THE GUYANA & TRINIDAD MUTUAL LIFE INSURANCE COMPANY LIMITED

PART A: APPLICATION FOR LIFE INSURANCE

COMPUTER NO: _____

APPLICATION NO: _____

POLICY NO: _____

USE BLOCK LETTER THROUGHOUT

S.R: _____ CODE _____

HORIZON CLASSIC

1. PROPOSED INSURED
FIRST NAME MIDDLE NAME LAST NAME

NAME OF APPLICANT

2. GENDER: M ☐ F ☐ **3.** SEND PREMIUM NOTICE TO: H ☐ O ☐

4. RESIDENCE ADDRESS: _____

_____ TELEPHONE # H _____ O _____ M _____

E-MAIL ADDRESS: _____

5. (A) MARITAL STATUS? M ☐ S ☐ COMMON LAW ☐

(B) IF FEMALE, GIVE MAIDEN NAME: _____

(C) SPOUSE'S NAME & OCCUPATION: _____

(D) SPOUSE'S LIFE INSURANCE: _____

6. (A) OCCUPATION: _____

(B) EMPLOYER'S NAME: _____

(C) EMPLOYER'S ADDRESS: _____

(D) NATURE OF BUSINESS: _____

7. DATE OF BIRTH: D ☐ M ☐ Y ☐ **8.** AGE LAST BIRTHDAY: ☐

9. COUNTRY OF BIRTH: _____ **10.** SUM INSURED: _____

11. (A) COST OF INSURANCE: YRT ☐ LEVEL ☐

SELECT DEATH BENEFIT OPTION: NON LEVEL ☐ LEVEL ☐

(B) SMOKER ☐ NON-SMOKER ☐

(C) ADDITIONAL BENEFITS

SUM INSURED

AIR ☐ _____

CARD ☐ _____

TD ☐ PWB ☐

HCIR ☐ UNITS _____

EXTRA SAVINGS ☐ _____

PREMIUM PAYABLE Y ☐ H ☐ Q ☐ M ☐

AMOUNT _____ CASH ☐ GSD ☐ BO ☐

12. IF YOU HAVE EVER APPLIED FOR OR WERE GRANTED INSURANCE , STATE

COMPANY	AMOUNT	PLAN	ISSUE DATE	STATUS OF POLICY

13. HAS ANY APPLICATION FOR LIFE INSURANCE OR RE-INSTATEMENT OF LIFE INSURANCE BEEN WITHDRAWN, RATED, POSTPONED OR DECLINED OR IN ANYWAY MODIFIED?
YES ☐ NO ☐ IF YES TO ANY OF THE ABOVE, GIVE DETAILS

_____

_____

14. (A) HAS YOUR FLYING AS A PASSENGER IN THE PAST 12 MONTHS EXCEEDED 50 HOURS, OR DO YOU EXPECT IT TO EXCEED 50 HOURS IN THE NEXT 12 MONTHS? YES ☐ NO ☐

(B) HAVE YOU IN THE PAST TWO YEARS ENGAGED, OR IN THE FUTURE EXPECT TO ENGAGE IN AVIATION AS STUDENT PILOT, PILOT OFFICER OR MEMBER OF THE CREW OF THE AIRCRAFT? YES ☐ NO ☐

N.B. IF YES TO EITHER (A) OR (B) ABOVE, AVIATION QUESTIONNAIRE MUST BE COMPLETED.

(C) DO YOU ENGAGE IN ACTIVITIES INVOLVING SPECIAL HAZARDS INCLUDING MOTOR CAR OR MOTOR CYCLE RACING, SCUBA OR SKY DIVING?
YES ☐ NO ☐ IF YES, ANSWER THE FOLLOWING:
TYPE AND DEGREE OF ACTIVITY (e.g. days per year)_____

_____

15. IF YOU HAVE CONSULTED A DOCTOR WITHIN THE LAST 10 YEARS OTHER THAN FOR THE PURPOSE OF EFFECTING INSURANCE COVERAGE, STATE:-

NAME: _____

ADDRESS: _____

REASON: _____

TREATMENT: _____

RESULT: _____

DATE: _____

16. HAVE YOU PAID THE FIRST PREMIUM? YES ☐ NO ☐

DATE: _____ AMOUNT: _____ RECEIPT NO: _____

I warrant that the above answers are full and true, that I have not withheld any material information and that I am now and am usually in sound health: and I agree that this declaration, with the answers to be given by me to the Medical Examiner, (and/or the answers on Part B of this application if for Insurance without Medical Examination), shall be the basis of the policy should one be granted; that if this proposal is accepted I will pay the first premium on the policy, and the said policy shall have no effect until the first premium has been paid during my life and while I am in good health: that if any premium be settled wholly or in part by cheque or other obligation, such obligation shall not be considered as payment until paid, and if not fully paid, the Company shall not be liable if death occurs while such obligation remains unpaid; that if any premium be not paid in full when due, such policy shall thereupon become void, unless specially provided in express terms in the policy that it shall be kept in force; that if any untrue statement is made in this proposal or to the Medical Examiner, any amount deposited with the Company pending consideration of the proposal shall be forfeited; and that if I die by my own act, whether sane or insane, within two years from issue of the policy, then the said policy shall be void.

