



# Corporate Co-Director Insurance

## Application Form

Guaranteed Term Protection



**Special Instructions**

Hold for Risk Commencement Date

YES  NO

**Policy Documentation Printing**

Do you want to print the policy documentation in your office?

YES  NO

**Note:**

If YES, do not input policy dispatch address below.

**Policy Dispatch Address**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Other Instructions**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Note:**

Please complete in BLOCK CAPITALS.

**Note:**

Under the Criminal Justice (Money Laundering and Terrorist Financing) Acts 2010 and 2013, Zurich Life may require clients to provide 'Evidence of Identity' and 'Proof of Address' and other supporting documentation.

**Note:**

If the company is a public company whose securities are listed on an EU-regulated stock exchange, we do not need a list of directors or the beneficial owners.

This policy is a protection policy, the primary purpose of which is to provide cover in the event of specified serious illnesses, permanent total disablement or death, as applicable.

Plan Type <small>(as per the illustration)</small>	<b>R</b>	Intermediary Number
Intermediary Name		
Financial Advisor Name		

**Your commitment to provide honest and complete information to us:**

You must carefully read the statements below regarding your commitment to provide honest and complete information to us together with all of the Consumer Declarations on pages 8 and 9 including:

- (i) the Policy Declaration,
- (ii) the Data Sharing Consent,
- (iii) the Consumer Disclosure, and
- (iv) the Permission to request further information.

**If you agree with each declaration, please sign at the end of page 9.**

- I am aware that if I do not answer all questions honestly and completely, then Zurich Life may not pay out if I need to make a claim in the future.
- I understand that Zurich Life will not necessarily obtain a report from my doctor, so it is vital that I fully disclose all Material Facts (see Section H, part i).
- I understand that Zurich Life will assess my application based on the information in this form. I understand that it is my responsibility to check that my completed application is honest and complete before submitting it to Zurich Life.

**A Policy Owner Details**

Company Name	
Address	
Email Address	
Telephone Number	
Fax Number	
Registered / Business Address	
Country of Incorporation	
Company Registration Number <small>(if applicable)</small>	
List of names of the directors	
The names of beneficial owners with greater than 25% of the shares or voting rights or who otherwise exercise control.	

**B Life/Lives Insured Details First Life Insured**

Mr     Mrs     Ms    Forename

Surname

Address for correspondence

Date of Birth 



    Age Next Birthday 



    Sex  M  F

Civil Status  Married     Single     Widow(er)     Separated     Divorced     Civil Partner     Former Civil Partner

Telephone Number (work)

(home)

(mobile)

Email Address

Nationality

Country of Residence

Occupation

**Life/Lives Insured Details Second Life Insured**

Mr     Mrs     Ms    Forename

Surname

Address for correspondence

Date of Birth 



    Age Next Birthday 



    Sex  M  F

Civil Status  Married     Single     Widow(er)     Separated     Divorced     Civil Partner     Former Civil Partner

Telephone Number (work)

(home)

(mobile)

Email Address

Nationality

Country of Residence

Occupation

**Note:**

For a single life policy, please complete first life section. For dual life policies, complete first and second life sections.

**Note:**

Only illnesses specified in your policy document are covered under Serious Illness benefit. Claims for any other serious or minor illnesses are not covered.

**C Plan Details**

**Basis of Cover**

Single Life    or     Dual Life    Term of Cover\* 



 Years

*\* Minimum - 2 years; Maximum - 40 years but cover cannot extend beyond the older life's 85th birthday (or 75th birthday if Serious Illness cover has been chosen).*

**i. Main Benefits**

Must choose Life or Serious Illness cover or both	→	Life Sum Insured <small>(only available if aged 75 next birthday or less)</small>	→	<table border="1" style="width: 100%; height: 40px;"> <tr> <td style="text-align: center;">First Life</td> </tr> <tr> <td style="text-align: center;">€</td> </tr> </table>	First Life	€	→	<table border="1" style="width: 100%; height: 40px;"> <tr> <td style="text-align: center;">Second Life</td> </tr> <tr> <td style="text-align: center;">€</td> </tr> </table>	Second Life	€
First Life										
€										
Second Life										
€										
Accelerated Serious Illness Sum Insured <small>(only available if aged 65 next birthday or less)</small>	→	Accelerated Serious Illness Sum Insured <small>(only available if aged 65 next birthday or less)</small>	→	<table border="1" style="width: 100%; height: 40px;"> <tr> <td style="text-align: center;">€</td> </tr> </table>	€	→	<table border="1" style="width: 100%; height: 40px;"> <tr> <td style="text-align: center;">€</td> </tr> </table>	€		
€										
€										

As accelerated, the Serious Illness sum insured must be less than or equal to the Life sum insured. The Life cover is then reduced by the amount of any Serious Illness/PTD claim.

