6. DECLARATION

I declare to the best of knowledge and belief that the above information is true and complete and shall be the basis of the policy issued thereon. I confirm that I am in good health and consent to Leadway seeking medical information from any doctor who at anytime has attended to me concerning anything which affects my physical or mental health and waive all provisions of law forbidding the disclosure of such knowledge or information.

I further agree that if any untrue statement be contained in this proposal, all monies which shall have been paid on account of the said assurance shall be forfeited and the assurance shall be absolutely null and void.

SIGNATURE

DATE | D | D | M | M | Y | Y | Y | Y |

Important Notice: The policy could be invalidated if you fail to disclose any fact which could influence our assessment and the acceptance of your proposal. If in doubt as to whether certain facts are material or relevant, or there are changes to the information given before the policy commences, you should disclose them to us in writing.

PROPOSAL FOR LEADWAY SAVINGS PLAN

LB/PF/SP/06

Registered Office: NN 28/29 Constitution Road, Kaduna.
Corporate Office: 121/123 Funso Williams Avenue, Iponri, Lagos. G.P.O. Box 6437 Marina, Lagos.
General Line: (01) 2700700 Customer Service Line: (01) 2800700.
E-mail: insure@leadway.com, Website:www.leadway.com

AN AGENT WHO COMPLETES A PROPOSAL FORM DOES SO AS AN AGENT OF THE PROPOSER

1. PERSONAL INFORMATION

(a) Surname

(b) First Name

(c) Middle Name

(d) Title

(e) Proof Of Name (Mark one box) — National ID Card ☐ International Passport ☐ Driver's Licence ☐

(f) Postal Address (Include box Number) — State

(g) Proof of Address (mark one box) — Electricity Bill ☐ Tenancy Agreement ☐

(h) Business/ Home Address — State

(I) Occupation

(j) Email

(k) Date of Birth D D M M Y Y Y Y (l) Gender ☐ Male ☐ Female

(m) Telephone Number

(n) PenCom Number

(o) Marital Status ☐ Married ☐ Single ☐ Widow ☐ Widower ☐ Divorced ☐ Seperated

(p) Nationality

(p) Are you a Nigerian Resident? ☐ Yes ☐ No

(p) How do you want us to communicate with you? Please tick as appropriate

☐ Email ☐ SMS ☐ Post ☐ Agent

2. CONTRACT DETAILS

(a) Total Annual Contribution =N=

(b) Life Cover Required (Min =N=1M) =N=

(c) Critical Illness Cover Required =N=

(d) Personal Accident Cover Required (Accidented Total and Permanent Disablement) =N=

(e) Policy Duration (years) (Minimum = 3 years)

*Cover terminates at age 65

3. COMMENCEMENT PLAN

(a) Frequency of Payment ☐ Yearly ☐ Half Yearly ☐ Quaterly ☐ Monthly ☐ Single Premium

(b) Commencement Date D D M M Y Y Y Y

(c) Deposit Premium =N=

(d) Payable by ☐ Cash ☐ Cheque ☐ Electronic Fund Transfer ☐ Direct Debit

(Cash should be made to Leadway Office or our FBN Account with the Policy number stated. Any cash payment made to an Agent shall be at risk of the Proposal)

4. MEDICAL QUESTIONNAIRE

(a) With respect to the following, Please respond to the questions below

Epilepsy	Stroke	Insanity	Blood Transfusion
Persistent Cough	Heamophylia	Pneumonia	Any Heart Related Disease
Swollen Glands	Hepatitis B	Retinis Pigmentosa	Any Recurring Ailment
Jaundice	Arthritis	Tuberculosis	High/ low blood pressure
Recurrent backache/pain	Diabetes	Glandular Fever	Cancer or tumor on any part/organ
Sexually Transmitted Disease	Porphyra	HIV	
Asthma or any respiratory disorder or disease		Recurrent headache	

	APPLICANT	RELATIVE
Have you or any of your relatives been hospitalized for 1 day or more in the last 4 years for any of the ailments?	Yes ☐ No ☐	Yes ☐ No ☐
Have you or any of your relatives consulted with a doctor regarding any of the ailments in the last 4 years? If Yes, give details below.	Yes ☐ No ☐	Yes ☐ No ☐
Are you currently taking any medication or is there any foresseeable need in the future to take medication in respect of any of the ailments? If Yes, give details below.	Yes ☐ No ☐	
Have you or any of your parents, husband, wife, brothers, sisters, suffered or is suffering from or died of the above? If Yes, give details below.	Yes ☐ No ☐	Yes ☐ No ☐
Is there any other chronic ailment for which you have consulted a doctor, taken medication or been hospitalized for other than those above?	Yes ☐ No ☐	Yes ☐ No ☐
Do you intend seeking medical advice in the next 8 weeks?	Yes ☐ No ☐	

If Yes in any of the above questions, Underline the ailment(s) and give details

(b) Have you ever been refused as a blood donor? ☐ Yes ☐ No

(b) Has any insurance on your life ever been declined, postponed or accepted? ☐ Yes ☐ No

If Yes in any of the above questions, give details

(d) What is your Height ? Meters What is your Weight ? Kg

(e) Please state your daily consumption of the following: Alcohol: bottles Narcotics

Tobacco: sticks Hard Drugs

(Note: You are required to notify Leadway Assurance Company Ltd. Should there be a change in your consumption of any of the following.)

5. BENEFICIARIES AND NEXT OF KIN

Beneficiary Name	Relationship	Phone Number	Allocation
			%
			%
			%
			%
			%

Next of Kin	Mobile Phone Number	Email Address

Legal Guardian	Mobile Phone Number	Email Address