Application for **Term Life**

RoyalStar House
Second Floor,
John F. Kennedy Drive
P. O. Box EE-15606
Nassau, Bahamas

NEW PROVIDENCE
LIFE INSURANCE COMPANY LIMITED

Primary Insured

		NIB Number		
Last name	First	Initial	Sex	Smoker? ❑ Yes ❑ No
Country of birth	DOB *(Day/Month/Year)*	Age	Height (ft/inch)	Weight (lbs)
Home address	City	Country & Zip		
Mailing address	City	Country & Zip		
Occupation and duties		Annual Income $		
Country of citizenship	Email address *(required, cannot be agent's email)*		Home phone/Cell	

Is the proposed applicant considered a Politically Exposed Person (PEP)? ❑ Yes ❑ No

Employer Information

Employer name	Type of business/ industry	Employer phone
Employer address	City	Country & Zip

Owner *(If not the primary insured)*

Full name		Relationship to insured
Address	City	Country & Zip
Occupation and duties		Annual Income $

Term Life Product

❑ *10 Year Term to Age 85* ❑ *25 Year Term* ❑ *30 Year Term* ❑ *Term to Age 80*

Coverage Amount Applying for

$

A valid form of identification should be presented with the application.

Cash Value/Return of Premium?

❑ *Yes* ❑ *No*

Critical Illness Rider (optional)

❑ *$10,000* ❑ *$20,000* ❑ *$30,000* ❑ *N/A*

Waiver of Premium Rider?

❑ *Yes* ❑ *No*

30-Month Income Protection Rider?

❑ *Yes* ❑ *No*

Frequency of Payment

❑ Annual

❑ Semiannual

❑ Monthly *(only availabe for premiums over $500)*

Mode of Payment

❑ Cheque *(make payable to: New Providence Life Insurance Company Limited)*

❑ Credit Card *(Visa, Mastercard, AMEX, & USD cards accepted Cardholder is responsible for financial institution fees.)*

❑ Wire Transfer

❑ Payroll Deduction

*Please provide **Customer ID** below if you are an existing client.*

Total Premium Due

(This amount must match the total premium shown on the Proposal PDF)

$

*Once your application has been submitted, you will receive a **Customer ID** and **Certificate Number**. Please use those numbers to submit your payment information in the **Online Payment Portal**.*

Part I Questions *Provide Complete Answers for the Applicant*

For "Yes" answers, give details in the "Part II Details" section or complete the appropriate questionnaire required by the company.

Part A: Non Medical Questions		Yes	No
1. Have you been declined, postponed, or charged an extra premium for life insurance?		❑	❑
2. Do you intend to travel to any foreign country within the next two years? What countries?		❑	❑
3. In the past 10 years, have you:			
a	Been a pilot or crew member of an airplane, or been on a balloon, hang glider or like device, or jumped therefrom?	❑	❑
b	Been a vehicle racer, diver, parachutist, mountain climber, bungee jumper, or participant in a hazardous sport or hobby?	❑	❑
c	Been convicted or driving under the influence of alcohol or drugs, of a criminal offense, or is now incarcerated, on parole or probation, or has been subject to kidnapping or ransom or received death threats?	❑	❑
d	Been convicted of four or more driving violations or had driver's license suspended or revoked?	❑	❑
e	Drink alcohol in excess, been treated or counseled by a healthcare provider for alcohol use, attended or are attending a support group for help to stop alcohol use.	❑	❑
f	Used cocaine, marijuana, heroin, amphetamines, narcotics, stimulants, or other illegal drugs or controlled substances?	❑	❑

Part B: Medical Questions		Yes	No
1. Have you ever had, or received medical advice or treatment for:			
a	High blood pressure, stroke, anemia, chest pain, heart attack, disease or disorder of the blood, heart arteries, or veins?	❑	❑
b	Ulcers, or diseases or disorders of the stomach, intestines, liver, gall bladder, or rectum?	❑	❑
c	Prediabetes, diabetes, cancer, tumors, cystic fibrosis, autoimmune diseases, leukemia, disorder of the pancreas, thyroid, adrenal or lymphatic system, or other glands.	❑	❑
d	Epilepsy, convulsions, nervous or mental disorder, paralysis, or disorder of the brain or nervous system?	❑	❑
e	Disease of the kidney, bladder, genital organs, or had sugar, albumin, or blood in the urine?	❑	❑
f	Asthma, emphysema, tuberculosis, chronic bronchitis, or disease of the lung, chest, or throat?	❑	❑
2. During the last 6 months, have you experienced an involuntary weight loss of more than 10 pounds?		❑	❑
3. Other than as answered above, within the past 5 years, have you:			
a	Been admitted to a hospital, treatment center, or other facility?	❑	❑
b	Been treated for acquired immunodeficiency syndrome (AIDS) or tested positive for the HIV virus?	❑	❑
c	Requested or received payments or reimbursements for a mental or physical disability?	❑	❑
d	Been advised to have surgery, hospitalization, treatment, or diagnostic test not yet completed?	❑	❑
4. Are you currently taking, or have taken, medication for any disease or condition not indicated above?		❑	❑

Family or Personal Physician's Information	
Name	Telephone number
Address	

Part C: Tobacco and Tobacco Use Questions		Yes	No
1. Do you Smoke?		❑	❑
2. Cigarettes?		❑	❑
a	If "yes," how many per day?		
3. Cigars, Pipe, E-Cigarettes or any other form of tobacco?		❑	❑
a	If "yes," specify the type and frequency?		