**Note:**

Serious Illness includes PTD on the basis of inability to perform at least 3 out of 5 activities of daily work.

**Inflation Protection Option:**

If dual life, this applies to both lives.

**C Plan Details (continued)**

**i. Main Benefits**

Permanent Total Disablement (PTD) 'Own' Occupation Cover

Only available if Serious Illness cover is chosen and Life (Lives) Insured is aged 60 next birthday or less. PTD cover ceases at age 65. Please note you must complete Section G.

If for any underwriting reasons you are not eligible for 'Own' Occupation PTD cover, please tick here if you **do not want** the application to proceed without 'Own' Occupation PTD cover.

**ii. Additional Benefits and Options**

Waiver of Premium Benefit

Only available if aged 59 next birthday or less. Benefit ceases at age 60.

Protection Continuation Option

Only available if aged 65 next birthday or less.

**First Life**

Yes  No

Yes  No

Yes  No

**Second Life**

Yes  No

Yes  No

Yes  No

**Inflation Protection Option - automatically included**

Please tick here if you **do not** want the Inflation Protection Option.

Note: This benefit is only available if aged 64 next birthday or less and the benefit ceases at age 65. Inflation Protection will be included in your policy unless this box is ticked.

**Note:**

A Government Insurance Levy (currently 1% as at July 2014 and may change in the future) will apply to your policy. Zurich Life will collect this levy in addition to your premium.

**Note:**

Under the Criminal Justice (Money Laundering and Terrorist Financing) Acts 2010 and 2013, Zurich Life is required to obtain certain documentation and information about you, the method of payment being used and the origin of the funds used to pay the premium. Further information may subsequently be requested.

**Note:**

IBAN (International Bank Account Number) and BIC (Bank Identification Code) details are included on bank statements.

**D Contribution Details and Source of Funds**

**(i) Contribution Details**

*(Exclusive of Government Insurance Levy)*

First Life Premium €

Second Life Premium €

**Total Premium** €

Note: If dual life, please enter premium for each life and total premium. If single life, please enter total premium only.

**Frequency of payment by:**

**DIRECT DEBIT**

Monthly  Quarterly  
 Half-yearly  Yearly

**OR**

Bank Draft/Cheque (only if paid half-yearly or yearly)

Half-yearly  Yearly

Bank Drafts and Cheques should be made payable to Zurich Life.

**(ii) Source of Funds**

**(Complete if payment is not by personal cheque or Direct Debit drawn on the Policy Owner's bank account.)**

**Payment by:**

Third Party Cheque/Direct Debit

Please provide Payor Name (if Third Party Cheque/Direct Debit).

Please state the exact nature of the relationship of Third Party Payor to Policy Owner.

**or**

Bank Draft

For Bank Drafts only please provide the details of the bank account from which the funds used to pay the premium were drawn.

Account Holder Name(s)

Name of Bank/Building Society

IBAN

SWIFT BIC

Country account is based in

If Third Party Payor, please state the exact nature of the relationship to Policy Owner.

**or**

Other - Please provide details.

**E Tobacco Consumption**

**Have you smoked any tobacco products in the last twelve months?  
(Please note 'Occasionally' means not smoking on a daily basis)**

If YES, please enter the amount of all tobacco products below:

Cigarettes per day

Cigars per day

Pipe tobacco grams per day

First Life	Second Life
<input type="radio"/> Yes	<input type="radio"/> Yes
<input type="radio"/> No	<input type="radio"/> No
<input type="radio"/> Occasionally	<input type="radio"/> Occasionally
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

**F Health Statement and Other Information**

**Important note**

**When answering the questions in this section you must give full and accurate information in relation to all Material Facts.**

**Material Facts:** I understand that I must disclose all Material Facts. A Material Fact is any fact that may influence the assessment and acceptance of an application for insurance or may increase the possibility that you will make a claim under this policy. If you are in any doubt about whether a fact is material, you should disclose full details.

