

COMPLETING THIS APPLICATION FORM

- To apply for **groupGUARD** protection, complete this Application Form in BLOCK CAPITALS using a ball point pen (blue or black ink).
- Insurance begins when Compass Underwriting on behalf of AXA Insurance has accepted your application and confirmed this to you in writing.
- You must give full and true answers to all questions. If you do not do so, your insurance cover may not protect you in the event of a claim.
- You should keep a record of all information supplied to Compass Underwriting (including copies of correspondence).
- A copy of the Application Form can be supplied on request within a period of 3 months after its completion.
- A copy of the Policy is available on request.

A General

1. Full registered name of the business to be insured

	Ltd Co/PLC/Partnership/Sole Trader (Delete as applicable)
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2. Business address

Postcode

3. Description of trade/business

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4. Date business established

5. Company registration No.

6. Commencement date of cover

7. Renewal date required

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Please answer the following questions by ticking the appropriate box. If you do not have enough room to complete additional information to answers please use the space provided in Section G at the end of this application form.

8. Have you previously held a group personal accident &/or sickness or PHI or similar policy? If YES, please state insurer and for what period? _____ _____	Answers YES NO <input type="checkbox"/> <input type="checkbox"/>
9. In relation to this type of insurance has any insurer ever declined to provide cover, imposed special terms, cancelled cover or declined to renew your insurance?	<input type="checkbox"/> <input type="checkbox"/>
10. In relation to any other type of insurance (i.e. Employers Liability, Building insurance, Combined All Risks, has any insurer ever declined to provide cover, cancelled your cover or declined to renew your insurance? If YES to 8, 9 or 10 above please provide details _____ _____	<input type="checkbox"/> <input type="checkbox"/>
11. Will the premium be paid wholly by you? If NO, please give details of Employee contributions _____ _____	<input type="checkbox"/> <input type="checkbox"/>
12. Do you wish to pay your premium by instalments? (Note: A Direct debit form must be received before commencement of the insurance.)	<input type="checkbox"/> <input type="checkbox"/>

B Persons to be insured

Please answer the following questions by ticking the appropriate box. If you do not have enough room to complete additional information to answers please use the space provided in Section G at the end of this application form.

1. Are all employees to be insured?	Answers YES NO <input type="checkbox"/> <input type="checkbox"/>
2. Are any part-time, temporary or casual employees to be insured?	<input type="checkbox"/> <input type="checkbox"/>
3. Do all of the employees to be insured work and operate totally within the UK, Channel Islands or Isle of Man? If NO, please state what percentage work abroad and for how long, and detail each specific country and the relevant staff numbers. _____ _____	<input type="checkbox"/> <input type="checkbox"/>
4. Is insurance to start at commencement of employment for new employees? If NO, please state qualification period before insurance is to commence _____	<input type="checkbox"/> <input type="checkbox"/>
5. Having made appropriate enquiries, to the best of your knowledge and belief, are all persons to be insured free from physical defect or infirmity and are in good health and will be actively at work at the inception of this insurance (other than for being off on holiday)? If NO, please give details _____ _____	<input type="checkbox"/> <input type="checkbox"/>

C Categories of persons to be insured

FULL-TIME persons to be insured split in to categories (white collar, light manual, heavy manual etc.)	Number of employees at start date	Total Salaries/Wage (£ pa)

PART-TIME persons to be insured split in to categories (white collar, light manual, heavy manual etc.)	Number of employees at start date	Total Salaries/Wage (£ pa)

D Fix sums insured?

Please state the basis you require as per the sections below:

1. On what basis are benefits to be insured:

Fixed sums Insured?

If salary or wage related indicate what % is required for the income-protection element (e.g. 50% to 100%) and what factor is required for the lump sum benefit (e.g. x1 to x10 annual salary).

2. Please reflect the basis you require in the table set out below:

Salary or wage related?

