



Keyperson 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 (as per the illustration)	R											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 (work)																		
(home)																		
(mobile)																		
Fax Number																		
Registered / Business Address																		
Country of Incorporation																		
Company Registration Number (if applicable)																		
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.																		

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	Details
<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"/>	

(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?
5. Do you have any intention of flying other than as a passenger on a public airline?
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.)
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.)
8. Do you take part or intend to take part in any hazardous pastime such as motor racing, diving, aviation or mountaineering?
9. Have you received a conviction for drink driving or driving under the influence of a controlled substance in the past 5 years?

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	
<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	

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?
 - (ii) Heart attack, angina, cardiac failure, cardiomyopathy, heart valve or structural disorders or other heart disease?
 - (iii) Stroke, brain haemorrhage or brain injury through any cause?
 - (iv) Disease of the arteries or veins, aortic aneurysms, or poor circulation in the legs?
 - (v) Disease or disorder of the blood, including anaemia?
 - (vi) Multiple sclerosis, optic neuritis, Parkinson's disease, Alzheimer's disease, dementia or paralysis from any cause?
 - (vii) Epilepsy or any other disease of the nervous system (brain, spinal cord or nerves)?
 - (viii) Cirrhosis or any other illness affecting the liver?
 - (ix) Kidney failure or kidney disease including cystic kidney disease?
 - (x) Diabetes, thyroid disorders or any hormone abnormalities?
 - (xi) Any mental illness including anxiety, depression, stress or eating disorder, or have you attempted to harm yourself?

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	
<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	

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)

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?
- (ii) High blood pressure, raised cholesterol, chest pain or irregular heart beat?
- (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?
- (iv) Ulcers or any disorder of the oesophagus, intestine, pancreas, bowel or urinary system?
- (v) Asthma, bronchitis, emphysema, shortness of breath or any other respiratory disorder?
(Colds, influenza, hay fever and simple respiratory tract infections can be omitted.)

(vi) Disorders affecting the eye (and not wholly corrected by spectacles or contact lenses), ear, nose or throat?

(vii) Arthritis or joint disorders, back, neck or muscular disorder or chronic fatigue syndrome?

(viii) **If male** - prostate or any other urinary disorders?
If female - abnormal cervical smear or any other gynaecological or urinary disorder?

(ix) Other than for the conditions you have already disclosed, are you taking any prescribed drugs, medicines, tablets or any other treatment at present?
(Please give the name of the condition for which you are taking this treatment and not the medication itself.)

(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?
(Colds, influenza and hay fever can be omitted.)

(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?

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.

(ii) Have you ever been treated for alcohol misuse, or advised/counselled to reduce your consumption of alcohol?

(iii) Have you taken cocaine, cannabis or any drugs other than for medicinal purposes within the last 10 years?

(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

Yes No

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.

F Health Statement and Other Information (continued)

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>
(i) Breast or ovarian cancer?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(ii) Multiple Sclerosis, Motor Neurone disease or Parkinson's disease?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(iii) Bowel or colon cancer?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(iv) Stroke or heart disease (for example heart attack or angina)?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(v) Cardiomyopathy?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(vi) Muscular dystrophy of any kind?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(vii) Polycystic kidney disease?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(viii) Huntington's disease or Alzheimer's disease?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(ix) Any type of cancer that has occurred in the same site in two or more family members? <i>Note: there is no need to repeat disclosure given in question 13 (i) and (iii) above.</i>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
(x) Any disorder which you know or suspect to be hereditary or for which you have received follow up or screening?	<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
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?	<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

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.

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
(a) Manual or physical activity? If YES: Percentage of time _____ % Please give nature of this activity.	<input type="radio"/> Yes <input type="radio"/> No _____ _____ % _____	<input type="radio"/> Yes <input type="radio"/> No _____ _____ % _____
(b) Use of machinery or tools? If YES: Percentage of time _____ % Please give nature of this activity.	<input type="radio"/> Yes <input type="radio"/> No _____ _____ % _____	<input type="radio"/> Yes <input type="radio"/> No _____ _____ % _____
(c) Annual business mileage greater than 25,000 miles (40,000 km)?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
(d) Working at heights? If YES: Average height worked _____	<input type="radio"/> Yes <input type="radio"/> No _____	<input type="radio"/> Yes <input type="radio"/> No _____

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.



Zurich Life Assurance plc

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

Telephone: 01 283 1301 Fax: 01 283 1578 Website: 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.