However, it is important that you are aware that in accordance with the provisions of Part 4 of the Disability Act 2005 you should **NOT** disclose the result of any **Genetic (DNA or RNA) test**.

You must disclose if you are having treatment for, experiencing symptoms of, or having investigations (other than a genetic test) for a genetic condition as well as disclosing all other conditions. You must also give us full information about your family history (without disclosing the name of any relatives), including all genetic conditions as requested in Question 13 on page 7.

**First Life Insured**

Doctor's Name

Address

For how many years?

**Second Life Insured**

Doctor's Name

Address

For how many years?

If you have changed your doctor in the last year, please also give the name and address of your previous doctor.

**First Life Insured**

Doctor's Name

Address

**Second Life Insured**

Doctor's Name

Address

**F Health Statement and Other Information (continued)**

**Note:**

Please answer carefully, giving full details and, if necessary, use a separate sheet for additional information. Tipp-ex should not be used on the application form. If you need to alter an answer please put a line through the incorrect part of the answer and initial the alteration.

**Personal Details**

1. (i) What is your height?
- (ii) What is your weight?  
(Please specify stones, pounds or kilos.)
2. Do you drink alcohol?  
What is your average weekly consumption in units?

First Life	Second Life
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>

**Details**

(One pint = 2 units, a bottle of beer is 1½ units, a standard glass of wine or a single measure of spirits is one unit.)

**Occupation/Activities/Travel**

3. Please state your occupation.
4. As part of your occupation, do you work at heights greater than 40 feet / 12 metres or underground or carry out any other potentially hazardous activity?  
 Yes  No
5. Do you have any intention of flying other than as a passenger on a public airline?  
 Yes  No
6. Have you travelled or resided outside the EU for more than 3 months in the last 5 years?  
(Travel to USA, Canada, Australia or New Zealand need not be disclosed.)  
 Yes  No
7. Do you have any intention or prospect of travelling or residing outside the EU other than on a holiday of less than 3 months duration?  
(Travel to USA, Canada, Australia or New Zealand need not be disclosed.)  
 Yes  No
8. Do you take part or intend to take part in any hazardous pastime such as motor racing, diving, aviation or mountaineering?  
 Yes  No
9. Have you received a conviction for drink driving or driving under the influence of a controlled substance in the past 5 years?  
 Yes  No

First Life	Second Life
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

**Details**

**Health**

10. Have you ever suffered from or received treatment, advice or had investigations for any of the following:
  - (i) Cancer or tumour, leukaemia, Hodgkin's disease or lymphoma?  
 Yes  No
  - (ii) Heart attack, angina, cardiac failure, cardiomyopathy, heart valve or structural disorders or other heart disease?  
 Yes  No
  - (iii) Stroke, brain haemorrhage or brain injury through any cause?  
 Yes  No
  - (iv) Disease of the arteries or veins, aortic aneurysms, or poor circulation in the legs?  
 Yes  No
  - (v) Disease or disorder of the blood, including anaemia?  
 Yes  No
  - (vi) Multiple sclerosis, optic neuritis, Parkinson's disease, Alzheimer's disease, dementia or paralysis from any cause?  
 Yes  No
  - (vii) Epilepsy or any other disease of the nervous system (brain, spinal cord or nerves)?  
 Yes  No
  - (viii) Cirrhosis or any other illness affecting the liver?  
 Yes  No

First Life	Second Life
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

**Details**

**Note:** **F** Health Statement and Other Information (continued)

Please answer carefully, giving full details and, if necessary, use a separate sheet for additional information. Tipp-ex should not be used on the application form. If you need to alter an answer please put a line through the incorrect part of the answer and initial the alteration.

