LIFESTYLE PROTECTOR PLAN

BROKER APPLICATION FORM

HIVE
Insurance Services

The customer understands that where the annual premium exceeds €1,000, due to AML regulations we will require proof of ID with the application.
Once you have submitted your application, please email proof of ID (photo of passport or driving licence) to: **AML@hiveinsure.ie** (we cannot start the plan or issue welcome documents until this has been received)

PREVIOUS APPLICATIONS

Have you applied for a medically underwritten life, critical illness or income protection policy in the past twelve months through any other insurer, and been declined? ☐ Yes ☐ No

If you have answered Yes to this question, please note that you are not eligible for this plan.

PERSONAL DETAILS

Title: *(please tick)*
☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other _____

Surname:

Forename(s):

Date of Birth:

Address:

Eircode:

Tel (mobile):

Tel (home):

Email:

YOUR OCCUPATION

Occupation:

Start date of occupation (mm/yy):

Monthly earnings: (Employed – gross salary, overtime, bonus. Self employed – pre-tax profit)
€ _____

Employment status:
☐ Employed ☐ Self Employed

If 'Employed' the number of contracted hours:

Do you have a second occupation to cover: ☐ Yes ☐ No
(If Yes, please answer the questions below)

Occupation:

Start date of occupation (mm/yy):

Monthly earnings: (Employed – gross salary, overtime, bonus. Self employed – pre-tax profit)
€ _____

Employment status:
☐ Employed ☐ Self Employed

If 'Employed' the number of contracted hours:

POLICY

Monthly income benefit: *Cannot exceed 60% of Monthly Earnings stated on page 1*

€ _____

Deferred period:

☐ 14 days ☐ 30 days ☐ 90 days

Total monthly premium:

€ _____

Start date:

☐ Immediately (please note that this could lead to a double Direct Debit collection)

☐ As soon as possible without incurring a double Direct Debit collection

☐ Specified Date (depending on date chosen, this could lead to a double Direct Debit collection).

Please state date:

DECLARATION *(Please read carefully)*

I hereby apply for insurance to AmTrust International Underwriters DAC (the insurer) under their usual terms and conditions. I confirm that the information supplied by me in connection with this proposal is complete and correct to my knowledge and belief.

Please tick the boxes a ter each statement:

I understand that claims relating to any medical condition which I am aware of, am experiencing symptoms of or which I have been aware of and/or have received treatment for in the last two years, or any associated conditions, shall not be payable under this Lifestyle Protector Plan unless I have been free from symptoms and not received treatment, medication, diagnostic tests or advice for the condition for at least two years preceding the claim. ☐

I understand that claims relating to any chronic condition which I currently know about, or of which I am /have been exhibiting the symptoms whether specifically diagnosed or not or for which I am /have been receiving medical treatment or advice during the last five years, shall not be payable under this Lifestyle Protector Plan. A chronic condition is a condition which has symptoms that are constant or recur, or which requires long-term monitoring, treatment, consultations, check-ups, examinations or tests. ☐

I understand that at claim stage, medical records showing my medical history relevant to the condition I am claiming for and any associated conditions must be available to the insurers in English from an Irish-registered GP for review, and that if I am unable to evidence medical history in English from Irish-registered GP then this policy is unlikely to be suitable for me. I note that I 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 have been provided with details of the procedure to follow in the event of a complaint. ☐

Warning: The current premium may increase with 30 days notice.

Signature: X

Date:

THIRD PARTY DECLARATION

Please note: This section is only to be completed if the person paying for the plan is not the policyholder

I declare that I will pay the Direct Debit for the policy in the name of: _____ and this level of financial commitment is affordable now and in the future. Should a claim arise, I understand that I am not eligible to benefit in any way from the policy.

My relationship to the customer is: _____

Signature of account holder: X

DISCOUNT FUEL CARD

As a Hive member, you're also eligible to apply for a Discount Fuel Card provided by DCI, Ireland's leading fuel management provider. The card gives you an exclusive discount on every litre of fuel you purchase at participating stations plus a host of amazing benefits. Tick this box to consent to us acting as an introducer and passing your contact details to DCI, who will provide you with more details. ☐

PLEASE HELP US TO GO GREEN

Each year we send policyholders an annual review letter and an Insurance Product Information Document, which is a summary of key information relating to your plan. As an environmentally responsible company, we would like to ask for your permission to send you this information by email - not only will this reduce the amount of paper we use, it will also make it easier for you to manage your policy paperwork.

Please can you tick the box below to confirm you are happy to receive this correspondence by email. Sincere thanks for your support in helping us to make a difference to the environment.

I request that my annual reviews and Insurance Product Information Documents are sent to me by email: ☐

LIFESTYLE PROTECTOR PLAN
HIVE INSURANCE SERVICES

SEPA DIRECT DEBIT MANDATE

HIVE Insurance Services

Unique Mandate Reference:

Creditor Identifier: **IE79API303578**

Legal text: By signing this mandate form, you authorise

a) Hive Insurance Services DAC to send instructions to your bank to debit your account and

b) your bank to debit your account in accordance with the instruction from Hive Insurance Services DAC.

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 complete all the fields below

Name:

Address: Eircode:

County:

IBAN (International Bank Account Number):

Swift BIC:

Hive Insurance Services DAC, Office 15, Lakeview Point, Unit 24 Claregalway Corporate Park, Claregalway, Co. Galway, H91 PX38

Type of payment is recurrent/repeated

Date of signing:

Signature(s):

Please return this mandate to:
Hive Insurance Services DAC, Office 15, Lakeview Point, Unit 24 Claregalway Corporate Park, Claregalway, Co. Galway, H91 PX38.

Person on whose behalf payment is made: *(Name of policyholder, if different to above)*

074 9161868 | www.hiveinsure.ie
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