



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an application for life, sickness, disability or critical illness insurance on your life ever been declined, deferred, withdrawn or accepted with a loading or exclusion?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





## 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
<b>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).</b>	<b>Risk Rating (Please tick)</b>
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
<b>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</b>	<b>Risk Rating (Please tick)</b>
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
<b>OVERALL RISK RATING: High - 3 Medium - 2 Low - 1</b>	<b>Average Score <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3</b>

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

