SEMI-ANNUALLY QUARTERLY MONTHLY

SINGLE PREMIUM

Do you have additional premium to the policy? Kindly tick option 1 or 2 or 3

- Option 1 The payment will be applied to future premiums when they become due. Once this sum is exhausted, regular premium will be collected by direct debit for which a direct debit instruction has been completed.
- Option 2 The payment covers the entire premium due for the duration of the policy. No further premium payments are due
- Option 3 The payment is supplementary to the regular premiums due. The regular premiums will be paid when they become due

PAYMENT BY: (Please tick) DIRECT DEBIT

DIRECT DEPOSIT CHEQUE WEBSITE ONLINE TRANSFER NIBSS E-BILLS PAY BANK DRAFT POS AT BANK CASH PAID INTO BANK ACCOUNT

MODE OF NOTIFICATION: (Please tick) E-MAIL SMS (charges apply)

Section 3. Details of Assurance

DATE OF COMMENCEMENT DURATION: Year(s)

SUM ASSURED

STATEMENT OF HEALTH OF THE LIFE ASSURED
(Fill in or tick as appropriate)

1. Has an application for life, sickness, disability or critical illness insurance on your life ever been declined, deferred, withdrawn or accepted with a loading or exclusion?
2. Have you ever claimed any benefit from sickness, disability, critical illness or accident policies?
3. Have you suffered an injury which has prevented the full use of your limbs and/or eyes?
4. Have you in the last 5 years: consulted any medical professionals; had medical examinations and/or special investigations (including blood tests); taken medication or treatment; been hospitalized or received medical advice to alter or discontinue your alcohol consumption?
5. Have you, in the last 5 years, suffered from or been diagnosed with any form of:
 - a) Blindness, hearing or speech problems?
 - b) Asthma, tuberculosis, chronic cough?
 - c) Heart attack, heart disease or disorder, high blood pressure, raised cholesterol?
 - d) Diabetes, stroke?
 - e) Cancer, tumours? (state whether benign or malignant)
 - f) Kidney disease, blood or protein in the urine?
 - g) HIV/AIDS or HIV/AIDS related conditions, Sexually Transmitted Diseases (STDs)?
 - h) Psychological problems or disability?
 - i) Body or limb defects, paralysis, physical disability?

- j) Any condition other than colds, flu or other minor, curable ailments? YES NO
6. Are you currently experiencing health-related symptoms or do you intend to seek medical advice or testing for any condition other than colds, flu or any other minor curable ailments in the next 6 months? YES NO
7. Has your weight changed by more than 5kg in the last 3 months? YES NO
8. If you answered "Yes" to any of the questions on the previous page and above, please give full details below indicating : nature of complaint of symptoms, types of treatment or medication, date of first symptoms or diagnosis, date of last symptoms, name and telephone number of attending doctor.

You may use additional paper for more information.

9. You are required to tell us anything that you may know about your health that may affect our decision to insure you. Any material medical history not mentioned may invalidate this application for insurance and it is possible that you may not be able to claim the insurance risk benefits under this policy. Please use the space below to provide this information.

You may use additional paper for more information.

Section 4. Tax Residency Self Certificate

Please complete this section.

Please list all countries (including Nigeria) in which you're resident for tax purposes, together with any Tax Identification Number(s) ("TIN"). if you have one.

Country/countries of tax residency	TIN
1.	1.
2.	2.
3.	3.

If there is any other reason why a TIN is not available please let us know the reason below:

Section 5. Beneficiaries

If you wish the proceeds to be paid to more than one beneficiary, please include the details of all the beneficiaries. You may use additional paper if the space provided below is not sufficient. Please ensure that the total of the percentages equals 100%. If no beneficiary is provided the proceeds will be paid to your estate.

BENEFICIARY ONE

FIRST NAME

MIDDLE NAME

SURNAME TITLE

GENDER (please tick) MALE FEMALE DATE OF BIRTH

ID NO. PERCENTAGE SHARE

EMAIL ADDRESS

MOBILE NO. +

RELATIONSHIP

BENEFICIARY TWO

FIRST NAME

MIDDLE NAME

SURNAME TITLE

GENDER (please tick) MALE FEMALE DATE OF BIRTH

ID NO. PERCENTAGE SHARE

EMAIL ADDRESS

MOBILE NO. +

RELATIONSHIP

BENEFICIARY THREE

FIRST NAME

MIDDLE NAME

SURNAME TITLE

GENDER (please tick) MALE FEMALE DATE OF BIRTH

ID NO. PERCENTAGE SHARE

EMAIL ADDRESS

MOBILE NO. +

RELATIONSHIP

If the beneficiary is under 18 years of age, the guardian details are required. Note: the appointment of a minor may delay settlement of a claim.

GUARDIAN

FIRST NAME

MIDDLE NAME

SURNAME

ID NO.

MOBILE NO. +

EMAIL ADDRESS

POSTAL ADDRESS

STATE

COUNTRY

INSURANCE HISTORY

Has any application for life insurance ever been made, or is now being made on your life (excluding this application)?

(Please tick)
 YES NO

If YES, please state:

Name of insurer(s)

Date of application Sum assured

Is the policy in force? YES NO

Do you have an existing Life Insurance policy with us? YES NO

Section 6. Declarations

DECLARATION BY THE POLICY OWNER AND LIFE ASSURED

I declare that the answers to the questions and statements in this application form, whether in my own handwriting or not, are true and complete. I understand that the answers to these questions and statements and any documents required by Prudential Zenith Life shall be the basis of the contract. I further declare that I have disclosed all material facts which may influence the assessment of this proposal by Prudential Zenith Life and any material medical history not mentioned may invalidate the application and any claim on the policy. I understand that this policy of insurance is subject to Prudential Zenith Life's terms and conditions which have been issued to me by the intermediary.

