

3. Do you or your nominated members have any health conditions?

Yes

No

If No please sign

If Yes please provide details below

FULL NAME OF MEMBER	ILLNESS	DURATION OF ILLNESS	HEALTH CARE PROVIDER

4. INFLATION PROTECTOR

Please note that all members have an automatic annual contribution increase of 5% as a hedge against inflation in to meet the average funeral cost.

Optional Update Table

% INCREASE - CONTRIBUTION	% INCREASE - DONATION
10	3.0%
15	4.5%
20	6.0%
25	7.5%
30	9.0%

5. BENEFICIARY INFORMATION *(for cash donation payment)*

BENEFICIARY

	FULL NAME	AGE	RELATIONSHIP	GENDER	%	TELEPHONE
1						
2						
3						
4						

6. TRUSTEE INFORMATION

TRUSTEE *(Individual or Institution)*

	FULL NAME	AGE	RELATIONSHIP	GENDER	%	TELEPHONE
1						
2						
3						
4						

NOTE

- 1. On signing this proposal form, you confirm that any statement either written by you or not is accurate and the information provided is complete.
- 2. Your membership shall come to effect only after this proposal has been accepted and the full payment of the first contribution

DECLARATION *(Must be filled in full)*

I _____ understand and agree to the membership terms and conditions of FamilyCare Funeral Trust and authorize the verification of the information provided on this form as my credit and employment information.

I have received a copy of this application. I also confirm that the members I have nominated above are financially dependent on me (during their life time and on death). I further acknowledge that I have been informed of the details regarding my membership, benefits and relevant contributions.

Signature of Applicant:

OR



(RTP)

7. INTERMEDIARY DETAILS

Name of Relationship Officer:

Branch:

Signature:

Date:

For Office Use Only

BUSINESS SERVICES UNIT

Captured by:

Date of Capture:

Signature:

Received by:

Date of Review:

Decision:

Accepted

Rejected

Reclaimed

Reason for Rejection:

Contribution Deduction Mandate

Membership Number:

Mandate Type:

1. Contribution Payer Details

Fixed Variable

Surname:

First Name:

Other Name(s):

Date of Birth:

Mobile Number:

2. Contribution Payment Details

Package Type:	Brass	Brass Plus	Bronze	Silver	Gold	Diamond	Platinum
Package Mode:	Direct Debit	Source Deduction	Alternative (Mobile Money, Cheques)				
Package Frequency:	Monthly	Quarterly	Annually				
Annual Contribution Increase:	5%	10%	15%	20%	25%	30%	

3. Direct Debit Deduction

Date of First Deduction:

Bank Name:

Bank Branch:

Account Name:

Account Number:

Branch Code:

Account Type: Current

Savings

Applicant's
Signature:

Contribution
Amount GH¢:

Date:

4. Source Deduction

Date of First Deduction:

Company Name:

Staff ID:

Name of Staff:

Date:

Department:

Signed by Client:

Contribution Amount GH¢:

5. Alternative Payment Instruction (Mobile Money, Cheques)

I the undersigned hereby agree to make my monthly contribution payment to FamilyCare through this approved mode of receiving the payment.

Contribution Amount GH¢:

Applicant's
Signature:

Date:

6. Official Use Only

Reviewed by:

Signature:

Date of review:

Contribution Deduction Mandate

Membership Number:

Mandate Type:

1. Contribution Payer Details

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Reviewed by:

Signature:

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