



**ATLASLIFE**

INTERNATIONAL LIFE INSURANCE



**INTERNATIONAL  
CITIZENS  
INSURANCE**



Individual  
**Application Form**

**Complete and Return To:**

Cameron Cross, Insurance Specialist  
[cameron@internationalinsurance.com](mailto:cameron@internationalinsurance.com)

**IT IS IMPORTANT THAT YOU READ THE FOLLOWING**

Prior to proceeding with your application you should seek guidance from your intermediary as to the suitability of the product. You should also read the terms and conditions of the policy which is available from your intermediary.

Please complete the form using blue or black ink and write clearly in capital letters. If you make any mistakes while completing the form please cross out the error, write the new information and initial any corrections. Do not use correcting fluid on the application form.

Make sure you answer all the questions honestly and accurately. Please note that non-disclosure, failure to provide all the relevant information or to make false statements on the application may result in a delay in processing your application and may give Atlas Life the legal right to cancel any policy issued from inception.

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**PLEASE INDICATE ON WHICH BASIS YOU ARE APPLYING.**

*\*for Trustee or Corporate applications, please complete section 3*

<input type="checkbox"/> Individual	<input type="checkbox"/> Joint Life, First Death	<input type="checkbox"/> Joint Life, Second Death
<input type="checkbox"/> Trustee Applicant*	<input type="checkbox"/> Corporate Applicant*	

## 1. Policy **Delivery**

**PLEASE SPECIFY HOW YOU WISH TO RECEIVE YOUR POLICY DOCUMENTS.**

<input type="checkbox"/> By Post	<input type="checkbox"/> By Email
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## 2. Details of **Life Assured**

	FIRST LIFE ASSURED	SECOND LIFE ASSURED
<b>TITLE</b>	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Other _____	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Other _____
<b>FAMILY NAME</b>	<input type="text"/>	<input type="text"/>
<b>FORENAME(S)</b>	<input type="text"/>	<input type="text"/>
<b>DATE OF BIRTH</b>	<input type="text" value="D"/> <input type="text" value="D"/> / <input type="text" value="M"/> <input type="text" value="M"/> / <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> / <input type="text" value="M"/> <input type="text" value="M"/> / <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
<b>ID/PASSPORT NUMBER</b>	<input type="text"/>	<input type="text"/>
<b>OCCUPATION</b>	<input type="text"/>	<input type="text"/>
<b>MARITAL STATUS</b>	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____
Do you have any dependants?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, please give details including the relationship and age of each dependant</i>	<input type="text"/>	<input type="text"/>
<b>CURRENT RESIDENTIAL ADDRESS</b> (Physical Address)	<input type="text"/>	<input type="text"/>
<b>CORRESPONDENCE ADDRESS</b> (e.g. P.O. Box)	<input type="text"/>	<input type="text"/>
Have you been resident in your current country of residence for less than two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, please state previous residence(s)</i>	<input type="text"/>	<input type="text"/>
<b>TELEPHONE NUMBER</b>	<input type="text"/>	<input type="text"/>
<b>EMAIL ADDRESS</b>	<input type="text"/>	<input type="text"/>

### 3. Policy **Owner** (if different from the Life Assured)

Only complete this section if the Life Assured named in section 2 is not to be the intended owner of the policy - if you complete this section the Individual, Trustee or Company shown below will be the policy owner.

#### INDIVIDUAL

TITLE	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Other _____
FAMILY NAME	<input type="text"/>
FORENAME(S)	<input type="text"/>
GENDER	<input type="checkbox"/> Male <input type="checkbox"/> Female
DATE OF BIRTH	<input type="text"/> D <input type="text"/> D / <input type="text"/> M <input type="text"/> M / <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y
ID/PASSPORT NUMBER	<input type="text"/>
NATIONALITY	<input type="text"/>
ADDRESS	<input type="text"/>

What is your relationship or interest to the life assured named in section 2?

