PRIVATE MEDICAL INSURANCE

SME PLAN APPLICATION FORM

For Regional Plus or inSpire SME plans (to be completed by the Group Administrator)

COMPANY DETAILS

Name of group administrator:	Position in company:
Name of company or group:	Nature of business:
Company address: Postcode:	
Telephone number:	Email:
Fax number:	Proposed commencement date:
Total no of employees to be covered:	

PAYMENT DETAILS

Total premium:

☐ Annually (by cheque)
Please make cheques payable to 'APRIL UK'

☐ Monthly (by Direct Debit)
Please complete and enclose a Direct Debit form

GUIDELINES FOR COMPLETING THIS FORM

Group Administrator please read before you start.

This application form is for companies with between 3 and 49 employees applying to purchase a Regional Plus or inSpire plan. All employees and any dependants to be covered should meet the eligibility criteria of the plan and be permanent and lawful residents in the UK.

The Group Administrator should complete this form in BLOCK CAPITALS and BLACK INK. Please note that it is vital that all relevant questions on this form are answered carefully and all information provided is accurate, true and complete and that all relevant information (material circumstances) is disclosed.

The Insurance Act 2015 came into force on 12 August 2016. As this insurance is being arranged wholly or mainly for the purposes of your trade, business or profession e.g. Group Private Medical Insurance then you, as the Group Administrator, have a duty of "fair representation of the risk". This means that you have to:-

- Disclose to us every material circumstance to which you ought to have known, this includes information that can be revealed by a reasonable search of information available to you including information held within your organisation including your senior managers and information held by your broker; or to
- Provide us with sufficient information to put us on notice that we need to make further enquiries into those material circumstances.

A material circumstance is a circumstance which may influence the insurer's decision to cover a risk and/or the terms applied. Examples of a material circumstance are where a member of the plan has pre-existing symptoms or a pre-existing medical condition, is undergoing medical treatment (NHS or private) or is awaiting tests or has routine follow up appointments, has previously been charged additional premium, has had cover denied or has made claims under a private medical insurance policy.

The requirement for fair presentation of risk not only applies at commencement and renewal of your policy, but also at any time during the period of insurance.

Material circumstances disclosed about your employees and their dependants should be accurate, true and complete. Any changes in the information given in this application which occur between the date of signing and the date cover starts should be advised to APRIL UK.

Non disclosure of any material circumstance may result in us not agreeing to pay a future claim, the applicants' underwriting being changed or their cover being cancelled.

Entry onto the plan will be with one of the following Underwriting methods:

Moratorium

This means any medical issues your employees or their dependants have experienced or had symptoms of, at any time in the 5 years prior to the start of cover, will be covered by the plan once they remain 2 consecutive years from the start date completely clear of symptoms, tests or medication for the condition or anything related to it.

Full Medical Underwriting (FMU)

Employees will be required to complete a Full Medical Underwriting application form and answer on behalf of themselves and children under the age of 16. The spouse/partner and any children over the age of 16 should answer on their own behalf. Our underwriters will review the completed forms and the employee will be advised if there are any medical conditions that cannot be covered under the policy. For any medical condition that is likely to reoccur or is ongoing, that condition (and anything related to it) may not be covered. With this option the employee will know exactly what they and any dependants are covered for.

Continued Personal Medical Exclusions (CPME) or Switching

You can choose this option to transfer your existing private medical insurance plan over to us. Employees and dependants who were previously accepted on a moratorium or full medical underwriting basis on another policy and are currently members of your existing plan can switch. If you wish to cover any dependants who aren't covered already, we cannot accept them on a CPME basis and they will need to apply on a moratorium or full medical underwriting basis and complete the appropriate application form.

You will be required to provide some medical information about your employees, as well as any spouse/partner and children who are to be covered on the plan. Our underwriters will review the completed forms and you will be advised if there are any medical conditions that cannot be covered under the policy. For any medical condition that is likely to reoccur or is ongoing, that condition (and anything related to it) may not be covered.