Dated at _____ the _____ day of _____

*Witness _____ Signature _____
(Life to be Insured/Applicant for Child)

***N.B:-** WHEN THE APPLICANT IS UNABLE TO SIGN HIS/HER NAME, A SECOND WITNESS IS REQUIRED AND THE QUESTIONS AND ANSWERS MUST BE READ AND EXPLAINED TO THE APPLICANT. THE CERTIFICATE BELOW MUST THEN BE GIVEN BY THE SALES REPRESENTATIVE OR ONE OF THE WITNESSES.

I CERTIFY THAT THE ABOVE QUESTIONS WERE READ AND EXPLAINED TO THE APPLICANT AND THE REPLIES WERE ALSO READ OVER TO THE APPLICANT.

NAME _____ SIGNATURE _____

17. TO BE COMPLETED, IF APPLICATION IS ON THE LIFE OF A CHILD.

I, _____ A PARENT OF _____
FULL NAME OF APPLICANT CHILD'S NAME

AM THE APPLICANT FOR INSURANCE AND WILL PAY THE PREMIUMS: I DESIRE TO BE ALONE ENTITLED TO THE BENEFITS AND TO EXERCISE THE RIGHTS, OPTIONS AND PRIVILEGES OF THE INSURED.

WITNESS _____ SIGNATURE OF APPLICANT _____

18. **I, THE UNDERSIGNED HEREBY AGREE TO PAY AN EXTRA PREMIUM DURING THE FULL PREMIUM-PAYING PERIOD ON ACCOUNT OF MY OCCUPATION OR HEALTH**

SIGNATURE _____ DATE _____

19. IN THE EVENT THAT I ADVISE THAT I AM NO LONGER INTERESTED IN EFFECTING THIS INSURANCE, IT IS UNDERSTOOD AND AGREED THAT THE COST OF MEDICALS AND TESTS DONE PURSUANT TO THIS APPLICATION FOR INSURANCE WILL BE DEDUCTED FROM ANY PREMIUMS WHICH WERE REMITTED TO THE COMPANY.

SIGNATURE _____ DATE _____

SALES REPRESENTATIVE'S CONFIDENTIAL REPORT

NOTE — THE SALES REPRESENTATIVE IS REMINDED THAT HIS/HER INTEREST AND THE INTEREST OF THE COMPANY ARE IDENTICAL AND THAT SHOULD THE HEALTH OF THE APPLICANT BE OR BECOME IMPAIRED, EITHER BEFORE OR AFTER THE APPLICATION IS MADE, OR SHOULD ANYTHING COME TO THE KNOWLEDGE OF THE SALES REPRESENTATIVE LIKELY TO RENDER THE RISK UNDESIRABLE OR IN ANY WAY WHATSOEVER TO THROW DOUBT ON THE LIFE OF THE APPLICANT, HE/SHE MUST NOTIFY THE COMPANY.

1. HOW LONG HAVE YOU KNOWN THE APPLICANT? _____ ARE YOU RELATED TO THE APPLICANT? YES ☐ NO ☐
2. IF YES, STATE RELATIONSHIP _____
3. ARE YOU AWARE OF ANYTHING CONCERNING THE PAST OR PRESENT HEALTH, HABIT, LIFE STYLE WHICH MIGHT AFFECT HIS/HER STABILITY OR LIFE? IF YES, GIVE DETAILS _____ YES ☐ NO ☐
4. TO THE BEST OF YOUR KNOWLEDGE IS HE/SHE IN GOOD HEALTH NOW? YES ☐ NO ☐
5. WAS THE APPLICATION COMPLETED IN YOUR PRESENCE? YES ☐ NO ☐
6. WILL THE POLICY BE ASSIGNED TO A THIRD PARTY? IF YES, GIVE DETAILS _____ YES ☐ NO ☐
7. HAVE YOU RECEIVED THE FIRST PREMIUM AND PAID IT INTO THE COMPANY? YES ☐ NO ☐
8. HAVE YOU VERIFIED THE APPLICANT'S AGE? ID NO. _____ BIRTH CERTIFICATE _____ YES ☐ NO ☐
9. (A) IS THE FINANCIAL POSITION OF THE APPLICANT SUCH AS TO WARRANT THE APPLICANT APPLYING FOR A POLICY FOR THE AMOUNT PROPOSED? YES ☐ NO ☐
   (B) WHAT IS THE APPLICANT'S ANNUAL INCOME? $ _____

PREMIUMS:-

BASIC _____ AIR _____ TDW _____ PWB _____

HCIR _____ CARD _____ EXTRA SAVINGS _____ TOTAL PREMIUM _____

(IF YOU HAVE ANY KNOWLEDGE OF THE PROPOSED INSURED THAT WOULD IMPACT ON THIS APPLICATION, KINDLY STATE ON A SEPARATE SHEET)

I DECLARE THAT THE ANSWERS THAT I HAVE GIVEN TO THE ABOVE QUESTIONS ARE FULL AND TRUE AND TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SALES REPRESENTATIVE _____ DATE _____ SPECIMEN SIGNATURE OF APPLICANT _____