EDUCATION INVESTMENT PLAN APPLICATION FORM

(PLEASE COMPLETE ALL SECTIONS IN CAPITAL LETTERS).

YOUR DETAILS

☐ Mr ☐ Mrs ☐ Miss ☐ Dr ☐ Male ☐ Female Date (DD/MM/YYYY)

Surname Forenames

Contact address

Town/city State Nationality

Contact tel no Tel no

E-mail address

Are you self-employed ☐ as a sole trader ☐ partnership ☐ professional Other

Or name of employer occupation/ job title

Annual income NGN ☐ < 1.2 m ☐ 1.2 - 3 m ☐ 3 - 6 m ☐ > 6 m

Next of kin Relationship with child

THE CHILD'S DETAILS

☐ Male ☐ Female Date (DD/MM/YYYY)

Surname Forenames

Contact address

Town/city State Nationality

YOUR INVESTMENT

I would like to add the Life Insurance option ☐ Yes ☐ No Total goal NGN

Monthly contribution Monthly insurance premium No of years you wish to fund for

Intended school First calender year which you will require the fund to be available

The calendar year in which you expect the child to enter university (eg 2020 for the academic year 2020/21)

Plans are accepted on standard terms as soon as the initial deposit is paid.

Insurance policy will be mailed to you within 14 days subject to any objection from the insurance provider.

If you are saving to provide funds for the benefit of a child, you may wigh to take steps to ensuer that, should you die before the plan matures, that a responsible person can retain control over the funds. Please refer to the product brochure and we also recommend that you seek appropriate professional advice.

YOUR DECLARATION

I apply for membership of the investment plan known as the Education Investment Plan. I agree to be bound by the Memorandum Of Understanding, (which I understand may be varied subject to the consent of the members of the plan), both present and future. A copy of the Memorandum Of Understanding, of this application and of the terms and conditions on which the plan will be effected is available on request.

I declare that the information given in this form is true and correct, and that I have disclosed all material facts relevant to my application. I agree that this application shall form the basis of the contracts between me and FCMB plc in accordance with, and subject to, the Memorandum Of Understanding of the plan, and that the contracts shall be deemed to be issued in Nigeria and shall, in all respects, be governed by, and construed in accordance with, the laws in Nigeria.

I consent to the Society: (a) processing any information provided in connection with this application; (b) retaining and storing such information (either electronically or otherwise) for as long s it remains relevant to this plan and/or to my Account Holding in FCMB plc; and (c) sharing relevant information about me with any party appointed by the bank or related parties to the plan to arrange or perform a medical examination, or other life insurers or reinsurers, or life insurers' database, for the purpose of deciding whether or not to accept this, or any other application and on what terms, or to prevent fraud.

I agree that a copy of any consent or agreement contained in this Declaration shall be as valid as the original.

EDUCATION INVESTMENT PLAN APPLICATION FORM *Continued*

(PLEASE COMPLETE ALL SECTIONS IN CAPITAL LETTERS).

Are there any additional facts affecting the risk of assurance on your life of which the company should be made aware?

If yes, please give details

DECLARATION

I, the Life assured, do hereby declare that all the foregoing answers are true, that I have not concealed nor ithheld anything with which the assurer should be acquainted with in order to assess my eligibility for assurance. I agree that these and all statements I have made or shall make to the assurer or to its medical examiner(s) in connection with this or previous proposal(s) shall be the basis of this contract.

I declare that I have not suffered from, undergone surgery nor been hospitalized for any specialized treatment for any life threatening medical conditions e.g. heart problems, high blood pressure, diabetes, lung disease in, the two years preceding the commencement of this policy.

I, my spouse or partner, have never tested positive or received medical advice, counseling or treatment in connection with AIDS related conditions.

I irrevocably authorize and request any doctor or other person who may be in possession of, or hereafter acquire, any information concerning my health up to the present time and to disclose such information to the assurer. I agree that this authority and request shall remain in force after my death as well as prior thereto.

RESTRICTIONS, WAR AND KINDRED RISKS

It is agreed and expressly understood that should the death of the Life Assured occur directly or indirectly from and his/her engaging in or taking part in riot, strike, civil commotion, mutiny, insurrection, war (whether war be declared or not), or any act incidental thereto, the total amount payable under this policy shall be limited to the amount of premium paid.

Signature of person whose life is to be assured

Date

Name of witness

Signature of witness

Address of witness

Date

CONFIDENTIAL FINANCIAL STATEMENT

Name of proposed insured The following financial disclosures are made for the purpose of establishing insurability in connection with the pending Life Assurance Application on my life. They are furnished as a true and accurate statement of my financial condition on and I agree that this shall form basis of the contract between the company and myself.

EIP SUBSCRIPTION/WEALTHBEING STANDING INSTRUCTION

(PLEASE COMPLETE ALL SECTIONS IN CAPITAL LETTERS). **NOTE:** ALL ITEMS MARKED WITH RED ASTERISK (*) ARE COMPULSORY

Date (DD/MM/YYYY)

☐ EIP Subscription SI ☐ WealthBeing SI

Name of Customer *

Mobile Number *

Land-line Number

Product Code *

EIP 01

Policy Number

Account Number *

Amount *

Name & A/C No of Beneficiary 1 *

FCAM ACCOUNT (EDU. INVEST PLAN ONLY) NGNLI99924430159

Email Address (Please Fill in CAPITAL LETTERS)

Frequency of Order *

☐ Monthly ☐ Quaterly ☐ Yearly

Duration of Standing Order (Tick as applicable) *

☐ Months ☐ Years ☐ Perpetual until terminator

Due Date (DD/MM/YYYY)

For EIP Subscription Standing Instruction Only

Is Insurance Required?

☐ Yes ☐ No

Customer's Account To Debit If Not The Same As Above

Premium

Due Date (DD/MM/YYYY)

Frequency of Order ☐ Monthly ☐ Quaterly ☐ Yearly

Product Code *

WTA01: FCMB TERM ASSURANCE

Policy Number *

Insurance Benericiary A/C Nos

1. NGNIN99954210027 10%
2. NGNLI99924430183 90%

Customer's Signature *

For Bank Use Only

VERIFICATION

Originating SOL

FP Code

Documentation Complete

☐ Yes ☐ No

Scanned by

Signature

Authorised by

Signature