

APPLICATION FOR LIFE AND PERSONAL ACCIDENT INSURANCE



American Life Insurance Company

(Incorporated in 1868 in the U.S.A. and Registered for Life Insurance Business in Nepal under Insurance Act, 2049) Company Regn. No. 6/062/063

NEPAL OFFICE:

Narayani Complex, Pulchowk, G.P.O. Box No. 11590, Kathmandu, Nepal.

P.P. Size
Photo of
Proposed
Insured

APP. No. _____

Agent's Code No. _____

Agency's/Unit's Name

Agent's Name

Agent Licence No. 16/ Renewed on

Medical Non-Medical

Please inform to the company if the policy for this application is not received within 30 days from the date of premium payment.

<p>A. PERSONAL DETAILS (Please write in Block)</p> <p>1.a) Name of Proposed Insured (shown in Identification Document)</p> <p>English</p> <p>Nepali</p> <p>b) Type of Identification Document</p> <p>Citizenship/Passport No.</p> <p>c) Place of Birth</p> <p>Date of Birth: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Age Last Birthday <input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Male <input type="checkbox"/> Single <input type="checkbox"/> Widowed/Widower</p> <p><input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Separated</p> <p>Father's Name:</p> <p>Mother's Name:</p> <p>Husband/Wife's Name:</p> <p>Nationality:</p> <p>2. Applicant/Owner (if other than insured)</p> <p>Full Name:</p> <p>Relationship to insured:</p> <p>Current Residence Address:</p> <p>Insurance detail:</p>	<p>3. a. Occupation: <input type="checkbox"/> Employee <input type="checkbox"/> Self-employed</p> <p>Position / Title: Education:</p> <p>State Exact Daily Duties:</p> <p>b. Employer/Business Registered Name:</p> <p>4. Average Monthly Income in the past 12 months:</p> <p>c. Nature of Business:</p> <p>d. Current office/Business Address:</p> <p>Phone No. Fax No.</p> <p>e. Permanent Account Number:</p> <p>Source(s) of Income:</p> <p>5. Permanent Address: House No. Village/Tole</p> <p>Ward No. V.D.C. / Municipality</p> <p>District Country Tel.:</p> <p>6. Current Residence Address: House No.</p> <p>Village/Tole Ward No.</p> <p>V.D.C. / Municipality</p> <p>District Country</p> <p>Tel: Mobile No.:</p> <p>E-mail :</p> <p>Send Correspondence to : <input type="checkbox"/> Residence <input type="checkbox"/> Office</p> <p>Other</p>																					
<p>B. DETAILS OF LIFE INSURANCE APPLIED FOR:</p> <p>If approved, a life policy will be issued</p>																						
<p>1. Plan of Insurance</p> <p>(State in full words)</p>	<p>2. Amount of Insurance in words (in Rupees)</p>	<p>3. Mode of Premium Payment</p>																				
<p>4. Supplementary Contracts: <input type="checkbox"/> WP <input type="checkbox"/> PA - (AD, D & PTD) Principle sum Rs.....</p> <p><input type="checkbox"/> ADB <input type="checkbox"/> Others</p>		<p>6. Payment Options (for Subhabishya Beema):</p> <p><input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3</p> <p><input type="checkbox"/> Option 4 <input type="checkbox"/> Option 5</p>																				
<p>5. Non-Forfeiture Options (Applicable, incase premium becomes due after expiry of grace period): (This provision is not applicable to Future Care-DPS Plan)</p> <p><input type="checkbox"/> Automatic Premium <input type="checkbox"/> Paid Up <input type="checkbox"/> ETI (For Three Payment & Endorsement Plan only)</p>																						
<p>C. NAME & ADDRESS OF BENEFICIARY FOR LIFE (and for PA, if applied for)</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:50%;">Name & Address of Beneficiary</th> <th style="width:15%;">Relationship with insured</th> <th style="width:10%;">Age</th> <th style="width:25%;">Name of Mother & Father of Beneficiary</th> </tr> </thead> <tbody> <tr> <td>.....</td> <td>.....</td> <td>.....</td> <td>.....</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>.....</td> <td>.....</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>.....</td> <td>.....</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>.....</td> <td>.....</td> </tr> </tbody> </table> <p>Unless otherwise requested, multiple beneficiaries will share equally, and the right to change the beneficiary is reserved.</p>			Name & Address of Beneficiary	Relationship with insured	Age	Name of Mother & Father of Beneficiary
Name & Address of Beneficiary	Relationship with insured	Age	Name of Mother & Father of Beneficiary																			
.....																			
.....																			
.....																			
.....																			
<p>Note: To expedite the approval of applied for insurance coverage, before submission, Please insure that the application is properly completed, signed and dated.</p>																						

Details to any "Yes" answers to above questions in section E, I & II include name of proposed insured, dates, names of doctors, hospitals, reason for consultation, tests, results, diagnosis, treatments and current condition.