Answers
YES NO

FULL-TIME person to be insured split into categories	LUMP SUM BENEFITS			WEEKLY OR MONTHLY TEMPORARY TOTAL INCAPACITY BENEFITS	
	Accidental Death	Permanent loss (loss of hearing, loss of limb and loss of sight)	Permanent Total Incapacity	ACCIDENT	SICKNESS

PART-TIME temporary and casual employees split into categories	LUMP SUM BENEFITS			WEEKLY OR MONTHLY TEMPORARY TOTAL INCAPACITY BENEFITS	
	Accidental Death	Permanent loss (loss of hearing, loss of limb and loss of sight)	Permanent Total Incapacity	ACCIDENT	SICKNESS

3. Where benefits are to be salary or wage related are these to be restricted to multiple or percentages of basic salary and/or wages declared above?

Answers
YES NO

If **NO**, what additional amounts are included within the salaries and/or wages declared above? (eg bonuses, overtime)

4. What is the maximum total benefit or what is the maximum sum insured for any one employee?

£

5. What is the maximum salary or wage paid to any one person including bonuses, overtime, etc? (If to be insured)

£

6. What extent of cover do you require? 24 hour At work only but including commuting* At work only excluding commuting*

*Note: commuting shall mean travelling to and from your normal home address to your usual place of work and back.

Answers	
YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

7. Do you wish to select cover for temporary total incapacity?

If YES, please complete as appropriate:

a) Maximum benefit period (i.e. 26, 52 or 104 weeks) Weeks/Months (delete as applicable) If you require different periods per occupation type then please set this out on section G overleaf.
 b) Deferred period required (number of consecutive days before any payment of benefit) Days

E Accumulation

Accumulations - please provide estimates of how many insured people would use the following methods of travel and what the maximum aggregate lump sum benefit of these insured people would be. This is to assess the risk to ensure that you are fully covered under the "Limit for any one event" clause as set out in Section 6.

Method of Travel	Maximum Number	Maximum Aggregate Lump Sum Benefit
Motor Vehicle		
Scheduled Air Travel		
Chartered Air Travel		
Other methods of travel (please specify)		

Note: This Insurance does not cover any form of air travel other than as a passenger travelling by recognised airlines or by any fully licensed multi-engined aircraft operated by a recognised air charter company, unless otherwise agreed by us.

F Accident and Sickness record

Please provide particulars of all accidents or sickness, which occurred during the past 5 years which, gave rise to a claim or would have done had this insurance been in force at the time.

Date	Name	Nature of Injury or Sickness	Period of Disablement	Amount Paid (if insured)

Declaration of Insurance

Please sign this declaration once you have read it. If you are unsure as to whether any information should be given, you should provide it.

I declare that:

I will inform the insurer of any changes that occur before this insurance commences. I understand that failure to do so may result in this insurance being declared void and that a claim for the benefits may not be paid.

To the best of my knowledge and belief all the statements made, which includes anything I have said, have been recorded accurately in this application or are as attached and are true and complete. This disclosure will form the basis of the contract.

I understand that this contract will renew at the end of each 12-month period subject to the terms and conditions of this insurance and as specifically stated in sections 3, 4, 17, 18 and 19 which I confirm that I have read and understood. I understand that I have 30-days to tell you about any changes to my business, insured person(s), their state of health or any other relevant material circumstances. I also understand that I will only have to complete a new direct debit mandate if I have changed bank accounts. I understand that at the end of each 12-month period I will be required to sign a declaration of health on behalf of all the insured people.

I agree to Compass and the insurer obtaining medical information from any doctor I or my insured person or persons have consulted about our physical or mental health, in order to assess my proposal. Compass and the insurer may obtain relevant information from other insurers about previous or concurrent applications for incapacity insurance that I have applied for.

I authorise those asked for such information to provide it on the production of a copy of this consent. This consent allows Compass and the insurer to obtain reports at any time during the life of the plan to support any claim made on the plan proceeds.

In the event of an insurance claim, I consent to any information which I provide to you, whether on this form, the claim form or otherwise, being put onto a Register of Claims through which insurers share such information to prevent fraudulent claims. I understand that a list of participants and the name and address of the operator are available from you.