**Health (continued)**

	First Life	Second Life	Details
(ix) Kidney failure or kidney disease including cystic kidney disease?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(x) Diabetes, thyroid disorders or any hormone abnormalities?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(xi) Any mental illness including anxiety, depression, stress or eating disorder, or have you attempted to harm yourself?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
11. In the last 5 years have you suffered from or received treatment, advice or had investigations for any of the following:			
(i) Lump, growth, cyst, mole or freckle that has bled, changed shape, colour or size or become painful?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(ii) High blood pressure, raised cholesterol, chest pain or irregular heart beat?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(iii) Any form of numbness or tingling, temporary loss of muscle power or tremor, severe headaches, dizziness, seizure, fit, fainting or blackout or any other symptom that may be due to a nervous system disorder?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(iv) Ulcers or any disorder of the oesophagus, intestine, pancreas, bowel or urinary system?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(v) Asthma, bronchitis, emphysema, shortness of breath or any other respiratory disorder? <small>(Colds, influenza, hay fever and simple respiratory tract infections can be omitted.)</small>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(vi) Disorders affecting the eye (and not wholly corrected by spectacles or contact lenses), ear, nose or throat?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(vii) Arthritis or joint disorders, back, neck or muscular disorder or chronic fatigue syndrome?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(viii) <b>If male</b> - prostate or any other urinary disorders? <b>If female</b> - abnormal cervical smear or any other gynaecological or urinary disorder?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(ix) Other than for the conditions you have already disclosed, are you taking any prescribed drugs, medicines, tablets or any other treatment at present? <small>(Please give the name of the condition for which you are taking this treatment and not the medication itself.)</small>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(x) Other than the conditions disclosed above have you sought medical advice, treatment or had investigations for any other condition in the past 5 years? <small>(Colds, influenza and hay fever can be omitted.)</small>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(xi) Are you awaiting the results of any tests/ investigations or referral to any hospital, clinic or doctor or do you have any medical condition, pain, discomfort or other symptoms for which you have not yet sought medical advice?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
12. (i) Have you used any nicotine replacement products in the last 12 months? This may include electronic cigarettes, nicotine patches or gum. Please confirm type of product used.	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(ii) Have you ever been treated for alcohol misuse, or advised/counselled to reduce your consumption of alcohol?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(iii) Have you taken cocaine, cannabis or any drugs other than for medicinal purposes within the last 10 years?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	

**F Health Statement and Other Information (continued)**

**Health (continued)**

12. (iv) Have you ever tested positive for HIV/AIDS or are you awaiting the results of such a test?
- (v) Have you ever tested positive for Hepatitis B or C or are you awaiting the results of such a test?

First Life	Second Life	Details
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	

**Family History**

13. Have any of your **parents, brothers** or **sisters** ever had one or more of the following medical conditions at the ages specified:

**Family member(s) age 50 OR less**

- (i) Breast or ovarian cancer?
- (ii) Multiple Sclerosis, Motor Neurone disease or Parkinson's disease?

**Family member(s) age 60 OR less**

- (iii) Bowel or colon cancer?
- (iv) Stroke or heart disease (for example heart attack or angina)?
- (v) Cardiomyopathy?
- (vi) Muscular dystrophy of any kind?
- (vii) Polycystic kidney disease?
- (viii) Huntington's disease or Alzheimer's disease?
- (ix) Any type of cancer that has occurred in the same site in two or more family members? *Note: there is no need to repeat disclosure given in question 13 (i) and (iii) above.*
- (x) Any disorder which you know or suspect to be hereditary or for which you have received follow up or screening?

First Life	Second Life	Details <i>(Please specify age at diagnosis of the relevant medical history.)</i>
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	

**Existing Cover**

14. Does the Serious Illness sum insured on this application and any other Serious Illness cover you have with any other company exceed €500,000?

First Life	Second Life	Details
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	

**G Please complete this section if 'Own' Occupation Permanent Total Disablement Cover is required.**

Do any of the following activities form an essential part of your work?

- (a) Manual or physical activity?  
If YES:  
Percentage of time \_\_\_\_\_ %  
Please give nature of this activity.
- (b) Use of machinery or tools?  
If YES:  
Percentage of time \_\_\_\_\_ %  
Please give nature of this activity.
- (c) Annual business mileage greater than 25,000 miles (40,000 km)?
- (d) Working at heights?  
If YES:  
Average height worked \_\_\_\_\_

First Life	Second Life
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
_____ %	_____ %
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
_____ %	_____ %
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
_____	_____

**Note to Financial Advisor:**

Please consult the online Occupational Benefits Guidelines (in the Underwriting section of the Broker Centre) to check if your client's occupation is acceptable for 'Own' Occupation PTD cover.