#### TRUSTEE OR CORPORATE

NAME OF COMPANY OR TRUSTEE	<input type="text"/>
TRUST NAME	<input type="text"/>
CONTACT NAME	<input type="text"/>
CORRESPONDENCE ADDRESS	<input type="text"/>
TELEPHONE NUMBER	<input type="text"/>
EMAIL ADDRESS	<input type="text"/>

### 4. Policy **Benefits**

POLICY CURRENCY	<input type="checkbox"/> US Dollar	<input type="checkbox"/> UK Sterling	<input type="checkbox"/> Euro
PREMIUM FREQUENCY	<input type="checkbox"/> Annually	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Monthly
	<b>FIRST LIFE ASSURED</b>	<b>SECOND LIFE ASSURED</b>	
LIFE COVER	<input type="text"/>	<input type="text"/>	
DISABILITY COVER <i>Expires at the age of 65</i>	<input type="text"/>	<input type="text"/>	
CRITICAL ILLNESS COVER <i>Expires at the age of 65</i>	<input type="text"/>	<input type="text"/>	
Do you want to add Indexation to the policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you want your premium guaranteed?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

## 5. Policy **Term**

### PERSONAL COVER

How long do you want to be protected?

<input type="checkbox"/> 5 years	<input type="checkbox"/> 10 years	<input type="checkbox"/> 15 years	<input type="checkbox"/> 20 years	<input type="checkbox"/> 25 years
<input type="checkbox"/> 30 years	<input type="checkbox"/> 35 years	<input type="checkbox"/> To age 80	<input type="checkbox"/> To age 90	<input type="checkbox"/> To age 99

### TERM - BUSINESS COVER (KEY MAN / LOAN / SHAREHOLDER)

How long do you want to be protected?

<input type="checkbox"/> 5 years	<input type="checkbox"/> 10 years	<input type="checkbox"/> Other _____
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## 6. Insurance **History**

### FIRST LIFE ASSURED

A. Do you have any existing life cover?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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*If yes, state names of insurers, type of cover and total sum assured*

B. Have you applied for or reinstated any cover in the last 12 months?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

*If yes, please provide details including total sum assured*

C. Are you applying for simultaneous cover with any other insurer?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

*If yes, state names of insurers, type of cover and total sum assured*

D. Has any other insurance application on your life been declined, deferred or assigned in any way?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

*If yes, please give details including name of insurer*

### SECOND LIFE ASSURED

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

## 7. Beneficiary **Nomination**

When you apply for a life insurance policy it is important to nominate a beneficiary so the proceeds can be paid out immediately to that person following the approval of the claim.

For many people the decision is straightforward and usually they will choose either their spouse, adult children or, if the policy is linked to business interests, then to a company or personal trust.

If you do not nominate a beneficiary, the policy proceeds may be paid into your estate which may create problems for your heirs. For example, the funds may not be available for distribution to any beneficiary until the legal process of settling the estate is complete. Additionally, anyone you owe money to could also make a claim against the policy proceeds.

A minor person cannot receive the benefits from a life policy until they are 18 and it is therefore important that legal advice is sought to ensure estate planning measures are put in place to protect minors. You may have already chosen a guardian in your Will who can offer appropriate support and guidance however it is very important that you choose someone trustworthy and responsible. Alternatively, you may wish to consider establishing a trust to ensure that the policy benefits are legally secure.

Some countries have specific laws governing the distribution of assets from the estate of a deceased person and although nominating a beneficiary technically removes the policy benefits from your estate this could be legally challenged. If you are in any doubt about the probate laws in your country of residence or you are concerned about claims from creditors, you should consult a lawyer or legal adviser before completing this section.

**PLEASE COMPLETE IN THE SPACE BELOW LISTING THE FULL NAME, DATE OF BIRTH, RELATIONSHIP, AND THE PERCENTAGE OF BENEFIT. PLEASE MAKE SURE THE PERCENTAGE FIGURES ADD UP TO 100%.**

Instructions to Atlas Life - please pay the primary beneficiary named in this section who survives me in the percentage specified against their name

PRIMARY BENEFICIARY	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE OF DEATH BENEFIT
			%
			%
			%
			%

If the primary beneficiary named above does not survive me then please pay the first contingent beneficiary in the percentage specified against their name

FIRST CONTINGENT BENEFICIARY	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE OF DEATH BENEFIT
			%
			%
			%
			%

If the primary and first contingent beneficiary do not survive me then please pay the second contingent beneficiary in the percentage specified against their name

SECOND CONTINGENT BENEFICIARY	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE OF DEATH BENEFIT
			%
			%
			%
			%

I fully understand that my circumstances and those of my beneficiaries may change and that this nomination is revocable by me at any time. I accept the responsibility of updating my beneficiary details should any changes need to be made.

