

... we're different because we care

# 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

Do you hold Terms of Business Agreements with other Insurers for International Healthcare and Travel Insurance?

Yes  No

If YES, please give details.

[Empty text box for 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.

[Empty text box for 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\$

Commissions not paid in original currency will 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



HEAD OFFICE

Chanctonfold Barn Chanctonfold  
Horsham Road Steyning West Sussex  
BN44 3AA United Kingdom  
T +44 (0) 1903 817970  
F +44 (0) 1903 879719  
www.alchealth.com www.alctravel.eu  
www.prima-iberica.eu

SPANISH OFFICE

Centro Plaza Oficina 70  
Nueva Andalucia  
29660 Marbella Málaga  
Spain  
T +34 952 93 16 09  
F +34 952 90 67 30  
CIF W8264779C

GIBRALTAR OFFICE

30 Ocean Village  
Promenade  
Gibraltar GX11 1AA  
T +350 200 77731  
F +350 200 77741  
Company No. 111964

ALC HEALTH (HONG KONG) LTD

Level 21 The Center  
99 Queen's Road  
Central Hong Kong  
T +852 3478 3751  
F + 852 3478 3880

