MEDICAL CASH PLAN

GROUP APPLICATION FORM

HIVE
Insurance Services

COMPANY DETAILS

Company name:	Industry
Group secretary name:	Other authorised contact:
Address: Eircode:	
Tel number:	Email:

PAYMENT INFORMATION

Payment frequency: ☐ Monthly ☐ Annually	Start date:	Preferred Direct Debit date:	Total Premium: €

Please also complete the Group Listing Form to provide the details of all employees to be covered and level of cover required.

DECLARATION *(Please read carefully)*

I hereby apply for insurance to Cowen Insurance Company Limited (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. 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.

☐ **MUST BE TICKED - Statement of suitability:**
This plan is suitable for employers looking to provide their employees with cover for everyday medical and hospitalisation expenses. I confirm this is suitable for my needs.

Signature: X	Date:

MEDICAL CASH PLAN GROUP
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)*