**SIGNATURE OF  
POLICYHOLDER(S)**

**NAME(S)**

**DATE**   /   /

## 8. Health and Lifestyle

IF YOU ANSWER 'YES' TO ANY OF THE QUESTIONS, PLEASE PROVIDE DETAILS IN THE SPACE PROVIDED AS NECESSARY, AT THE END OF THIS SECTION. PLEASE ENSURE THAT THE ANSWERS PROVIDED ARE TRUE AND COMPLETE.

		FIRST LIFE ASSURED		SECOND LIFE ASSURED	
A.	Have you smoked or used any form of tobacco in the last 12 months? (forms of tobacco: cigarettes, cigars, hubbly, e-cigarettes, chewing tobacco) <i>If yes, please provide quantity per day</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
B.	Have you been advised by a medical professional to stop smoking? <i>If yes, please provide details</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
C.	Do you consume alcohol? <i>If yes, please provide number of units &amp; type consumed weekly. (1 unit = 1 bottle of beer or 1 glass of wine or 1 tot of spirits/liquor)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
D.	Have you ever been advised to stop drinking, received medical advice or participated in a rehabilitation programme to reduce alcohol intake? <i>If yes, please provide details of when you were advised to stop drinking and reasons why</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
E.	Do you have any intention of visiting, living or working in countries outside your current country of residence (other than for vacation of less than 30 days)? <i>If yes, please state which countries you intend to visit, live or work</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
F.	Have you participated or do you intend to participate in any hazardous activity, hobby or pastimes (e.g. motor racing, motorcycling, diving, parachuting, mountaineering, mining, working on oil refineries etc)? <i>If yes, please provide details of hazardous pursuits</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
G.	Have you participated or do you intend to participate in any aviation related activity other than as crew or fee paying passenger on a scheduled flight of a commercial airline e.g. private test flights, casual 'lifts' in a private plane. <i>If yes, please provide details</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
H.	Has any of your biological parents or siblings ever suffered from diabetes, cancer, stroke, kidney disease, multiple sclerosis, Huntington's disease, heart complaint or disease or any other major illness or hereditary condition before the age of 65? <i>If yes, please provide details</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
I.	Do you take any medications, drugs, stimulants, sedatives or tranquilizers or have you done so in the last five years? <i>If yes, please provide details of medications taken</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					



## 8. Health and **Lifestyle** (continued)

IF YOU ANSWER 'YES' TO ANY OF THE QUESTIONS, PLEASE PROVIDE DETAILS IN THE SPACE PROVIDED AS NECESSARY, AT THE END OF THIS SECTION.

		FIRST LIFE ASSURED		SECOND LIFE ASSURED	
J	Have you ever had respiratory or lung problems (e.g. asthma, recurrent bronchitis, persistent coughs, tuberculosis (TB), shortness of breath), apart from colds and flu? <i>If yes, please provide details</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
K.	Have you ever had any disorder of the heart, blood vessels or circulatory system (e.g. high blood pressure, chest pain, heart murmurs, palpitations, coronary thrombosis, tightness of chest, stroke, raised cholesterol or rheumatic fever)? <i>If yes, please provide details</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
L.	Have you ever had any disorder of the digestive system and/or liver (e.g. stomach ulcers, gall stones, hepatitis, bleeding from the bowel, gastric or duodenal ulcer, recurrent indigestion or hiatus hernia)? <i>If yes, please provide details</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
M.	Have you ever had any disorder of the kidneys or bladder (e.g. kidney-stones, infections, blood or protein in urine, prostatitis, trouble to pass urine)? <i>If yes, please provide details</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
N. a)	Have you ever had any central nervous system (e.g. fits, concussion, losing consciousness, persistent headaches, epilepsy, blackouts, paralysis, schizophrenia, multiple sclerosis, neuralgia, chronic fatigue or other central nervous system abnormalities)? <i>If yes, please provide details</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
N. b)	Have you ever had any mental health complaints (e.g. anxiety, stress related disorders, bi-polar disorder or depression)? <i>If yes, please provide details</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
O.	Have you had any problems related to the breasts or reproductive organs (e.g. if female: ovaries or womb problems, miscarriages, premature labour, abortions or breasts lumps. If male: prostate or testicle problems)? <i>If yes, please provide details</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
P.	Have you ever had any disorder or disease of skin, spine, joints, muscles, bones, limbs (e.g. arthritis, gout, rheumatism or backache, slipped vertebrae/disc prolapse, any other back or neck trouble)? <i>If yes, please provide details</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					

## 8. Health and **Lifestyle** (continued)

IF YOU ANSWER 'YES' TO ANY OF THE QUESTIONS, PLEASE PROVIDE DETAILS IN THE SPACE PROVIDED AS NECESSARY, AT THE END OF THIS SECTION.

