

PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS USING BLACK INK

YOUR PERSONAL DETAILS

First Names:		Surname:	Mr/Dr/Mrs/Ms/Miss		
Postal Address:		Date of birth:	Date	Month	Year
		Sex:	Male / Female		
		Telephone No:			
		Fax No:			
		E-mail address:			
Your Nationality: <small>Please enclose a copy of your passport</small>					
Your country of overseas residence:					
Please state your current salary: <small>Proof of your salary will be required in the event of a claim.</small>					
What is your occupation?					
Is your occupation 100% office based?		<input type="checkbox"/> YES <input type="checkbox"/> NO			
If your occupation is not 100% office based, please provide a full job description:					
Do you participate in any hazardous activities?		<input type="checkbox"/> YES <input type="checkbox"/> NO			
If yes, please give full details of any hazardous activities you participate in including how often you participate:					

GLOBAL LIFE PLAN APPLICATION

Please state the amount of life cover you require: <small>The maximum benefit available is £600,000 or \$1,000,000 or €1,000,000.</small>	<small>Your life cover must not exceed 20 times your current salary.</small>
Do you have any other life insurance cover in force?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If you do have other life insurance, please state the amount(s) and the insurer(s):	

ACCIDENT PROTECTION BENEFIT APPLICATION Available only when you take the Global Life plan

Please state the amount of Accident Protection Benefit you require: <small>The maximum Benefit available is £300,000 or \$500,000 or €500,000. If you are also applying for a Global Income plan the maximum benefit available is £200,000 or \$335,000 or €335,000.</small>	<small>Your Accident Protection Benefit must not exceed your Global Life plan benefit.</small>
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GLOBAL INCOME PLAN APPLICATION

Please state the amount of Income benefit you require: <small>The benefit we pay will be restricted to 75% of your pre-disability salary, less any other income you are entitled to receive whilst you are disabled. The maximum benefit available is £90,000 or \$144,000 or €144,000.</small>	
Please state the deferment period you require:	<input type="checkbox"/> 3 months <input type="checkbox"/> 6 months
Do you have other disability insurance?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If you do have other disability insurance, please give full details:	

PAYMENT DETAILS

METHOD & FREQUENCY OF PAYMENT	YOUR CREDIT/DEBIT CARD DETAILS			
Please delete as appropriate	Credit/debit card	VISA / MASTERCARD / AMEX / SWITCH / VISA DELTA		
Annually by cheque/transfer <input type="checkbox"/>	Full card number	3 digit security number*		
Annually by credit card/direct debit* <input type="checkbox"/>	Expiry date	Issue Date (if applicable)	Issue No (if applicable)	
Monthly by credit card/direct debit* <input type="checkbox"/>	Name as on card			
Quarterly by credit card/direct debit* <input type="checkbox"/>	Address to which card is registered <small>(if different from the postal address given above)</small>			
Semi-annually by credit card/direct debit* <input type="checkbox"/>				

*If you pay by direct debit you must pay in sterling from a UK bank account

YOUR HEALTH DECLARATION

Height cm feet & inches

Weight kg lbs

Please answer each of the following questions by ticking the appropriate box.

	YES	NO
1. Have you been absent from work for more than five consecutive days in the last five years?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you any physical defect or infirmity?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you consulted a doctor within the last three years?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever undergone a surgical operation?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you any reason to believe that a surgical operation will be required in the near future?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been hospitalised?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever suffered from:		
(a) Any nervous or mental disorder, fainting, blackouts or fits?	<input type="checkbox"/>	<input type="checkbox"/>
(b) High blood pressure, heart or circulatory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Any rheumatic or arthritic condition or diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Slipped disc or other spinal disorder?	<input type="checkbox"/>	<input type="checkbox"/>
(e) Any respiratory, urinary or allergic condition?	<input type="checkbox"/>	<input type="checkbox"/>
(f) Any stomach, liver or bowel disorder?	<input type="checkbox"/>	<input type="checkbox"/>
(g) Any disease of the immune system (e.g. AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>
(h) Any other medical condition requiring investigation?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever been tested for the HIV virus?	<input type="checkbox"/>	<input type="checkbox"/>
If the answer to this question (# 8) is YES, was the result positive?	<input type="checkbox"/>	<input type="checkbox"/>

If the answer to any of the above questions is yes, please give full details below. If necessary, please continue on to another sheet of paper.

Question No.	Diagnosis of illness and the name and address of the treating physician	Date on which first diagnosed	Full details of treatment and tests received, and test results (attach medical reports where possible)	Dates of treatment and/or tests	Your present state of health with regard to this ailment. If treatment is still being received, please give full details

DECLARATION

I hereby apply for cover under the Global Protection plan. I declare that the information I have given in this application form is true and complete. I understand that upon receipt of my Global Protection plan documents, if I am not entirely satisfied, I can cancel my application and receive a full refund of the premium I have paid, provided I return the documents to William Russell Limited within 30 days of the start of the policy.

I authorise any doctor named above and any other doctor or medical practitioner who has attended me to provide William Russell Limited with any information they may require in connection with this application and/or in connection with any claim on my Global Protection plan.

If I have indicated that I wish to pay by credit/debit card, or by direct debit, I authorise William Russell Limited to debit my account with the appropriate premiums due, and all subsequent renewal premiums due as notified by William Russell Limited until I give notice in writing that I wish to terminate my plan. I understand that William Russell Limited cannot be liable if my plan is lapsed because my account could not be debited.

I understand that William Russell Limited will give me 4 weeks notice of renewal and that premiums will vary each year.

I declare that I am actively at work and in the event of a claim I authorise my employer or accountant to release information to William Russell Limited and Hauteville Insurance Company Limited regarding my salary.

I agree that William Russell Limited and Hauteville Insurance Company Limited may rescind this plan and release themselves from any liability whatsoever if it is proved that I have omitted to declare any relevant information, or have given any incorrect, incomplete or misleading information.

Signature:	<input type="text"/>	Date:	<input type="text"/>
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