RF&G LIFE INSURANCE COMPANY LTD.
Gordon House
One Coney Drive, P.O. Box 1762, Belize City, Belize C.A.
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PERSONAL ACCIDENT APPLICATION FORM

Section I. Insured's Personal information

Insured's Name: (First, Middle, Last) ______________________________

Home Address: ______________________________ Mailing Address: ______________________________

Place of Birth: __________________ Date of Birth: ______/______/________ Sex: Male ____ Female ____ Marital Status: ______________
dd mm yr

Nationality: ______________________ Occupation: __________________________ Employer: ________________________________

Soc Sec #: ___________________ or Passport No: __________________ Email Address: ______________________________________

Height: ___________ Weight: ___________ Phone No: _____________ Cell No: ______________ Work No: __________________

Employer's Address: ______________________________

Are you a RESIDENT or CITIZEN of Belize?

Are you a Citizen of any other country other than Belize? Yes ☐ No ☐ If yes, please state which country(ies):__________________________

Applicant's Annual Salary: ___________________ Sum Insured: ______________________ Annual Premium: _______________________

Section II. Employer's Information (*applicable to group insurance only*)

Name of Employer: ____ Nature of Business:____

Address of Employer: ______________________________

Email Address:_____________________________________ Phone No:__________________ Fax No: _______________________

Name of Authorized Personnel: __________________________ Company's Stamp: ____________________________________

Section III. Primary Beneficiary Information

1. Legal Name: (First, Middle, Last) ______________________________

Home Address: ______________________________

Date of Birth: ______/______/_______ Sex: Male _______ Female ________
dd mm yr

Phone No: ___________________ Cell No: ____________________ Relationship to Insured: _________________________________

Email Address: ____ Percentage: _______________

2. Legal Name: (First, Middle, Last) ______________________________

Home Address: ______________________________

Date of Birth: _______/_______/________ Sex: Male _______ Female _______
dd mm yr

Phone No: ________________ Cell No: ___________________ Relationship to Insured: ____________________________________

Email Address: ____ Percentage: _______________

Contingent Beneficiary

1. Legal Name: (First, Middle, Last) ______________________________

Home Address: ______________________________

Date of Birth: _______/_______/________ Sex: Male _______ Female _______
dd mm yr

Phone No: __________________ Cell No: ___________________ Relationship to Insured: ________________________________

Email Address: ____ Percentage: ____________________

Trustee Information (For minors stated as beneficiaries)

1. Legal Name: (First, Middle, Last) ______________________________

Home Address: ______________________________

Date of Birth: _______/_______/________ Sex: Male _______ Female _________
dd mm yr

Phone No: __________________ Cell No: __________________ Relationship to Insured: _________________________________

Email Address ____ Percentage: _____________________

1. To the best of your knowledge and belief.
   i) Do you have any physical or other defects or weakness of any kind? If so, give details.

   ____

   ii) Are you of sound health? ____

   iii) Are you currently suffering or have you ever suffered from any illness or disease, or receiving any treatment or medication or or was restricted to any special diet? If yes, please give full details.

   ____

   iv) Have you seen any medical provider in the last five months? If yes, please give full details.

   ____

2. What injuries or illnesses had you suffered in the last three (3) years? (Give dates and duration in each case.)

   ____

   ____

3. Have you been declined or offered special terms by any company for sickness or accident insurance?

   If yes, please give full details. ____

4. Have you or do you intend to engage in hand gliding, parachuting, vehicle racing, sky or scuba diving or any other hazardous sport or hobby? Give full details.

   ____

5. Do you use a motor cycle/scooter as a means of transportation? If yes, kindly provide us with details on (1) type and engine size, (2) frequency of use, (3) purpose for use of motor cycle/scooter, (4) approximate distance traveled per day & (5) type of protective gear used

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   ____

I hereby apply for personal accident insurance to be issued solely and entirely in reliance upon the written answers to the foregoing questions and I agree that the insurance provided only covers the applicant and who is accepted. I have read the answers to the questions before signing this application and the answers are correctly written as given by me to the best of my knowledge; true and complete. I understand and agree that no coverage shall be in force until the policy premium is paid and the policy issued, that coverage will be in force as of the effective date shown in the policy.

I understand that no Agent is authorized to make change or notify in any way any applicable coverage section of the policy or to suppress any of the Company's requirements.

I hereby authorized any licensed Physician, Medical Practitioner, Hospital, Clinic or any other medically related facility, Insurance Companies, Medical information Bureau or any other organization, institution or person that has any records or knowledge of my health, to give RF&G Life Insurance Company Limited.

DECLARATION: I hereby declare that all proposed Insured persons are domiciled in Belize for at least nine months and that my answers to medical questions asked in this application are answered truthfully and to the best of my knowledge. Also, I am aware and agree that an Administration Fee is payable by me if I choose not to accept the terms and conditions of the approved coverage.

I hereby certify that the foregoing answers are true and correct to the best of my knowledge.

Witness Signature: ___________________________ Insured's Signature: __________________________ Date: _____________

Official Use ONLY

Effective Date of Coverage: _______________________

Approved By: ___________________________________ Approval Date: ____________________________