		FIRST LIFE ASSURED		SECOND LIFE ASSURED	
Q.	Do you have diabetes, raised blood sugar, other endocrine, glandular, blood, hormonal disorders or spleen problems (e.g. thyroid, or other gland disorder, anaemia, bleeding disorders)? <i>If yes, please provide details</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
R.	Do you have any existing form of cancer, or have you ever had cancer or other growths, lumps, moles or tumours of any kind, whether benign or malignant? <i>If yes, please provide details</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
S.	Have you ever had any tropical disease (e.g. bilharzia, malaria)? <i>If yes, please provide details including dates</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
T.	Have you ever had any ear, eye, nose or throat disorder (e.g. ear discharge, defective vision, recurrent tonsillitis)? <i>If yes, please provide details</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
U.	Have you any intention of having medical investigations, procedures or check-ups done for any condition in the next 6 months, or sought medical advice in the last five years for any condition or symptoms including investigations such as ECG, x-rays, laboratory tests or surgery? <i>If yes, please provide details</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
V.	What is your height and weight? <i>Please confirm if your weight has altered by more than 5kgs over the past year</i>	Height	<input type="text"/> cm	Height	<input type="text"/> cm
		Weight	<input type="text"/> kg	Weight	<input type="text"/> kg
<div></div>					
W.	Have you taken any medications, drugs, stimulants, sedatives or tranquilisers in any form for any reason other than colds and flu (e.g. antidepressants, homeopathic medicines, anabolic steroids, cannabis, cocaine)? <i>If yes, describe the substance and date last used</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					
X.	Have you ever received medical advice or participated in a rehabilitation programme to reduce drug use? <i>If yes, please provide details</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div></div>					

## 8. Health and **Lifestyle** (continued)

IF YOU ANSWER 'YES' TO ANY OF THE QUESTIONS, PLEASE PROVIDE DETAILS IN THE SPACE PROVIDED AS NECESSARY, AT THE END OF THIS SECTION.

**Y.** Have you ever received or do you expect to receive counseling, treatment or blood tests in connection with HIV infection or any AIDS related disorder, or any sexually transmitted disease (e.g. gonorrhea or syphilis)? Have you ever had an HIV ELISA test that was reactive or a positive HIV test?  
*If yes, please provide details*

**FIRST LIFE ASSURED**

**SECOND LIFE ASSURED**

☐ Yes ☐ No

☐ Yes ☐ No

**Z.** Are there any circumstances such as illness, disorder, disability, accident or any other factors past or present not disclosed in the application which may affect the risk of an insurance policy on your life?  
*If yes, please provide details*

☐ Yes ☐ No

☐ Yes ☐ No

*Please note all medical costs relating to your application will be met by Atlas Life. Should you decide not to proceed with your application for any reason other than that of an adverse underwriting decision, Atlas Life reserves the right to request full payment of all the medical costs incurred.*

I CONFIRM THAT ALL THE ANSWERS ARE TRUE AND COMPLETE.

**SIGNATURE OF LIFE ASSURED**

**FIRST LIFE ASSURED**

**SECOND LIFE ASSURED**

**DATE**  D  D /  M  M /  Y  Y  Y  Y

**DATE**  D  D /  M  M /  Y  Y  Y  Y

Additional space for answers

QUESTIONS	DETAILS



## 9. Doctor and Pharmacy Details

PLEASE GIVE DETAILS OF YOUR USUAL DOCTOR OR MEDICAL ATTENDANT. IF YOU DO NOT HAVE ONE, PLEASE STATE THE NAME OF THE DOCTOR YOU LAST CONSULTED.