**H Declaration (continued)**

**(iv) Permission to request further information**

I agree to give Zurich Life permission to request medical information from any doctor that I have attended and to request relevant information from any other insurance office that I have applied to for life insurance cover. I agree that this authority will remain in force after my death.

**I confirm that I have read, fully understand and agree to all parts of the above declarations ((i), (ii), (iii) and (iv)), the commitment to provide honest and complete information on page 1 and that, as policy owner I will be the beneficial owner(s) of this policy.**

**I am aware that if I do not answer all questions honestly and completely, Zurich Life may decline to pay a future claim.**



**Policy Owner:**

Please sign and date.

Signature for and on behalf of the Company  
**X**

Date



**Life (Lives) Insured:**

Please sign and date.

Signature of First Life Insured  
**X**

Date

Signature of Second Life Insured  
**X**

Date

**Part B - This part should be completed by your Financial Advisor.**

I hereby declare that in accordance with Regulation 6(1) of the Life Assurance (Provision of Information) Regulations, 2001, the applicant(s) has been provided with the information specified in Schedule 1 to those Regulations (the relevant Zurich Life Customer Guide) and that I have advised the client(s) as to the financial consequences of replacing an existing policy with this policy by cancellation or reduction, and of possible financial loss as a result of such replacement.



**Financial Advisor:**

Please sign and date.

Signature of Financial Advisor  
**X**

Date

**Please see overleaf for Direct Debit Mandate.**

# SEPA Direct Debit Mandate



**Important Note:** By signing this mandate form, you authorise (A) Zurich Life Assurance plc to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instruction from Zurich Life Assurance plc. As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited. Your rights are explained in a statement that you can obtain from your bank.

Zurich Life Unique Mandate Reference Number

Creditor Identifier **IE43ZZZ992829**

Please complete all the fields below:

Account Holder Name

Account Holder Address

City/Postcode  Country

Please Return to:

Creditor Name **ZURICH LIFE ASSURANCE PLC**

Creditor Address **ZURICH HOUSE, FRASCATI ROAD, BLACKROCK  
CO. DUBLIN, IRELAND**

Type of Payment **RECURRENT**

IBAN (International Bank Account Number)

Signature(s) of Account Holder(s)

SWIFT BIC (Bank Identification Code)

Date of Signing

### Mandate Declaration

Direct debits will be collected from your bank on the chosen date\* of the month the contribution is due. Under Single Euro Payments Area (SEPA) legislation, you are entitled to 14 calendar days prior notice of: (i) the commencement of a direct debit collection from your bank account by Zurich Life or (ii) where there is a change in the direct debit amounts or bank account details. However, SEPA also allows for a shorter notification period and to ensure timely collection of your contributions, Zurich Life operates a three day notification period. This does not affect your rights as outlined in the SEPA Direct Debit Mandate. \*The default chosen date is 1st of the month; the 7th and 15th of the month are available with agreement. **By signing this mandate form you are agreeing to a three day notification period before Zurich Life can collect contributions from your bank account.**

**Please note:** Your IBAN and BIC details are included on your bank statements.

## **I** Application Checklist

**Please ensure that the following details have been completed on the application form.**

**Please tick**

- Any questions which are amended have been initialled.
- Indicated whether this replaces an existing policy in whole or in part, and that the Customer and Financial Advisor Declarations have been signed. If this replaces an Zurich Life policy please confirm the existing policy number.
- All personal details are fully complete.
- Intermediary name, Financial Advisor name and Intermediary number are complete.
- All medical questions are fully answered, including height/weight and family history.
- The occupation(s) of the Life (Lives) Insured has been supplied.
- The Declaration has been signed and dated by the Life (Lives) Insured and Policy Owner.
- The risk benefits and sums insured have been clearly stated.
- The information submitted with this application is consistent with any previously submitted online application.

**Zurich Life Assurance plc**

Zurich House, Frascati Road, Blackrock, Co. Dublin, Ireland.

Telephone: 01 283 1301 Fax: 01 283 1578 Website: [www.zurichlife.ie](http://www.zurichlife.ie)

Zurich Life Assurance plc is regulated by the Central Bank of Ireland.

Intended for distribution within the Republic of Ireland.

The information contained herein is based on Zurich Life's understanding of current Revenue practice as at July 2014 and may change in the future.