PRECISION underwriting

INDIVIDUAL PERSONAL ACCIDENT APPLICATION FORM

HOW TO FILL OUT THIS FORM

Please fill out every question neatly and clearly. This will assist us in evaluating your application and if we are unable to read the information you have given us, we may not be able to provide your insurance.

Full Name of the Insured _____

Address _____

_____

_____ **State** _____ **Postcode** _____

Date of Birth |____/____/____| **Sex** _____ **Height** _____ **Weight** _____

What are your duties of your occupation? _____

_____

Are you an employee or are you self-employed? _____

Period of Insurance **From:** |____/____/____| **To:** |____/____/____|

Insured Person's Acknowledgment

a) Have you ever had medical or surgical advice or treatment, or been hospital confined during the past 5 years?

Yes ☐ **No** ☐ **If Yes, please provide name and address of Doctors and/or Hospitals**

_____

b) Have you ever been declined accident, sickness or life insurance, or been issued such insurance which has been postponed, modified, rated up, canceled or renewal refused?

Yes ☐ **No** ☐ **If Yes, please provide details**

_____

c) Have you ever claimed for benefits under any accident or sickness insurance?

Yes ☐ **No** ☐ **If Yes, please provide details**

_____

d) Will the total amount of your weekly compensation during disablement from this and all other sources exceed your weekly salary or income?

Yes ☐ **No** ☐ **If Yes, please provide details**

_____

e) Are there any circumstances connected with your occupation or other activities which render you liable to injury or sickness? e.g. Football

Yes ☐ **No** ☐ **If Yes, please provide details**

_____

f) Are there any reasons that would cause you to consider yourself not presently in good health?

Yes ☐ **No** ☐ **If Yes, please provide details**

_____

Are you at present insured under any accident or sickness insurance. If so, please give details:

Name of Insurer _____ Capital Sum Insured _____Weekly Sum Insured_____

Insurance applied for Sum Insured:

Death & Capital Benefits _____ Weekly Accident _____ Weekly Sickness _____

(Events 1 – 19)

Benefit Period (Weeks) _____ Excess (Days) _____

Scope of Cover – Please select when you would like to be covered:

a) 24 hours/365 days ☐

b) Working hours only ☐

c) Outside working hours ☐

Self Employed persons only

Do you require cover for Monthly Business Expenses? YES/NO

If yes, what limit do you require?

$_____ per month (please note that the Excess applicable is noted above)

IMPORTANT INFORMATION

INSURER

The Insurer of Your policy are Certain Underwriters at Lloyd's of London, who are authorised under the Insurance Act 1973 to write Australian Insurance business.

PRIVACY

We are committed to protecting your privacy. We only use the personal information you give us to quote on and insure your risks. We only give personal information to Our Underwriters (and their representatives), Our Reinsurers (and their representatives), and people We appoint to assist us with any claims under your policy. We will not trade, sell or rent your information.

DUTY OF DISCLOSURE

Before you enter into a contract of general insurance with an insurer, you have a duty, under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of insurance and, if so, on what terms. You have the same duty to disclose those matters to the insurers before you renew, extend, vary or reinstate a contract of general insurance.

DECLARATION

I/We hereby agree that this Declaration shall be the basis of the contract between me/us and Insurers.

Date _____ **Signature of Insured** _____