	FIRST LIFE ASSURED	SECOND LIFE ASSURED
NAME	<input type="text"/>	<input type="text"/>
HOW LONG HAVE THEY BEEN YOUR DOCTOR?	<input type="text"/>	<input type="text"/>
ADDRESS	<input type="text"/>	<input type="text"/>
TELEPHONE NUMBER	<input type="text"/>	<input type="text"/>
EMAIL ADDRESS	<input type="text"/>	<input type="text"/>
NAME OF PHARMACY OR MEDICINE SUPPLIER	<input type="text"/>	<input type="text"/>
HOW LONG HAVE YOU KNOWN THEM?	<input type="text"/>	<input type="text"/>

## 10. Occupation

	FIRST LIFE ASSURED	SECOND LIFE ASSURED
OCCUPATION	<input type="text"/>	<input type="text"/>
NATURE OF BUSINESS	<input type="text"/>	<input type="text"/>
DESCRIBE ACCURATELY THE OVERALL NATURE OF THE DUTIES INVOLVED	<input type="text"/>	<input type="text"/>

What percentage of time do you spend on the following?

ADMINISTRATION	<input type="text"/> %	<input type="text"/> %
SUPERVISION	<input type="text"/> %	<input type="text"/> %
MANUAL DUTIES	<input type="text"/> %	<input type="text"/> %
TRAVELLING	<input type="text"/> %	<input type="text"/> %
OTHER	<input type="text"/> %	<input type="text"/> %

Have you been employed in a permanent and full time occupation for at least 12 months? ☐ Yes ☐ No

☐ Yes ☐ No

Do you intend to change your career or become involved in any other occupation in the next 12 months? ☐ Yes ☐ No  
*If yes, please provide details*

☐ Yes ☐ No

Does your occupation require you to travel outside of your country of residence? ☐ Yes ☐ No  
*If yes, please provide details of how long, where to and mode of transport*

☐ Yes ☐ No

Please provide details of your annual income including bonuses / commissions

	CURRENT YEAR	1 YEAR AGO	2 YEARS AGO
FIRST LIFE ASSURED	<input type="text"/>	<input type="text"/>	<input type="text"/>
SECOND LIFE ASSURED	<input type="text"/>	<input type="text"/>	<input type="text"/>

## 11. Financial Questionnaire

ONLY COMPLETE THIS SECTION IF YOU ARE APPLYING FOR PERSONAL COVER IN EXCESS OF US\$750,000 OR BUSINESS COVER IN EXCESS OF US\$500,000.

### What is the purpose of the Life Cover?

☐ Personal Protection over US\$750,000

☐ Loan Protection over US\$500,000

☐ Key Man Protection

☐ Partnership or Shareholder Protection

☐ Other (please provide details)

### Instructions for completion

Answer sections A, B, F

Answer sections A, B, C, F

Answer sections A, D, F

Answer sections A, E, F

Answer sections A, F and other relevant questions

### A) GENERAL INFORMATION

I. What is the reason for applying for Life Cover?

II. How was the sum assured calculated?

III. Have you ever been declared bankrupt?  
If yes, please provide dates and relevant details

☐ Yes ☐ No

### B) PERSONAL INFORMATION (TO BE COMPLETED FOR PERSONAL AND LOAN PROTECTION)

Please provide details of your assets and liabilities

#### ASSETS

Value of Primary Residence	
Cash at Bank	
Other Investments	
<b>A = TOTAL ASSETS</b>	

#### LIABILITIES

Mortgage on Primary Residence	
Personal Loans	
Other Loans	
<b>B = TOTAL LIABILITIES</b>	
<b>A - B = NET ASSETS</b>	

## 11. Financial Questionnaire (continued)

### C) LOAN PROTECTION

Please provide details of your loan commitments that you wish to protect. We will require sight of the Loan Agreement.

PURPOSE OF LOAN	NAME OF BORROWER	NAME OF LENDER	LOAN AMOUNT	TERM OF LOAN	INTEREST RATE	HAS THE LOAN BEEN RECEIVED?	IS THE POLICY REQUIRED FOR LOAN APPROVAL

### D) KEYMAN PROTECTION

I. What is the role within the business?

II. Please describe your duties and responsibilities

III. What specialised skills, qualifications and experience make you a key person?

IV. Approximately how much revenue is directly attributable to you?

V. Is there anyone else in the business also considered as key persons? ☐ Yes ☐ No  
If yes, please provide details and state whether insurance is also being sought on these other persons

VI. Do you have an ownership interest or shareholding in the business? ☐ Yes ☐ No  
If yes, please provide relevant details including the value of this interest or shareholding