Please note: we reserve the right to exclude additional symptoms or conditions according to the information provided in the application form.

We will require your previous provider's most recent medical insurance certificates during the application for all employees.

We recommend that you consider not giving notice on your current plan until you know whether all your employees have been accepted on this method. For any employees who are mid treatment moving from one insurer to another may mean that treatment that was covered previously may not be covered under their new plan.

EMPLOYEE DETAILS

Please complete this section for each employee that you wish to cover under this plan. If you require more space, please use pages from another application form and attach to this form:

EMPLOYEE 1

Total premium: ☐ Monthly ☐ Annually

Address:

Postcode:

Title:

Forename(s):

Surname:

☐ Male ☐ Female

Date of birth:

Email:

Occupation:

Tel (mobile):

Tel (home):

Tel (work):

Underwriting basis: ☐ Moratorium ☐ CPME ☐ Full Medical Underwriting

Policy basis: ☐ Single ☐ Family ☐ Joint ☐ Single parent

IF YOU ARE APPLYING FOR REGIONAL PLUS PLAN Please indicate benefits below. (Future changes can only be actioned at renewal)

Benefit selection: *(please tick)* ☑ Foundation cover ☐ Limited out-patient ☐ Full out-patient ☐ Psychiatric

Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

IF YOU ARE APPLYING FOR INSPIRE PLAN Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

Other people to be covered (partner/children) If more space is required, please continue on a separate sheet of paper

Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)

EMPLOYEE 2

Total premium: ☐ Monthly ☐ Annually

Address:

Postcode:

Title:

Forename(s):

Surname:

☐ Male ☐ Female

Date of birth:

Email:

Occupation:

Tel (mobile):

Tel (home):

Tel (work):

Underwriting basis: ☐ Moratorium ☐ CPME ☐ Full Medical Underwriting

Policy basis: ☐ Single ☐ Family ☐ Joint ☐ Single parent

IF YOU ARE APPLYING FOR REGIONAL PLUS PLAN Please indicate benefits below. (Future changes can only be actioned at renewal)

Benefit selection: *(please tick)* ☑ Foundation cover ☐ Limited out-patient ☐ Full out-patient ☐ Psychiatric

Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

IF YOU ARE APPLYING FOR INSPIRE PLAN Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

Other people to be covered (partner/children) If more space is required, please continue on a separate sheet of paper

Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)

EMPLOYEE 3

Total premium: ☐ Monthly ☐ Annually

Address: Postcode:

Title: Forename(s): Surname:

☐ Male ☐ Female Date of birth: Email: Occupation:

Tel (mobile): Tel (home): Tel (work):

Underwriting basis: ☐ Moratorium ☐ CPME ☐ Full Medical Underwriting

Policy basis: ☐ Single ☐ Family ☐ Joint ☐ Single parent

IF YOU ARE APPLYING FOR REGIONAL PLUS PLAN Please indicate benefits below. (Future changes can only be actioned at renewal)

Benefit selection: *(please tick)* ☑ Foundation cover ☐ Limited out-patient ☐ Full out-patient ☐ Psychiatric

Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

IF YOU ARE APPLYING FOR INSPIRE PLAN Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

Other people to be covered (partner/children) If more space is required, please continue on a separate sheet of paper

Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)

EMPLOYEE 4

Total premium: ☐ Monthly ☐ Annually

Address: Postcode:

Title: Forename(s): Surname:

☐ Male ☐ Female Date of birth: Email: Occupation:

Tel (mobile): Tel (home): Tel (work):

Underwriting basis: ☐ Moratorium ☐ CPME ☐ Full Medical Underwriting

Policy basis: ☐ Single ☐ Family ☐ Joint ☐ Single parent

IF YOU ARE APPLYING FOR REGIONAL PLUS PLAN Please indicate benefits below. (Future changes can only be actioned at renewal)

Benefit selection: *(please tick)* ☑ Foundation cover ☐ Limited out-patient ☐ Full out-patient ☐ Psychiatric

Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

IF YOU ARE APPLYING FOR INSPIRE PLAN Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

Other people to be covered (partner/children) If more space is required, please continue on a separate sheet of paper

Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)

EMPLOYEE 5

Total premium: ☐ Monthly ☐ Annually

Address: Postcode:

Title: Forename(s): Surname:

☐ Male ☐ Female Date of birth: Email: Occupation:

Tel (mobile): Tel (home): Tel (work):

Underwriting basis: ☐ Moratorium ☐ CPME ☐ Full Medical Underwriting

Policy basis: ☐ Single ☐ Family ☐ Joint ☐ Single parent

IF YOU ARE APPLYING FOR REGIONAL PLUS PLAN Please indicate benefits below. (Future changes can only be actioned at renewal)

Benefit selection: *(please tick)* ☑ Foundation cover ☐ Limited out-patient ☐ Full out-patient ☐ Psychiatric

Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

IF YOU ARE APPLYING FOR INSPIRE PLAN Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

Other people to be covered (partner/children) If more space is required, please continue on a separate sheet of paper

Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)

EMPLOYEE 6

Total premium: ☐ Monthly ☐ Annually

Address: Postcode:

Title: Forename(s): Surname:

☐ Male ☐ Female Date of birth: Email: Occupation:

Tel (mobile): Tel (home): Tel (work):

Underwriting basis: ☐ Moratorium ☐ CPME ☐ Full Medical Underwriting

Policy basis: ☐ Single ☐ Family ☐ Joint ☐ Single parent

IF YOU ARE APPLYING FOR REGIONAL PLUS PLAN Please indicate benefits below. (Future changes can only be actioned at renewal)

Benefit selection: *(please tick)* ☑ Foundation cover ☐ Limited out-patient ☐ Full out-patient ☐ Psychiatric

Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

IF YOU ARE APPLYING FOR INSPIRE PLAN Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

Other people to be covered (partner/children) If more space is required, please continue on a separate sheet of paper

Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)

EMPLOYEE 7

Total premium: ☐ Monthly ☐ Annually

Address: Postcode:

Title: Forename(s): Surname:

☐ Male ☐ Female Date of birth: Email: Occupation:

Tel (mobile): Tel (home): Tel (work):

Underwriting basis: ☐ Moratorium ☐ CPME ☐ Full Medical Underwriting

Policy basis: ☐ Single ☐ Family ☐ Joint ☐ Single parent

IF YOU ARE APPLYING FOR REGIONAL PLUS PLAN Please indicate benefits below. (Future changes can only be actioned at renewal)

Benefit selection: *(please tick)* ☑ Foundation cover ☐ Limited out-patient ☐ Full out-patient ☐ Psychiatric

Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

IF YOU ARE APPLYING FOR INSPIRE PLAN Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

Other people to be covered (partner/children) If more space is required, please continue on a separate sheet of paper

Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)

EMPLOYEE 8

Total premium: ☐ Monthly ☐ Annually

Address: Postcode:

Title: Forename(s): Surname:

☐ Male ☐ Female Date of birth: Email: Occupation:

Tel (mobile): Tel (home): Tel (work):

Underwriting basis: ☐ Moratorium ☐ CPME ☐ Full Medical Underwriting

Policy basis: ☐ Single ☐ Family ☐ Joint ☐ Single parent

IF YOU ARE APPLYING FOR REGIONAL PLUS PLAN Please indicate benefits below. (Future changes can only be actioned at renewal)

Benefit selection: *(please tick)* ☑ Foundation cover ☐ Limited out-patient ☐ Full out-patient ☐ Psychiatric

Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

IF YOU ARE APPLYING FOR INSPIRE PLAN Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

Other people to be covered (partner/children) If more space is required, please continue on a separate sheet of paper

Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)

EMPLOYEE 9

Total premium: ☐ Monthly ☐ Annually

Address: Postcode:

Title: Forename(s): Surname:

☐ Male ☐ Female Date of birth: Email: Occupation:

Tel (mobile): Tel (home): Tel (work):

Underwriting basis: ☐ Moratorium ☐ CPME ☐ Full Medical Underwriting

Policy basis: ☐ Single ☐ Family ☐ Joint ☐ Single parent

IF YOU ARE APPLYING FOR REGIONAL PLUS PLAN Please indicate benefits below. (Future changes can only be actioned at renewal)

Benefit selection: *(please tick)* ☑ Foundation cover ☐ Limited out-patient ☐ Full out-patient ☐ Psychiatric

Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

IF YOU ARE APPLYING FOR INSPIRE PLAN Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

Other people to be covered (partner/children) If more space is required, please continue on a separate sheet of paper

Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)

EMPLOYEE 10

Total premium: ☐ Monthly ☐ Annually

Address: Postcode:

Title: Forename(s): Surname:

☐ Male ☐ Female Date of birth: Email: Occupation:

Tel (mobile): Tel (home): Tel (work):

Underwriting basis: ☐ Moratorium ☐ CPME ☐ Full Medical Underwriting

Policy basis: ☐ Single ☐ Family ☐ Joint ☐ Single parent

IF YOU ARE APPLYING FOR REGIONAL PLUS PLAN Please indicate benefits below. (Future changes can only be actioned at renewal)

Benefit selection: *(please tick)* ☑ Foundation cover ☐ Limited out-patient ☐ Full out-patient ☐ Psychiatric

Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

IF YOU ARE APPLYING FOR INSPIRE PLAN Excess: (**MUST** tick one) ☐ £100 compulsory, or: ☐ £250 ☐ £500 ☐ £1,000

Other people to be covered (partner/children) If more space is required, please continue on a separate sheet of paper

Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)
Full name:	☐ Male ☐ Female	Date of birth:	Occupation: (if over 16)

IF YOU ARE APPLYING FOR CPME COVER *PLEASE READ CAREFULLY AND COMPLETE*

Please note: This declaration is very important and must be answered to the best of your knowledge, following a reasonable search.

In line with the Insurance Act 2015, as Group Administrator of the private medical insurance scheme, and therefore the person acting on behalf of the Company, you have a duty to provide a 'fair representation of the risk'.

This means that you are required to take reasonable steps to ensure that the responses you give below are full and honest, and may provide APRIL UK with information that can be revealed by a reasonable search carried out within your organisation. This includes any material facts held by your senior managers and/or relevant details held by your broker if you have one.

Failure to do so may result in a claim not being paid, the applicants' underwriting terms being changed, their cover being cancelled and/or any treatment costs already paid by us being reclaimed. If you have any questions, please consult the APRIL UK underwriting team on **01454 857901**, or ask your broker to do so if you have one.

Medical questions - please read carefully and complete

1 Has anyone to be insured under this plan been advised that in the next 12 months they will need, or have sought advice for a consultation, test, investigation, treatment or surgery on either an in-patient, day-patient or out-patient basis?

☐ Yes ☐ No

2 Has anyone to be insured under this plan been diagnosed with, suffered from, been monitored for, had medical treatment or advice for (including check-ups), or are currently awaiting investigations or being investigated for any of the following?

In the last 2 years:

a Cancer *(including basal cell carcinomas)* ☐ Yes ☐ No

b Any type of psychiatric condition *(if psychiatric benefit chosen)* ☐ Yes ☐ No

c Any type of heart or cardiovascular condition *(including coronary artery disease, heart valve disease, arrhythmia, heart failure, atrial fibrillation, hypertension & high cholesterol, pace makers and heart disease)* ☐ Yes ☐ No

If you have answered Yes to any of the above questions on behalf of your employee (and family members if they are covered on the plan), please inform your employee and ask them to complete the Employee Medical Questionnaire.

GROUP ADMINISTRATOR DECLARATION *TO BE READ AND COMPLETED BY THE GROUP ADMINISTRATOR*

This application will form the basis for the contract between the company and the insurer. Any employee(s) proportion of the Group Policy premium will be paid in full by the company, without recovery from the employee(s). All group members and any dependants are permanent and legal residents in the United Kingdom and meet the eligibility criteria for the plan.

It is important that you understand that any information, statements or answers made by you to us are your responsibility. You must take reasonable care not to make misrepresentations when answering our questions. If you are careless in answering our questions or deliberately make a misrepresentation, this may render the insurance void from inception (the start of the policy) and enable the insurer to repudiate liability (entitle the insurer not to pay claims). You are advised to keep copies of documentation sent to or received from us for your own protection. Please do consult us if you are in doubt of any aspect. The requirement for correct information not only applies at commencement and renewal of your policy, but also at any time during the period of insurance.

I hereby apply for insurance with the insurer for those shown on this form. I agree to be bound by their usual terms and conditions contained in the policy document.

I understand this application is subject to written acceptance by us. Cover will commence once approved and accepted by us at which point any special terms relating to your cover will be highlighted. We reserve the right to decline any application.

I declare that the statements made in this application form, and any supplementary information provided as part of this application form, are accurate, true and complete. I shall read the terms and conditions of the policy when received and agree to be bound by them.

I declare that I will advise APRIL UK if there are any changes in the information given in this application which occur between the date of signing and the date cover starts under this policy.

Underwriting Declarations

Continued Personal Medical Exclusions (CPME)
I understand that subject to the benefits, terms and conditions, exclusions and limitations of the policy, an individual can transfer their private medical insurance cover from one provider to another on the same individual underwriting terms that were applied by the previous insurer, providing that continuous cover is maintained. This means that any personal medical exclusions or restrictions that were imposed on your private medical insurance cover by your previous insurer will continue under your cover with us. Please note: we reserve the right to exclude additional symptoms or conditions according to the information provided in the declaration.

If the insurance is arranged wholly or mainly for the purposes of your trade, business or profession e.g. Group Private Medical Insurance then you have a duty of “fair representation of the risk”. This means that you have to:

- Disclose to us every material circumstance to which you ought to have known, this includes information that can be revealed by a reasonable search of information available to you including information held within your organisation including your senior managers and information held by your broker; or to

- Provide us with sufficient information to put us on notice that we need to make further enquiries into those material circumstances.

A material circumstance is a circumstance which may influence the insurer’s decision to cover a risk and/or the terms applied. Examples of a material circumstance are where a member of the plan has pre-existing symptoms or a pre-existing medical condition, is undergoing medical treatment (NHS or private) or is awaiting tests or has routine follow up appointments, has previously been charged additional premium, has had cover denied or has made claims under a private medical insurance policy.

The requirement for fair presentation of risk not only applies at commencement and renewal of your policy, but also at any time during the period of insurance.

I understand that non-disclosure of any material circumstance may result in you not agreeing to pay for a future claim, the applicants’ underwriting being changed or their cover being cancelled.

You must provide a copy of an up to date certificate of registration detailing underwriting terms from the previous insurer.

Full Medical Underwriting

Employees will be required to complete a medical questionnaire. The questionnaire will be reviewed and the employee will be advised which conditions cannot be covered by the policy.

GROUP ADMINISTRATOR DECLARATION *CONTINUED...*

Moratorium

I understand that the policy will not cover any investigation and/or treatment for any illness or related medical condition for which the persons to be insured underwent treatment, sought medical advice or were aware of symptoms within the five years before the start of this policy.

However, if the persons to be insured do not have any symptoms, treatment, medication, or advice for those pre-existing conditions, and any directly related medical conditions, for two continuous years after the policy starts, then we will reinstate their cover for those conditions.

Data Protection Act 1998

I/we confirm and agree that information about me/us and this application form may be retained on paper and computer by APRIL UK and used:

a By Axeria Insurance Limited and other businesses that provide insurance services relating to the policy as may be necessary for the administration of my/our policy and dealing with our claims under my/our policy. I/we agree that it may be necessary for Axeria Insurance Limited to obtain and use sensitive personal information about me/us.

b To provide information about me/us (whether provided in the application form or any claim form) to other third parties for the purpose of administration of any claim. Details of such third parties will be made available on request.

The information may also be used to send you details about other services available from APRIL UK that might be of interest to you. If you wish to opt out of this service, please tick this box. ☐

I declare that I am authorised by the Company to apply to APRIL UK Regional Plus or inSpire Private Medical Insurance plan and to make this declaration.

Signature: X	Print name:
Date:	Position held in the company:

Once completed please send your application form to your advisor.

PRIVATE MEDICAL INSURANCE PLAN

Instructions to your bank or building society to pay by Direct Debit

Please fill in the whole form using a ball point pen and send it to:

APRIL UK
April House, Almondsbury Business Centre,
Bradley Stoke,
Bristol BS32 4QH

Service user number

2	4	9	1	9	0

Reference (APRIL UK use only)

Name(s) of account holder(s)

Please provide your address if you are not the policyholder
This is not part of the instruction to your bank or building society

Address:

Postcode:

Bank/building society account number

Branch sort code

Name and full postal address of your bank or building society

To: The Manager — Bank/Building Society

Address:

Postcode:

Instruction to your bank or building society
Please pay APRIL UK (Insurance Services) Ltd Direct Debits from the account detailed in this instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this instruction may remain with APRIL UK (Insurance Services) Ltd and, if so, details will be passed electronically to my bank/building society.

Signature(s):

Date:

Banks and building societies may not accept Direct Debit Instructions for some types of account.

This guarantee should be detached and retained by the payer

The Direct Debit Guarantee

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits.
- If there are any changes to the amount, date or frequency of your Direct Debit, APRIL UK (Insurance Services) Ltd will notify you 3 working days in advance of your account being debited or as otherwise agreed. If you request APRIL UK (Insurance Services) Ltd to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your Direct Debit, by APRIL UK (Insurance Services) Ltd or your bank or building society, you are entitled to a full and immediate refund of the amount paid from your bank or building society.
  - If you receive a refund you are not entitled to, you must pay it back when APRIL UK (Insurance Services) Ltd asks you to.
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.

April House, Almondsbury Business Centre, Bradley Stoke, Bristol BS32 4QH
Tel: 01454 619500 | www.april-uk.com

APRIL UK is a trading name of APRIL UK (Insurance Services) Ltd (registered in England No 3179382), who is authorised and regulated by the Financial Conduct Authority, registered number 308655.

This product is insured by Axeria Insurance Limited (Malta Company Registration number C 55905), which is a company authorised under the Maltese Insurance Business Act, 1998 to carry out general business and is regulated by the Malta Financial Services Authority. Registered office: Progetta House, Level 2, Tower Road, Swatar, Birkirkara BKR 4012, Malta. Tel: (+356) 2137 7107. PMISMEA0817

DISCLOSURE OF INTERESTS: In terms of the provisions of Directive 2002/92/EC of the European Parliament and of the Council of 9 December 2002 on insurance mediation, please note that APRIL S.A., a Company organised in terms of French Law with registration number 377994553RCS of Immeuble Aprilium, 114 Bd Vivier Merle, 69439 Lyon, France holds more than 10% of the voting rights of both Axeria Insurance Limited and APRIL UK. Axeria Insurance Limited and APRIL UK are affiliates by virtue of the common shareholding of APRIL S.A. as outlined above.

Insurance made easy.