Please affix a recent

passport or attach a valid identification

Association Group Life Assurance Membership form

Name of Group	Date of Birth	Member name	Member Telephone number

Primary Beneficiary (ies):

I designate the person(s) named below as my primary beneficiary (ies) to receive payment under the policy in the event of my death. The share of any primary beneficiary, who is no longer living or is otherwise disqualified by law at the time of my death, will pass to any remaining beneficiary (ies) in equal shares.

Name of Beneficiary	Date of Birth	Relationship	Telephone number	Address (Not P.O. BOX)	%

If Beneficiary is a Minor

Legal Guardian name	BVN number	ID card (provide copy)	Telephone number	Address (Not P.O. BOX)

Kindly tick ailment have received/are receiving treatment for or state specific ailment if not in the list for further processing ……

□ Diabetes□High/Low Blood pressure □Persistent cough □Fever □Pile □Pneumonia □Kidney Failure
□Arthritis □Recurrent Headache □Tumor in the body □Recurrent Backache/ pain □Asthma
□Liver failure □Cancer □Heart Disease □Stroke

Declaration of Health

I, the life assured, declare that I am currently in good health and there is no known medical impairment that can make me to be more of a higher risk. I also declare that all statements made above are true, complete and accept responsibility for the consequences of any error arising from relying or using the information so provided. I also declare that this form shall form the basis of the insurance granted under this policy and that if any material information is withheld, the insurance benefit shall be forfeited.

Name of Member…… **Authorised Signatory for Association _____**

Signature …….. **Designation _____**

Date…… **Signature & Date _____**

Cover will be confirmed only on members that have submitted completed membership form and whose premium has been paid