VII. Is a succession plan for the business in place? ☐ Yes ☐ No  
If yes, please provide details

### E) PARTNERSHIP AND SHAREHOLDER PROTECTION

I. Name of business

II. Nature of business

III. When did the business commence?

IV. What is the current value of the business?

## 11. Financial Questionnaire (continued)

### E) PARTNERSHIP AND SHAREHOLDER PROTECTION (continued)

V. How and when was this value calculated?

VI. What is the value of your interest in the business?

VII. Please state the names and shareholdings of all other partners or shareholders

VIII. Is a partnership or shareholder agreement in place?

*If yes, please provide details*

☐

Yes

☐

No

IX. Is insurance cover being proposed or already in-force on the other business owners?

*If yes, please provide details*

☐

Yes

☐

No

**THE FOLLOWING SHOULD BE COMPLETED FOR BUSINESS PROTECTION APPLICATIONS WHERE THE SUM ASSURED EXCEEDS US\$ 500,000**

X. Please provide income and expense details

	CURRENT YEAR	1 YEAR AGO	2 YEARS AGO
GROSS INCOME			
TOTAL EXPENSES			
NET PROFIT			

XI. Please provide details of Business Assets and Liabilities

#### ASSETS

Value of Primary Residence	
Cash at Bank	
Other Investments	
<b>A = TOTAL ASSETS</b>	

#### LIABILITIES

Mortgage on Primary Residence	
Personal Loans	
Other Loans	
<b>B = TOTAL LIABILITIES</b>	
<b>A - B = NET ASSETS</b>	

### F) OTHER INFORMATION

Please provide any additional information that you feel is important



## 12. Declaration

This declaration is my request to enter into a life insurance contract with Atlas Life and I understand and accept that my application will be subject to medical underwriting.

### Furthermore, I understand and accept that:

- 1 Atlas Life is a long term non-domestic life insurance company incorporated under the laws of Seychelles and regulated by the Seychelles Financial Services Authority.
- 2 Atlas Life products are only available in countries where they may be lawfully offered and to the best of my knowledge and belief, I am not subject to any legislation that would make my life insurance application unlawful.
- 3 A copy of this completed application and the policy terms and conditions are available from Atlas Life at any time and if I am applying on the advice of an intermediary, this person is acting on my behalf and not as an agent of Atlas Life.
- 4 The life cover I am applying for will only commence upon acceptance of risk and when Atlas Life has received the first premium. The policy has no surrender value and if I stop paying the premium the policy will be cancelled.
- 5 Atlas Life is committed to protecting policyholder information and ensuring that personal data is gathered legally and under strict conditions and they have adopted the guidelines of the General Data Protection Act 2018 with regards to how all client information is processed and stored.
- 6 I must inform Atlas Life in writing if I relocate to another country, take up a new occupation or avocation between the date of this application, the commencement date of the policy and anytime thereafter.
- 7 I will be required to undergo HIV testing as part of the application process and, if I am required to have a medical examination, the replies to the questions will form part of this application.
- 8 Atlas Life will use the information I have given in my application for underwriting, administration and for claims management. My personal information may also be passed to medical practitioners, specialist underwriters, reinsurers, claims investigation companies or any other agency appointed for these purposes.
- 9 All medical costs will be met by Atlas Life however should I decide not to proceed with my application for any reason other than that of an adverse underwriting decision, Atlas Life reserves the right to request full reimbursement of all the medical costs incurred.
- 10 If I select the Indexation option in my application the sum assured and the premium will increase automatically each year.
- 11 As part of the application process, Atlas Life may require historic medical information about my physical or mental health and I hereby authorise any doctor or medical facility that holds such information to disclose it when they see a copy of this declaration.
- 12 Atlas Life may require relevant medical information from other insurers about any other applications for life, disability, accidental death or private medical insurance that I have previously applied for and I hereby authorise any insurance company that holds such information to disclose it when they see a copy of this declaration.
- 13 Atlas Life may require sight of my full medical history to consider a claim and I hereby authorise any doctor, medical facility, insurance company or person who may be in possession of such information to disclose it when they see a copy of this declaration.
- 14 The policy acceptance letter issued by Atlas Life may instruct me to cancel existing life insurance and I understand that if I fail to cancel any such policies, Atlas Life reserves the right to adjust or cancel the benefits of this policy.

### CLIENT DECLARATION

The answers given to the questions in this application, whether by my hand or not, are to the best of my knowledge and belief, accurate and true and no fact has been withheld. I understand and accept that failure to disclose a fact or provide false information will give Atlas Life the right to cancel any policy issued from inception. I understand that any misrepresentation or non-disclosure of relevant medical or factual information may result in any claim being repudiated.

