

Full postal address of the mortgaged property

Postcode

Telephone number

Title and full name of **First Applicant (1)** - Please delete as applicable

Date of birth (1)

--	--	--	--

Employment status (1) - Please tick the appropriate box

 Employed

 Self employed

Name of employer (1)

Occupation (1)

What benefit split do you require? - Please tick the appropriate box

 Single cover

 Split cover

If you have chosen split cover please complete the sections below for the **Second Applicant (2)**

Title and full name of **Second Applicant (2)** - Please delete as applicable

Date of birth (2)

--	--	--	--

Employment status (2) - Please tick the appropriate box

 Employed

 Self employed

Name of employer (2)

Occupation (2)

Please answer the following questions by ticking the appropriate box.

If You have chosen split cover both parties will need to answer the questions.

Are you actively working in the United Kingdom, Channel Islands or Isle of Man for at least 16 hours per week?				
Is your work of a temporary, casual or seasonal nature (including temporary, casual or seasonal contracts)?				
Have you at any time during the past 12 months been registered as unemployed?				
Are you aware of any circumstances which may result in you becoming unemployed?				
Are you in dispute or in the course of any disciplinary action with your employer?				
Have you consulted a medical practitioner in the last 12 months?				
Are you aware of any circumstances which may result in you becoming disabled?				

Applicant (1)		Applicant (2)	
YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Important Note - If you have ticked any of the shaded boxes above, please provide further information on a separate sheet.

What type of cover do you require? - Please tick the appropriate box

 Unemployment and disability cover

 Unemployment only cover

 Disability only cover

What is the name of your mortgage lender?

Mortgage start date

--	--	--	--

Policy start date

--	--	--	--

Under no circumstances can cover under this policy be backdated. If you are currently unable to work due to a disability, insurance under this policy will only commence on the day you return to work.

A Enter the amount of cover you require (this must not exceed either £1500 or 65% of your normal income)

£

B Enter the premium rate for the cover that you have selected

£

C Calculate your monthly premium using the formula **(A x B ÷ 100)**

£

Declaration of insurance

INSURANCE DECLARATION: I/We am/are applying to you for insurance under your normal terms and conditions. I/We confirm that as far as I/we know, all the statements made in connection with this proposal are true and complete whether or not in my/our own handwriting and I/we have not concealed any important fact. I/We have received a copy of the policy information brochure and I/we will keep a record of all information I/we give under this proposal. I/We agree to inform you in writing of any change of circumstances affecting the statements I/we have made in this proposal, which occur between the date of this application and the date the policy commences.

I/We have read and understood my/our statutory rights under the Access to Medical Reports Act 1988 (in Northern Ireland the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991) as explained in the policy information brochure. You (or your agents) may seek medical information from any doctor who at any time has attended me/us concerning anything which affects my/our physical or mental health or seeking information from any insurance office to which an application has been made for personal insurance and I/we authorise the giving of such information in perpetuity. I/We understand that if access is not allowed to my/our medical records either during my/our lifetime or after my/our death that you (or your agents) cannot be held liable for any delay or non payment of any claim.

DATA PROTECTION DECLARATION: you may process the information in my/our proposal for the purposes of this insurance and release it to other people for insurance purposes. You may pass this information to other financial organisations but only for the purpose of this insurance.

Full name of Applicant (1) in block capitals Signature of Applicant (1) Date

Applicant (1) - I wish to see a copy of any medical report before it is sent to Paymentsshield Limited - please tick appropriate box Yes No

Full name of Applicant (2) in block capitals Signature of Applicant (2) Date

Applicant (2) - I wish to see a copy of any medical report before it is sent to Paymentsshield Limited - please tick appropriate box Yes No

Direct debit mandate

Instruction to your bank or building society to pay by direct debit



Name(s) of account holder(s) Originators identification number Reference number (office use only)

Bank or building society account number Branch sort code

Instruction to your bank or building society

Please pay Paymentsshield 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 Paymentsshield and, if so, details will be passed electronically to my bank/building society.

Name and full postal address of your bank or building society branch
 The Manager Bank or building society

 Postcode

Signature (1)
 Signature (2)
 Date

Banks or building societies may not accept direct debit instructions on some types of accounts

Payment date I wish to pay monthly on - (Please tick preferred date) 1st 7th 14th 21st 24th or just after this date.

The direct debit guarantee

- This guarantee is offered by all banks and building societies that take part in the direct debit scheme. The efficiency and security of the scheme is monitored and protected by your own bank or building society.
- If the amounts to be paid or the payment dates change, Paymentsshield Ltd will notify you five working days in advance of your account being debited or as otherwise agreed.
- If an error is made by Paymentsshield Ltd or your bank or building society, you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a direct debit at any time by writing to your bank or building society. Please also send a copy of your letter to us.

Agency details and policy reference number

Policy reference number Agency number