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

Mailing address	City	Country

Occupation	Home phone / Cell

Country of citizenship	Email address *(required, cannot be agent's email)*

Employer Information

Employer name	Type of business	Employer phone

Employer address	Occupational duties

Term Life Product

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

With Cash Value Option?

❑ *Yes* ❑ *No*

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

Coverage Amount Applying for	$

Owner *(If not the primary insured)*

Full name	Relationship to insured

Address	City	Country

Beneficiary Info

Primary Beneficiary Name(s)	Relationship	Age	DOB (Day/Month/Year)	Amount
Contingent Beneficiary Name(s)	**Relationship**	**Age**	**DOB (Day/Month/Year)**	**Amount**

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

Questions *Provide Complete Answers for the Applicant*

For "yes" answers, give details in the "additional information" section or complete the appropriate questionnaire required by the company.

Part I: 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 II: 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, tyroid, 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	Have you seen a doctor for any purpose?	❑	❑
d	Requested or received payments or reimbursements for a mental or physical disability?	❑	❑
e	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?		❑	❑

Additional Information:

_____

_____

_____

_____

_____

_____

_____

_____

Applicant's initials: _____

Part II Details *Give Full Details Below*

If you answered "yes" to any of the questions in the previous page, please complete this form or indicate the required information below:

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

Premium/Frequency

Total Annual Premium: $ _____

Modal Factor (Monthly .092 + $2.00 or Semiannual .55) x Annual Premium: $ _____

Modal Premium Due $ _____

Mode of Payment

❑ Credit Card* ❑ Cheque
❑ Wire Transfer* ❑ Payroll Deduction

Payments by Cheque:
Please make cheque payable to: New Providence Life Insurance Company Limited

Frequency of Payment

❑ Annual ❑ Semiannual ❑ Monthly*

** Monthly payment option only available for premiums over $500*

**$15.00 fee applies for wire transfer When paying by credit card, please complete the credit card authorization below. New Providence Life will charge a $50.00 fee for each payment returned unpaid by your banking institution.*

Credit Card Authorization

❑ Visa ❑ Mastercard

_____/_____/_____/_____ Card number

_____/_____ Expiration

_____ Amount (BSD)

Cardholder name
Cardholder address
Customer #
Customer name

I, the undersigned, authorize New Providence Life Insurance Company Limited to charge this credit card for insurance premiums when they become due, until written notice is otherwise received.

Applicant's signature: Date:

Day/Month/Year

Applicant's initials: _____

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. However, if any applicant for coverage, who is accepted and insured by the insurer in the applicant's country or residence, moves to the United States of America, the insurer will provide an option to continue insurance coverage.

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.

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

❑ For electronic delivery of policy documents, check this box and provide email address below.

Email address: _____

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 • Fax: (242) 328-4141 • Email: administrator@newprovidencelife.com