I also understand that all premiums due on the policy are to be paid by me directly into the bank account of Prudential Zenith Life Insurance and not to any intermediary including the intermediary who sold this policy to me and that Prudential Zenith Life Insurance will not be liable for any funds that I do not pay directly to them.

I accept that I am limiting my right to privacy. However, to access the insurance benefits, I authorise Prudential Zenith Life to obtain from any person whom I hereby permit and request to give any information which Prudential Zenith Life needs and to share with other insurers that information and any information in this application or any related source at any time in a form approved by Prudential Zenith Life.

I confirm that the details given in this form are correct and complete. If the information provided above becomes invalid, I agree to advise Prudential Zenith Life Insurance Limited and provide an updated declaration form within 30 days of such change occurring.

I acknowledge receipt of the terms and conditions of my policy and agree to abide by them.

I consent to Prudential Zenith Life Insurance Limited's request to use the information and documentation provided by me with other third parties for risk management, assurance review and regulatory audit purposes.

NAME

(life to be assured)

SIGNATURE

DATE

FOR OFFICIAL USE ONLY

DECLARATION BY THE AUTHORISED INTERMEDIARY/AGENT *(always complete this section)*

By submitting this application I declare that I have provided the applicant with a complete quotation in respect of the policy applied for in writing. I further undertake that I have explained all material terms and conditions of the policy to the applicant and that I have issued the applicant with the terms and conditions of the policy.

I am satisfied that I have confirmed the identity of the client in accordance with the requirements set out in the Insurance Act and any related legislation, regulations or guidelines. I have forwarded copies of all the required documents to Prudential Zenith Life.

INTERMEDIARY/AGENT

FIRST NAME

SURNAME

BRANCH NAME

FSE/AGENT'S CODE

REFERRAL NAME

REFERRAL BRANCH

INTERMEDIARY/
AGENT'S SIGNATURE

DATE

DECLARATION BY THE INTERMEDIARY'S/AGENT'S SUPERVISOR *(always complete this section)*

I have reviewed the application form and confirm that all necessary information has been obtained and that the form is complete. I also confirm that all the necessary documentation has been obtained in order to capture and assess this proposal.

SUPERVISOR

FIRST NAME

SURNAME

ZONE

SUPERVISOR CODE

SUPERVISOR'S
SIGNATURE

DATE

Risk Assessment Form

Assess the Assured's level of risk based on the following criteria as shown below :	Response (Please tick)
1. Geographical Location Risk: Is the insured's address located in a sanctioned country or region (i.e. Crimea region, Cuba, Iran, North Korea and Syria) Yes - Do not accept the business / No- Proceed with risk assessment	<input type="checkbox"/> Y <input type="checkbox"/> N
Please fill as applicable. i.e. under risk rating, fill "3" if the risk is high, "2" if it is medium and "1" if it is low).	Risk Rating (Please tick)
2. Product Risk: Is the annual premium above N3,060,000 (N225,000 monthly) or is the single premium above N3,600,000? Yes -3 / No -1	<input type="checkbox"/> 1 <input type="checkbox"/> 3
3. Customer Risk: Is the policy in the name of a political figure(s) (Military or Civilian), or is the Assured directly related to a political figure? Yes -3 /No -1	<input type="checkbox"/> 1 <input type="checkbox"/> 3
If the answer to either of the 2 questions above is Yes , customer's overall risk rating is 3-High. If not, proceed to use scores in the overall average risk rating	Risk Rating (Please tick)
4. Product Risk: Is the customer purchasing a savings policy or a pure risk policy? Provide details Savings - 2 /Pure risk -1	<input type="checkbox"/> 1 <input type="checkbox"/> 2
5. Customer Risk: Is the policy a joint or single ownership policy? Joint ownership -2/Single ownership-1	<input type="checkbox"/> 1 <input type="checkbox"/> 2
6. Customer Risk: Does the assured have a history of premature policy terminations (Over 2 policy terminations in the last 1 year) Yes -3/No-1	<input type="checkbox"/> 1 <input type="checkbox"/> 3
7. Geographical Location Risk: Is the insured's address located in a volatile area (i.e. security level)? Or is the policyholder resident in a foreign country? North-East Nigeria - 3 South-East, North-Central, South-South and North-West Nigeria or other foreign country resident - 2 South-West and North-West Nigeria- 1	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
8. Other Risk: Provide details of any other money laundering or bribery risk indicators (if any and rate 1, 2 or 3 as you deem fit)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
OVERALL RISK RATING: High - 3 Medium - 2 Low - 1	Average Score <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3

COMMENTS (IF ANY):

PREPARED BY

SIGNATURE

DATE

"I concur with the above assessment"

REVIEWED BY

SIGNATURE

DATE

UNDERWRITER/SDO COMMENTS (IF ANY):

NB: The underwriter or Sanction Desk Officer may revise the risk rating if sanction screening the customer on the approved tool has yielded true positive alerts

Proposal Number:

FOR ENHANCED DUE DILIGENCE ONLY **Response**
(Please tick)

1. Does this customer require enhanced due diligence?
If yes, please fill the section below

Y N

2. Has independent verification of the authenticity of information provided above been done?

Y N

Has due diligence on source of funds been performed? If yes, specify

Y N

(Please tick)
Bank account statement Customer pay slip Investment account statement Others

INTERMEDIARY/AGENT

FIRST NAME

SURNAME

INTERMEDIARY/
AGENT'S SIGNATURE

DATE

3. Has approval of senior management been obtained authorizing establishment of business relationship?

Y N

UNDERWRITER

FIRST NAME

SURNAME

UNDERWRITER
SIGNATURE

DATE