I agree that a copy of the agreement given in this declaration will have the validity of the original.

Data Protection Act 1998

To set up and administer your policy AXA Insurance UK plc and Compass Underwriting Limited will hold and use information about you supplied by you and by medical providers. We may send it in confidence for processing to other companies in the AXA Group (or companies acting on our instructions) including those located outside the European Economic Area.

By signing this declaration you consent to such use of your personal data.

Important Notes:

You are free to choose the law applicable to this policy. Your policy will be governed by the law of England and Wales unless you and we have agreed otherwise.

You are reminded that you must inform us within 30 days if the nature of your business changes, take on more hazardous work, arrivals and departures of your employees or if you stop trading at any time during the period of this insurance.

To sign this form you must be an officer or director of the company.

Signature Name Position
 Date



Instructions to your bank or building society to pay direct debits



Originators identification number

7 2 8 0 1 0

Name(s) of account holder(s)

Compass Underwriting Ltd reference number (office use only)

Bank or building society account number

Branch sort code

Instruction to your bank or building society

Please pay Compass Underwriting Ltd direct debits from the account detailed in this instruction subject to the safeguards assured by the direct debit guarantee. I understand that this instruction may remain with Compass Underwriting Ltd and if so details will be passed electronically to my bank or building society.

Name and full postal address of your bank or building society branch

Signature (1)

Signature (2)

Date

Banks or building societies may not accept direct debit instructions on some types of accounts

This guarantee should be detached and retained by the payer

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, Compass Underwriting Ltd will notify you five working days in advance of your account being debited or as otherwise agreed.

If an error is made by Compass Underwriting Ltd 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 us.



What to do now

✓ Please detach the application form from the key features document

✓ Please ensure you have completed and signed the relevant sections of the application form

✓ Please ensure that you have completed and signed the Direct Debit Mandate

✓ Please forward the completed documents to your financial advisor.

<p>Agent Number</p> <table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>									<p>Agent Stamp</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>

Important Notes

This insurance will not commence until we have assessed and accepted your application and confirmed this to you in writing.

In most instances your payments will be as originally quoted. Revised terms may be offered to you, but occasionally we may be unable to offer any terms.

If we ask any of your employees to attend a medical examination, it may be necessary for us to share the application information with another company authorised by us. They will make the arrangements for the examination to take place, usually by telephone.

The insurer has a confidentiality policy in place which means that your employees' medical information is held securely and access is limited to authorised individuals only.

It may be necessary to send your application and relevant medical reports to our insurer for their opinion or agreement of the terms offered.

You are entitled to ask for a copy of the terms and conditions of your insurance at any time and can request a copy of your application form within a period of 3 months after its completion.

You are free to choose the law applicable to this policy. Your policy will be governed by the law of England and Wales unless you and we have agreed otherwise.

Access to Medical Reports Act 1988

It may be necessary for us to obtain medical reports to support your application. Before we can ask any doctor that you have consulted to complete a report, we need your permission under the Access to Medical Reports Act 1988.

Your rights under the Act are as follows:

You do not have to give your consent, but if you do not we may be unable to proceed. This does not stop you from applying to other companies for insurance.

You can ask to see the report before the doctor returns it to us. If this is the case, we will tell the doctor to retain the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time your doctor will send the report to us.

If you choose not to see the report at this stage, you may ask the doctor for a copy within 6 months of it being sent to us. A duplicate report can be sent to your doctor on request should you wish to see it at a later date.

If you consider any aspect of the report to be incorrect or misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him/her to attach a statement outlining your views, which will then accompany the report.

Your doctor can withhold access to the report if he feels that it would cause physical or mental harm to you or others.

Your medical report will contain details of relevant consultations, treatment, operations, investigations and test results that you have undergone at any surgery, hospital or clinic. Your consent will give us and the insurer access to this information.

If you have any questions regarding your rights under the Act or any questions relating to the process of obtaining, assessing or storing medical information, please write to the Chief Medical Officer at our Head Office.