### SIGNATURES

I, the undersigned confirm that I have read this declaration and understand its implications. I acknowledge that I have been fully informed of the details of this policy and have read and understood the policy Terms and Conditions and all relevant documents.

#### SIGNATURE OF LIFE ASSURED

FIRST LIFE ASSURED

DATE  D  D /  M  M /  Y  Y  Y  Y

SIGNATURE OF OWNER  
IF NOT THE LIFE ASSURED

SIGNATURE OF AUTHORISED  
INDIVIDUAL IF OWNER IS A  
TRUST OR COMPANY

NAME AND CAPACITY

DATE  D  D /  M  M /  Y  Y  Y  Y

SECOND LIFE ASSURED

DATE  D  D /  M  M /  Y  Y  Y  Y

DATE  D  D /  M  M /  Y  Y  Y  Y

NAME AND CAPACITY

DATE  D  D /  M  M /  Y  Y  Y  Y

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### 13. Intermediary

COMPANY NAME	<input type="text"/>
NAME OF ADVISER	<input type="text"/>
AGENCY NUMBER	<input type="text"/>
COUNTRY WHERE ADVICE WAS GIVEN	<input type="text"/>
COUNTRY WHERE APPLICATION WAS SIGNED	<input type="text"/>

#### DECLARATION

I declare that, to the best of my knowledge and belief, the information given is true and shall form the basis of the proposed contract with Atlas Life.

SIGNATURE	DATE
	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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### 14. Payment **Details**

Please indicate below your preferred method of payment. Please note the payment of your premium will only be required following the final underwriting decision and a letter confirming the payment instruction will be sent to you at this time.

<input type="checkbox"/>	Telegraphic Transfer
<input type="checkbox"/>	Credit Card
<input type="checkbox"/>	Debit Card

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### 15. Third Party **Payments**

If someone other than the policy owner is making the premium payment please complete this section.

COMPANY NAME	<input type="text"/>
TITLE	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Other <input type="text"/>
FAMILY NAME	<input type="text"/>
FORENAME(S)	<input type="text"/>
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"/>
NATIONALITY	<input type="text"/>
RESIDENTIAL ADDRESS	<input type="text"/>
RELATIONSHIP TO LIFE ASSURED	<input type="text"/>
REASON FOR THIRD PARTY PAYMENT	<input type="text"/>

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## 16. Proof of **Identity**

For the Life Assured, please ensure that a certified copy of one of the following documents is attached.

☐

Passport

☐

Government issued ID Card

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## 17. Proof of **Address**

For the Life Assured, please ensure a certified copy of one of the following documents is attached - the document must be less than 3 months old.

☐

Bank Statement

☐

Utility Bill

☐

Address Verification Form

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## 18. Origin of **Wealth**

For sums assured exceeding US\$ 500,000 or currency equivalent, please confirm the origin of the funds used for the premium. Please note that all documents submitted should be certified by a suitable certifier.

☐

Payslip

☐

Recent Bank statement

☐

Letter from accountant confirming annual income

☐

Other e.g. personal savings, sale of investments, maturing policy or inheritance

**We reserve the right to ask for additional information, as may be required.**

**NAME OF EMPLOYER**

**ADDRESS**

**TELEPHONE NUMBER**

**COMPANY WEBSITE**

**EMAIL ADDRESS**

FOR OFFICE USE ONLY - THIS SECTION IS TO BE COMPLETED BY ATLAS LIFE

POLICY NUMBER

NAME OF INTERMEDIARY

AGENCY NUMBER OF  
INTERMEDIARY



Atlas Life is  
proud to support the  
**Seychelles Islands  
Foundation**

The Seychelles is an archipelago of 115 islands in the Indian Ocean. It is known for its pristine beaches, coral reefs, nature reserves and rare wildlife such as the giant Aldabra Tortoise and the Hawksbill Turtle. The islands are also home to two world heritage sites, namely Vallee de Mai and Aldabra.

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**REGISTERED OFFICE: ATLAS LIFE SEYCHELLES**  
108 Premier Building, Victoria, Mahe, Seychelles

**t** +248 432 1480 **e** [info@atlas-life.com](mailto:info@atlas-life.com) **w** [atlas-life.com](http://atlas-life.com)

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Seychelles Financial Services Authority with registration number 8416474-4