

...peace of mind for whatever is beyond your horizon

Agency Application Form

Name/Trading Style

Registered Office

Correspondence Address

Postcode

Telephone Number Fax Number

Email Address Web Address

Date Business Established (dd/mm/yyyy) Company Registration Number

Type of Company (i.e. sole trader/partnership/limited company)

Are you associated with any other company or have you traded under a previous title? If YES, please give details Yes No

Details of Director(s)/Principal(s)

Name

Qualifications No of years insurance experience

Name

Qualifications No of years insurance experience

Name

Qualifications No of years insurance experience

(if insufficient space, please submit on separate sheet)

Total number of staff employed Full time Part time

Has any Director, Principal or employee:

a) ever been adjudged Bankrupt or subject to a Receiving Order or County Court Judgement? Yes No

b) ever been convicted of any criminal offence other than motoring convictions? Yes No

If YES to any of the above, please state the name of the person and details.

Are you registered with any professional, regulatory or industry governing bodies? Yes No

If YES, please state (including registration number).

Do you hold Professional Indemnity Insurance? Yes No

If YES, please state:

Limit of Indemnity

Excess

Expiry Date (dd/mm/yyyy)

Name of Insurer

Do you hold Agencies with other Insurers for International Healthcare and Travel Insurance?

Yes No

If YES, please give details.

Have you ever had an Insurance Agency cancelled or refused other than for lack of support?

Yes No

If YES, please give details.

What is your projected gross premium income for the next 12 months in respect of these specific areas of business?

International Healthcare Travel Insurance

If your application for an agency is accepted, how would you like your commissions paid?

Tick as appropriate

Currency in which you would like your commissions paid:

All in original currency of the policy All in Sterling All in Euros All in US\$

(Commissions not paid in original currency will be converted at the prevailing rate)

Where would you like your commission paid?

Cheque to your office Payment direct to bank account

If payment required direct to your bank, please provide the following information.

Bank name	<input type="text"/>	Bank address	<input type="text"/>
Account name	<input type="text"/>		<input type="text"/>
Sort code	<input type="text"/>	Account No.	<input type="text"/>
IBAN No.	<input type="text"/>	Swift ID	<input type="text"/>

I confirm that I/we wish to apply for an Agency with à la carte healthcare limited.

I confirm that the above information is correct to the best of my knowledge.

Signature Date (dd/mm/yyyy)

Name (please print)

Position in Company

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