Question No.	Name	Date	Reason for consultation, test results, treatment and current condition	Names of doctors, hospitals, etc. and address






Special Request:

Company Endorsement Only :

DECLARATION:

(a) I hereby declare that I and my family members proposed for insurance are in good health and agree that there shall be no contract of insurance unless a policy is issued and delivered on this application and full first premium actually paid thereon provided no change shall have occurred in the insurability of the Proposed Insured(s) since completion of the application. (b) I hereby declare that all statements and answers in this application together with those in any required medical examination, questionnaire or amendments are full, complete and true and bind all parties in interest under the policy herein applied for. (c) I understand that no agent or medical examiner or other person except an authorized officer of the Company is permitted to make or discharge contracts or waive or change any of the conditions or provisions of any application, policy, or receipt, or to accept risks or pass upon insurability; that notice to or knowledge of any agent or medical examiner is not notice to or knowledge of the Company unless stated in either this application or any medical examination considered as part of it. (d) I understand that no right to borrow, surrender or assign or other privilege of ownership may be exercised by a minor; and that acceptance of any policy issued on this application shall be a ratification of any correction or changes to this application which the company may make in the space entitled "Company Endorsement Only." (e) I hereby exonerate any Physician and/or Hospital and/or Clinic and/or Insurance Company and/or other Organization that has any records or knowledge of me and/or my family members proposed for insurance (if any) from professional secrecy and hereby authorize such person and/or entities to give to American Life Insurance Company (ALICO) any and all information about me and/or my family member proposed for insurance and copy of records with reference to our health and/or medical history and/or hospitalization, medical advice, diagnosis, treatment, disease and/or ailment. (f) I also authorize American Life Insurance Company (ALICO) to obtain, from any source it deems appropriate, information concerning my financial and/or professional and/or personal status, as well as information related to my driving history. A photocopy of this authorization shall be as valid as the original. (g) I also declare that, I have personally gone through/read the text of the application and fully understood it's content before putting my signature.

Important Notice:

-  Before signing this declaration please check that the answers given in this application are completed and correct. An incorrect or incomplete answer may invalidate the policy and the invalidated policy will not make the Company liable to pay any future claim or refund of premium.
-  Any change in occupation or health condition of the proposed Insured(s) and in any of the declaration made in the application, after the date of application and before the issuance of first premium receipt, must immediately be notified to the company. Failure to such notification will invalidate the policy and the invalidated policy will not make Company liable to pay any future claim or refund of premium.
-  The premium paid after approval of application shall not be refunded under any circumstances except under the provisions of the policy.
-  Please obtain premium receipt signed by authorized employee of the company after paying premium as there shall be no insurance coverage until premium receipt for Life Insurance is issued by the company.
-  Please pay premium by account payee cheque/draft drawn in favour of the company.

Dated at: this day of 201.....
(Village/City & District) (Date) Name of Proposed Insured in own Handwriting

Witness Name: Signature
Signature of Proposed Insured

Address/Code No.
Name and Signature of Owner if other than Proposed Insured

If the above answers are given by a person who can not understand language of application or who is illiterate or who can not read & write due to some other reasons, a declaration has to be made by a family member of the applicant and/or by a well-known person not related to the Company, who read, explained and/or filled up application form :

I declare that I have well explained the subject matter of the application to the applicant and all answers have been recorded correctly and the proposed insured has affixed the thumb print after having been well understood.

Date at this day of 201.....
(Village/City & District) (Date)

Full Name:

Occupation:

Full Address:

.....
Signature



AGENT'S REPORT

American Life Insurance Company

(Incorporated in 1868 in the U.S.A. and Registered for Life Insurance Business in Nepal under Insurance Act, 2049) Company Regn. No. 6/062/063

NEPAL OFFICE:

Narayani Complex, Pulchowk, G.P.O. Box No. 11590 Kathmandu, Nepal.

