Intermediary Application Form

Name/Trading Style

Registered Office

Correspondence Address

Postcode

Telephone Number

Fax Number

Email Address

Web Address

No. of years Business Established

Company Registration Number

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

Details of Director(s)/Principal(s)

Name

No of years insurance experience

Name

No of years insurance experience

Name

No of years insurance experience

(if insufficient space, please submit on separate sheet)

Total number of staff employed within International Private Medical Insurance

Has any Director, Principal or employee:

a) ever been adjudged Bankrupt or subject to any legal action? 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

Name of Insurer

aLC GLOBAL HEALTH INSURANCE

Do you hold Terms of Business Agreements with other Insurers for International Healthcare and Travel Insurance? Yes ☐ No ☐

If YES, please give details.

Have you ever had an Insurance Terms of Business Agreement 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 a Terms of Business Agreement 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$ ☐

Commisions not paid in original currency wll be converted at the prevailing rate at time of commission payment

Please complete details below for payment into your bank account

Bank name | Bank address

Account name

Sort code | Account No.

IBAN No. | Swift ID

I am an authorised signatory and am applying for a Terms of Business Agreement with ALC Health. ☐

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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