eurosure
INSURANCE COMPANY LTD

PROPOSAL FOR GROUP PERSONAL ACCIDENT INSURANCE

(For Office Use Only)

Account Code	Insured Code	U/R	Warranties	Endorsements	Other Instructions	Policy No

PLEASE COMPLETE THIS PROPOSAL WITH CLEAR CAPITAL LETTERS AND MARK WITH «✓» THE APPROPRIATE BOXES

1. a) Full Name of Proposer

Address			
Identity No		Nationality	
Date of Birth		Occupation/Profession	
VAT No (if Company)		Company Registration No.	
Home Telephone No.		Office Telephone No.	
Office Telefax No		Home Telefax No.	
Mobile Telephone No		Email	

b) Trade or business (full description)

2. Persons to be insured

(a) (i) State total number of persons employed ☐ (ii) State number or persons to be insured ☐

(b) How many of the persons to be insured are over 60 years of age? ☐

(c) Will the persons to be insured pay part of the premium for this insurance? ☐ NAI ☐ OXI

If YES, what proportion? ☐

(d) Will any of the persons to be insured travel together by air? ☐ NAI ☐ OXI

If YES, state the maximum number to travel by air, and the frequency of flights ☐

(e) Will any of the persons to be insured travel together by car or any other conveyance? ☐ NAI ☐ OXI

If YES, state the maximum number and the frequency ☐

(f) Does any of the persons to be insured ride a motorcycle? ☐ NAI ☐ OXI

If YES, state:

Cubic capacity of motorcycle(s)	
Number of Employees	
Total Annual Salaries/Wages and other Benefits paid to such Employees per Category of Occupation	

3. Cover and Benefits, Cover is only with respect to Accidental Bodily Injury

Benefits

(a) *Permanent Disablement - Tick appropriate box to show scale required*

(i) Permanent Disablement - STANDARD SCALE — TABLE A ☐ OR

Permanent Disablement - EXTENDED SCALE — TABLE B ☐

(ii) **Medical Expenses** (NOT payable if the Insured Persons are entitled to free Medical Treatment under any Government or Private Scheme) ☐ NAI ☐ OXI

(b) Do you wish the initial weeks of benefit for Temporary Total or Partial Disablement to be excluded? (Compulsory Excess: The first 3 days) ☐ NAI ☐ OXI

If YES, state number of weeks (in addition to the Compulsory Excess) ☐

(c) *Period of Cover - Operative Time - Please, tick the box for the Operative Time required*

Twenty-four hours ☐	Employment Accidents ☐	Employment Accidents & Commuting ☐

(d) Complete **SECTION A** below if all persons or all persons in certain Occupational Categories are to be insured.

If named persons are to be insured, complete **SECTION B**

SECTION A - All Persons or all Persons in certain Occupational Categories

				Benefits required for each person. Show either amount or % of Earnings (see Note (i) below]				
Occupations of Persons to be insured	Class	Estimated Number	Estimated Annual Earnings [See Note (1) Below]	Death by Accident	Permanent Disablement by Accident	Temporary Total Disablement by Accident [See Note (ii) Below]	Temporary Partial Disablement by Accident	Medical Expenses by Accident
				1	2	3 p.w.	4 p.w.	5
Managerial employees who do not engage in manual labour and clerical staff.						p.w.	p.w.	
All other employees (give full description of Occupational Categories)						p.w.	p.w.	
						p.w.	p.w.	
						p.w.	p.w.	
						p.w.	p.w.	

NOTES

(I) Earnings

Earnings : shall mean the total gross salary or wages plus any other benefits paid/payable to each Employee by the Proposer

Annual Earnings : shall mean the Earnings for 52 weeks

(ii) Amount per week : Benefit shall not exceed 4‰ of the largest capital benefit insured or 80% of average weekly earnings whichever is the minimum

SECTION B Named Persons basis

					Benefits required for each person. Show either amount or % of Earnings (see Note (i) below]				
Names of persons to be insured	Age	Occupation	Class	Estimated Annual Earnings [See Note (1) Below]	Death by Accident	Permanent Disablement by Accident	Temporary Total Disablement by Accident [See Note (ii) Below]	Temporary Partial Disablement by Accident	Medical Expenses by Accident
					1	2	3 p.w.	4 p.w.	5
							p.w.	p.w.	
							p.w.	p.w.	
							p.w.	p.w.	

