



CHANGE FORM

REQUEST FOR ADDITION OF OTHER LIVES

I, holder of policy number

hereby put in an application to make changes to my policy effective/...../20..

Details of Additional Lives

	NAME	RELATIONSHIP	DATE OF BIRTH	AGE	BENEFITS	GH¢
1						
2						
3						

Details of Lives to be Cancelled/Taken Out

	NAME	RELATIONSHIP	DATE OF BIRTH	AGE	BENEFITS	GH¢
1						
2						

Change of Policy Options

Option: From To:

Sum Assured: From.....To:

Premium: From: To: (Attach completed mandate form)

Conditions for change

1. Once cover level / sum assured is increased a waiting period of three months for main life and six months for other lives will apply before the new cover level / sum assured will become payable on the event of death.
2. Any additional life added will attract a waiting period of six months from the date of endorsement.
3. No waiting period will apply on accidental death.

FAILURE TO DISCLOSE RELEVANT INFORMATION AND MISREPRESENTATION MAY RESULT IN NON PAYMENT OF A CLAIM AND ALL COVER UNDER THE POLICY BEING CANCELLED.

COMPLETE THE FOLLOWING:

1. To the best of your knowledge, is the person(s) being proposed for this insurance alive and in good health? Yes No

2. If you answered "No" to the above, please give details below;

.....

3. Has anyone being proposed for this insurance suffered from any illness, disease, injury or disability in the past five years? Yes No

If you answered "Yes" to the above, please give details below;

.....

OTHER CHANGES

1. Name From:

To: (Attach prove of name)

2. Date of Birth

Name of Life:

From:To: (Attach prove of age)

3. Beneficiary (1) From: To:

Relationship:

Age: Percentage:

Trustee:Trustee's contact:

4. Source From:

To: (Attach completed mandate form)

5. Trustee From:

To: Trustee's contact:

I do hereby declare the above information to be true and I have not concealed or withheld anything with which the miLife Insurance Company Limited, ought to be acquainted in order to assess my eligibility for insurance and that I am willing to be medically examined if required. I agree these statements I have or shall make to the Company or to its medical examiner(s) in connection with this or previous proposal(s) shall be the basis of the contract of this insurance.

.....
DATE SIGNATURE TELEPHONE NO.
FOR OFFICE USE ONLY

Attending officer:

Underwriting officer:

Date:

Date of Endorsed: