

Avalon Healthcare & Hospitalisation Cash Plan Application Form

Applicant's Address:		Postcode:
Home tel number:	Work tel number:	
Mobile tel number:	E-mail address:	

FIRST APPLICANT

Title: <i>(Mr/Mrs/Ms/Miss/Other)</i>
Surname:
Forenames:
Date of Birth:
Occupation:
Monthly earnings: <i>(Employed - gross salary, overtime, bonuses)</i> £ <i>(Self Employed - pre-tax profit)</i>
Employment Status: Employed <input type="checkbox"/> Self Employed <input type="checkbox"/>

SECOND APPLICANT (Partner)

Title: <i>(Mr/Mrs/Ms/Miss/Other)</i>
Surname:
Forenames:
Date of Birth:
Occupation:
Monthly earnings: <i>(Employed - gross salary, overtime, bonuses)</i> £ <i>(Self Employed - pre-tax profit)</i>
Employment Status: Employed <input type="checkbox"/> Self Employed <input type="checkbox"/>

Children to be insured (if applicable):

Full Name	Date of Birth

Policy

Avalon Healthcare & Hospitalisation Cash Plan

On the following basis:

Single Joint Family Single Parent

Level of Cover:

Bronze Silver Gold Platinum

Premium:

£

PAYMENT INFORMATION

Payment Frequency:

Monthly Quarterly Half Yearly Annually

Start Date:

Preferred Direct Debit Date:

Declaration

I/We hereby apply for insurance to Axeria Life International PCC Limited (the insurer) under their usual terms and conditions. I/We confirm that the information supplied by me/us in connection with this proposal is correct to my knowledge and belief. I/We note that I/We should keep a record of all information supplied for the purpose of this proposal and that a copy of such information will be supplied if requested by me. I/We consent to the seeking of information from other insurers and I/We authorise the giving of such information for such purposes. I/We also consent to the insurer or their agents seeking medical information from any doctor who at any time has attended me concerning anything which

affects my physical or mental health and I/We authorise the giving of such information.

Notice under the Data Protection Act 1998

I/We confirm and agree that information about me/us and this Proposal may be retained on paper and computer by APRIL Insurety and used:

A) by Axeria Life International PCC Limited, APRIL Insurety and other businesses that provide insurance services relating to the proposal as may be necessary for the administration of my/our policy and dealing with claims. In dealing with claims under my/our policy I/We agree that it may be necessary for APRIL Insurety to obtain and use

sensitive personal information about me/us.

B) to provide information about me/us (whether provided in the proposal or claim form) to other insurers for the prevention of fraud and to other third parties for the purpose of administration of their policy or any claim. Details of such third parties and other insurers will be made available on request.

I/We have been provided with details of the procedure to follow in the event of a complaint. Your contact information may be used to send you details about other products and services available from APRIL Insurety that might interest you. If you do not wish to receive this information please tick this box.

Signature First Applicant:

X

Date:

Signature Second Applicant:

X

Date:

For Broker's use only

Broker's Name:

Broker's Signature:

Broker's Agency No:

Cheque/Credit Card/Direct Debit Mandate attached? **Yes / No** Amount: £

Direct Debit Form

INSTRUCTIONS TO YOUR BANK OR BUILDING SOCIETY TO PAY BY DIRECT DEBIT

Service User Number:

2	4	9	1	9	0
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Please fill in the whole form and send it to: **Insurety Plc, 15 Apex Court, Almondsbury, Bristol, BS32 4JT.**

Name and full postal address of your Bank or Building Society:

To: The Manager	Bank/Building Society
Address:	

Name(s) of Account Holder(s)

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Bank or Building Society
Account Number

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Branch Sort Code

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Banks and Building Societies may not accept Direct Debit Instructions for some types of accounts.

Reference Number:

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Your Instructions to Your Bank or Building Society and Signature

- I instruct you to pay Direct Debits from my account at the request of Insurety Plc.
- The amounts are variable and may be debited on various dates.
- I understand that Insurety Plc may change the amounts of dates only after giving me prior notice.
- I shall inform the Bank/Building Society in writing if I wish to cancel the Instruction.
- I understand that if any Direct Debit is paid which breaks the terms of the instruction the Bank/Building Society will make a refund.

Signatures(s):
Date:

THE DIRECT DEBIT GUARANTEE



- This Guarantee is offered by all Banks and Building Societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by your own Bank or Building Society.
- If the amounts to be paid or the payment dates change, Insurety/Capital Healthcare will notify you ten working days in advance of your account being debited or as otherwise agreed.
- If an error is made by Insurety/Capital Healthcare or your Bank or Building Society you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a Direct Debit at any time by writing to your Bank or Building Society. Please also send a copy of your letter to Insurety/Capital Healthcare.



APRIL Insurety is a trading name of Insurety Plc, a member of the APRIL Group.
Insurety Plc (registered in England No. 3179382) is authorised and regulated by the Financial Services Authority, registered number 308655.
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