

Trust Essentials 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"/>

Policy

Trust Essentials Income Protection and Life Insurance Plan

Income Protection Plan:

Option 1: Accident & Sickness cover, £600 monthly benefit - £29.95

Option 2: Accident, Sickness & Unemployment cover, £500 monthly benefit - £49.95 (Must have been continuously working for the last 6 months)

Life Insurance Benefit

If you are applying for life insurance, please answer the questions below. You will receive automatic acceptance if you can answer 'NO' to all the health questions. If 'YES' is answered to any question, a full application form must be completed. Please contact APRIL Insurety for a copy.

- | | |
|--|--|
| 1. Are you currently taking prescribed drugs, medicines or tablets and/or are you due to have any check-up in the next 12 months in connection with any medical condition (other than for minor ailments such as colds and flu), or are you waiting for the result of any medical investigation? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Do you currently have or have you ever had any of the following:
a) Lump or growth, cancer, leukaemia, Hodgkin's disease, lymphoma, brain or spinal tumour?
b) Heart attack, angina, stroke, circulatory problems, brain haemorrhage or permanent brain injury? | Yes <input type="checkbox"/> No <input type="checkbox"/>
Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. In the last 12 months has your doctor advised you to have any investigations, scans or blood tests in connection with any medical condition? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4. Has any application you have made for life, critical illness or health insurance ever been declined, postponed or subject to an increased premium or other special terms? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Smoker Status: Non smoker Smoker **Current age:**

Level of cover: 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 Cassidy Davis (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 Cassidy Davis, 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: £



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