



# Partnership 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:**

Proof of date of birth of Life Insured is required to make a claim. If your date of birth is incorrect any claim payment will be recalculated.

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)	<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.
- 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 Life Insured Details

<input type="radio"/> Mr	<input type="radio"/> Mrs	<input type="radio"/> Ms	Forename																	
			Surname																	
			Address for correspondence																	
			Date of Birth							Age Next Birthday			Sex	<input type="radio"/> M	<input type="radio"/> F					
			Civil Status	<input type="radio"/> Married	<input type="radio"/> Single	<input type="radio"/> Widow(er)	<input type="radio"/> Separated	<input type="radio"/> Divorced	<input type="radio"/> Civil Partner	<input type="radio"/> Former Civil Partner										
			Telephone Number (work)																	
			(home)																	
			(mobile)																	
			Email Address																	
			Nationality																	
			Country of Residence																	
			Occupation																	

## B Policy Owner Details - if different to Life Insured

<input type="radio"/> Mr	<input type="radio"/> Mrs	<input type="radio"/> Ms	Forename														
			Surname														
			Address														
			Date of Birth							Sex	<input type="radio"/> M	<input type="radio"/> F					
			Civil Status	<input type="radio"/> Married	<input type="radio"/> Single	<input type="radio"/> Widow(er)	<input type="radio"/> Separated	<input type="radio"/> Divorced	<input type="radio"/> Civil Partner	<input type="radio"/> Former Civil Partner							
			Telephone Number (work)														
			(home)														
			(mobile)														
			Email Address														
			Nationality														
			Country of Residence														
			Occupation														

## C Partnership Details

Name of Partnership												
Address of Partnership												
Nature of business/activity												
Location of business/activity (operating address)												
Names of Partners												
Names of beneficial owners												

**Note:**

Name of beneficial owners with greater than 25% of the capital or profits of partnership or more than 25% of the voting rights or who otherwise exercise control.

## D Plan Details

### Basis of Cover

Single 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 (only available if aged 75 next birthday or less) →

Accelerated Serious Illness Sum Insured (only available if aged 65 next birthday or less) →

#### Details

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€

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:**

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

Continued overleaf





**G Health Statement and Other Information (Continued)**

**Note:**

If your occupation is "Company Director"/ "Partner" please advise the nature of the business.

**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.

**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?

**Life Insured**

**Life Insured**

- Yes  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?
  - (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?
  
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?

**Life Insured**

- Yes  No

**Details**

**Note:** **G** 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.(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?  Yes  No
- (iv) Ulcers or any disorder of the oesophagus, intestine, pancreas, bowel or urinary system?  Yes  No
- (v) Asthma, bronchitis, emphysema, shortness of breath or any other respiratory disorder?  
(Colds, influenza, hay fever and simple respiratory tract infections can be omitted.)  Yes  No
- (vi) Disorders affecting the eye (and not wholly corrected by spectacles or contact lenses), ear, nose or throat?  Yes  No
- (vii) Arthritis or joint disorders, back, neck or muscular disorder or chronic fatigue syndrome?  Yes  No
- (viii) **If male** - prostate or any other urinary disorders?  
**If female** - abnormal cervical smear or any other gynaecological or urinary disorder?  Yes  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?  
(Please give the name of the condition for which you are taking this treatment and not the medication itself.)  Yes  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?  
(Colds, influenza and hay fever can be omitted.)  Yes  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?  Yes  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.  Yes  No
- (ii) Have you ever been treated for alcohol misuse, or advised/counselled to reduce your consumption of alcohol?  Yes  No
- (iii) Have you taken cocaine, cannabis or any drugs other than for medicinal purposes within the last 10 years?  Yes  No
- (iv) Have you ever tested positive for HIV/AIDS or are you awaiting the results of such a test?  Yes  No
- (v) Have you ever tested positive for Hepatitis B or C or are you awaiting the results of such a test?  Yes  No

Life Insured

Details

Continued overleaf

**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.

**G 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?

**Life Insured**

- Yes  No

**Details**

*(Please specify age at diagnosis of the relevant medical history.)*

**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?

- Yes  No

**H 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 \_\_\_\_\_

**Life Insured**

- Yes  No

\_\_\_\_\_ %

\_\_\_\_\_

- Yes  No

\_\_\_\_\_ %

\_\_\_\_\_

- Yes  No

- Yes  No

\_\_\_\_\_

**Continued overleaf**



**I 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 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 of Policy Owner  
X

Date



**Life Insured**

(if different from Policy Owner):

Please sign and date.

Signature of Life Insured, if different from Policy Owner  
X

Date

**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

**SEPA Direct Debit Mandate**

Zurich Life Unique Mandate Reference Number  
(to be completed by the creditor)

Creditor Identifier

**IE43ZZZ992829**

**Please complete all the fields below:**

Account Holder Name  
Account Holder Address  
City/Postcode Country

IBAN (International Bank Account Number)

Signature(s) of Account Holder(s)

SWIFT BIC (Bank Identification Code)

Date of Signing

**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.

**Please Return to:**

Creditor Name: **ZURICH LIFE ASSURANCE PLC**  
Creditor Address: **ZURICH HOUSE, FRASCATI ROAD, BLACKROCK CO. DUBLIN, IRELAND**  
Type of Payment: **RECURRENT**

**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 statement.

## **J** 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 of the Life Insured has been supplied.
- The Declaration has been signed and dated by the Life 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**

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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.