Application No.:.....

Name of Proposed Insured.....

How well do you know Well Casually Just met

1. PROPOSED INSURED? OWNER? Well Casually Just met

2. Give relationship if related to Proposed Insured or Owner

3. What is ANNUAL EARNED income of PROPOSED INSURED OWNER

4. Specify Accident insurance on the Life of PROPOSED INSURED: Accidental Death Benefit Weekly income

5. Is this insurance applied for intended to replace existing coverage ? Yes No

6. Does the PROPOSED INSURED have any application for Life, Accident or Health Insurance now pending ? Yes No

7. Do you have knowledge of any unfavourable information about the health, habits, character, mode of life or occupation of the Proposed Insured or Owner. Give details, if "Yes" Yes No

8. REMARKS AND ADDITIONAL INFORMATION

IF PROPOSED INSURED IS A FEMALE

9. With whom does she reside ?.....

10. Source of her support

11. Education Standard/Level.....

12. Name and relationship of any dependents.....

13. Give ages of any children:.....

IF MARRIED

14. Her maiden name:.....

15. Husband's full name:.....

16. Husband's age: Occupation: His Annual income

17. Insurance on husband's life: Company Pol. No. Amount Year Issued

Give details here if any answer to above questions is "Yes"

If applicant is not permanently resident in your territory state his address in home country.

I hereby certify that the answers to the questions in this Application and Report are correct to the best of my knowledge and belief that know nothing detrimental to the risk that is not recorded herein.

Dated at..... this..... day of..... 201..... (Village/City & District) (Date)

Full Name of Agent

Agent Code No.

Signature of Agent

I have carefully reviewed this application and confirm that it has my approval for consideration by the company.

Signature of Unit Manager

Signature of Agency Manager

*Please check if supplementary Report is required on account of sums insured

Premium Calculation:

Table with columns for Premium Calculation items (Basic Plan, Basic Premium, Policy Factor, Extra Premium, WP, ADB, PA, AX/AI, MIB, Other(s)) and Face Amount, and a column for Mode of Premium Payment. Includes a Total Rs. row at the bottom.



American Life Insurance Company

(Incorporated in 1868 in the U.S.A. and Registered for Life Insurance Business in Nepal under Insurance Act, 2049) Company Regn. No. 6/062/063

NEPAL OFFICE:

Narayani Complex, Pulchowk, G.P.O. Box No. 11590 Kathmandu, Nepal.

DECLARATION

Forming an integral part of the "Application" No

In applying for insurance coverage as indicated in the Application and in signing this Declaration, the applicant(s) certify(ies) that the applicant(s) and any designated beneficiary(ies) ARE/ARE NOT¹ United States Persons for United States ("U.S.") Federal Income Tax purposes.^{2,3} The applicant(s) agree(s) to inform the Company within thirty (30) days of the applicant(s) knowledge of such change if the applicant(s) or any designated beneficiary become(s) a U.S. Person for U.S. Federal Income Tax purposes or if the applicant(s) assign(s) the policy to such a U.S. Person. Please note that a false statement or misrepresentation of tax status by a U.S. Person could lead to penalties under U.S. law.

U.S. Tax ID Number of applicant(s)

U.S. Tax ID Number of beneficiary(ies)

IMPORTANT: BEFORE SIGNING THIS DECLARATION PLEASE CHECK THAT THE ANSWERS GIVEN ABOVE ARE CORRECT. AN INCORRECT ANSWER MAY INVALIDATE THE POLICY.

Dated at
(Village/City & District) (Date) Signature of Proposed Insured

.....
Full Name (in own handwriting)

Witness
Signature of Agent

.....
Signature of Owner if other than Proposed Insured

.....
Full Name (in own handwriting)

-
1. Strike off the term that does not apply.
 2. This question is for U.S. Federal Income Tax purposes. The U.S. Internal Revenue Service requires the Company to report to it taxable income paid to persons subject to United States Federal Income Tax. **PLEASE NOTE** that if you are a U.S. person for U.S. tax purposes and fail to provide a U.S. Tax Identification Number to the Company, the IRS requires the Company to withhold tax from taxable income payments made to you at the rate of 31%.
 3. For purposes of this declaration a U.S. Person is a citizen or resident of the United States, a United States partnership and any trust which is controlled by one or more U.S. persons and is subject to the supervision of a U.S. court.