Applicant's initials: _____

Part II Details *Give Full Details Below*

If you answered "Yes" to any of the questions in the "Part I Questions" section, please complete this form or indicate the required information below:

No.	Applicant's name	Diagnosis, treatments, results	Date Day/Month/Year	Physician/Hospital details

Part III Insurance Information

Part A: Existing and Pending Insurance Questions	Yes	No
1. Do you currently have any life insurance policy in force, or do you have an application(s) pending in any other company?	❑	❑
2. Do you intend to replace an existing policy with this one?	❑	❑

If answered "yes," to Question 1, please provide the following information below:

Company Name	Policy Number	Face Amount BSD$	ADB Face Amount BSD$	Year Issued

Beneficiary Designation

Total designated beneficiary share percentage must equal 100%. Please use last page of the application to list more as needed.

All benefits are assigned to the designated beneficiary.		*In the event of death of beneficiary.*	
Beneficiary	**Percentage: %**	*Contingent Beneficiary*	**Percentage: %**
Name:		**Name:**	
Date of birth *(DD/MM/YY)*:		Date of birth *(DD/MM/YY)*:	
Address:		Address:	
Phone:		Phone:	
Relationship:		Relationship:	

Applicant's initials: _____

Telephone Interview

Please be advised you may be contacted by a representative to verify your health history.

The best time to call would be: _____ **a.m.** _____ **p.m.** **Phone number:** _____

Printed name of applicant_____

Signature of applicant_____ Date _____ /_____ /_____
Day Month Year

Applicant's Statement

I understand the broker, agent or agency receiving this application does not have authority to modify or waive any portion of this application or any coverage, conditions or restrictions contained in the insurance policy applied for and all information requested in this application must be set forth in writing on the application. I further understand this application will become part of the insurance policy to be issued and the insurer will be utilizing the information contained in this application to determine whether or not to issue the insurance policy applied for.

I understand the broker, agent or agency taking this application from me is an independent representative and is acting on my behalf and not the administrator nor the insurance company offering this insurance. Neither the administrator nor the company offering this insurance can be held liable for any circumstance if the broker, agent or agency taking this application fails now or in the future to transmit or communicate any documentation or funds from the administrator to me and/or any documentation or funds from me to the administrator.

It is understood the insurance applied for shall not become effective until this application is approved and accepted by the insurer, full payment of the first term premium is made, and the policy issued is subject to all conditions and restrictions contained therein. I understand this policy is not available to permanent resident of the United States or others who reside in the United States.

Signature of proposed applicant _____ Date _____ /_____ /_____
Day Month Year

Medical Authorization

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, the Medical Information Bureau, Inc. (MIB, Inc.) or other organization, consumer reporting agency, insurance or reinsuring company, institution or person having any record or knowledge of me or my health, including any member of my family, to give to the insurer offering the insurance, any reinsurer or its legal representative any and all such information. The nature of the information authorized to be disclosed includes information about all medical evaluation, care, treatment, diagnosis or consultation provided to the undersigned insured, or my dependents. I understand the information obtained by use of this authorization will be used by the insurer offering the insurance, and its reinsurers to determine eligibility and payment of claim benefits under this policy. I direct that a copy of this authorization shall be given the same force and effect as the original. This authorization shall remain valid as long as this policy is in force.

❑ By checking this box you consent to receive communications from NPL electronically, and you agree that all agreements, notices, disclosures, lapses and other communications that NPL provides to you electronically satisfy any legal requirement that such communications or agreements be in writing. Please provide email address below.

Email address: _____

Signature of proposed primary insured_____

Signature of owner *(if different than proposed primary)* _____
If business insurance, show the title of officer and name of firm

I personally solicited and completed this application. All medical and non-medical questions were asked of each proposed insured and their answers were recorded as given or the answers were made by the proposed insured in his or her own handwriting.

Agent signature / Witness: _____Agent code:_____

Agent email: _____ Date _____ /_____ /_____
Day Month Year

Mail completed, signed enrollment form to:

New Providence Life Insurance Company Limited
RoyalStar House Second Floor, John F. Kennedy Drive • P.O. Box EE-15606 • Nassau, Bahamas
Tel: (242) 326-6779, (242) 677-6945, (242) 677-6946 • Email: administrator@newprovidencelife.com

Additional Beneficiaries (optional)

Primary Beneficiary 2				
Name	Relationship	Age	DOB *(Day/Month/Year)*	Percentage
Home address	City	Country & Zip		Phone
Mailing address	City	Country & Zip		

Primary Beneficiary 3				
Name	Relationship	Age	DOB *(Day/Month/Year)*	Percentage
Home address	City	Country & Zip		Phone
Mailing address	City	Country & Zip		

Primary Beneficiary 4				
Name	Relationship	Age	DOB *(Day/Month/Year)*	Percentage
Home address	City	Country & Zip		Phone
Mailing address	City	Country & Zip		

Contingent Beneficiary 2				
Name	Relationship	Age	DOB *(Day/Month/Year)*	Percentage
Home address	City	Country & Zip		Phone
Mailing address	City	Country & Zip		

Contingent Beneficiary 3				
Name	Relationship	Age	DOB *(Day/Month/Year)*	Percentage
Home address	City	Country & Zip		Phone
Mailing address	City	Country & Zip		

Trustee (required if listing a minor child as Beneficiary) 1				
Name	Relationship	Age	DOB *(Day/Month/Year)*	Percentage
Home address	City	Country & Zip		Phone
Mailing address	City	Country & Zip		

Trustee (required if listing a minor child as Beneficiary) 2				
Name	Relationship	Age	DOB *(Day/Month/Year)*	Percentage
Home address	City	Country & Zip		Phone
Mailing address	City	Country & Zip		