NOTES (i) Earnings

Earnings : shall mean the total gross salary or wages plus any other benefits paid/payable to each Employee by the Proposer

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4. Insurance History and Losses

a) Has any Insurer of the risk now proposed declined your proposal imposed special terms, refused to renew or cancelled your policy? ☐ NAI ☐ OXI

If YES, explain and give the name of the Insurer

b) Are you or have you been insured for the risk now proposed? ☐ NAI ☐ OXI

i) If YES, state below the claims for the past 3 years, including those outstanding

ii) If NO, state the number of accidents during the past 3 years, involving death or absence from work of more than one week

Claims or absences

		Accidents	
Year	**Number of Persons insured or employed**	**Number**	**Total Weeks Lost**
20			
20			
20			

c) Has any of the persons to be insured

i) any physical or mental defect, impairment of eyesight or hearing, ill-health of any description or any recurrent condition? ☐ NAI ☐ OXI

If YES, give particulars

ii) during the past 10 years suffered from or been disabled for more than 7 days by any injury or illness? ☐ NAI ☐ OXI

If YES, state

(i) Nature	
(ii) Year	
(iii) Duration	

iii) received medical advice or treatment during the past 12 months. If YES, give particulars ☐ NAI ☐ OXI

iv) Take any drugs regularly? If YES, are they prescribed by a Doctor? Please give particulars ☐ NAI ☐ OXI

PREMIUM PAYMENT

I wish my annual premium to be paid as follows (please mark ✓ or X whichever option applies)

☐ **Settlement in ONE (1) Instalment**

☐ **Settlement in:**

- ☐ **TWO (2)**
- ☐ **THREE (3)**
- ☐ **FOUR (4)**

consecutive monthly instalments (one-off charge €1,00 for each instalment)

Note: ***In all cases, the 1st Instalment is due for payment on or before the starting date of the period of the Insurance***

☐ **Direct Debit Banking Mandate**

I would like to pay my policy premium using a Direct Debit, and hereby enclose a signed Direct Debit Mandate form

Note: ***Where the duration of the policy is less than one year, premium must be fully prepaid***

STATUTORY DECLARATION AND CONSENT FORM FOR THE PROCESSING OF PERSONAL DATA

Forming part of this Proposal Form which together shall constitute the basis of the Policy which may be issued.
(All references to the singular shall also mean to the plural unless the context otherwise requires)

I declare that the answers and information which have been given in this Insurance Proposal Form are absolutely correct and that I have not withheld, misstated or misrepresented any material information in connection with this Proposal. I agree that this Declaration as well as the answers and information which I have given in this as well as any other information, declaration or statement made by me or by anybody acting on my behalf will form the basis of the Insurance Policy which may be issued to me by Eurosure Insurance Company Ltd (hereinafter referred to as Eurosure or the Company). I further agree that I shall accept to be indemnified based on the Terms and Conditions which will appear in and/or which will be endorsed in the Insurance Policy which may be issued to me.

I declare that any Insurance Intermediary or other Representative or Employee of Eurosure who helps me in completing or who completes on my behalf the Proposal Form and/or assists me in the completion of any other document and/or provides any information to the Company for the purpose of obtaining a quotation and/or any subsequent Insurance coverage for me is acting on my behalf.

I declare that the cover which may be provided as well as my responsibilities and obligations under the Insurance Policy in respect of which this Proposal is completed has been fully explained to me by the Insurance Intermediary named below or by any representative or employee of Eurosure I declare that it fully satisfies my insurance requirements in relation to the subject matter of insurance under this Proposal.

I declare that I understand that Eurosure is not obliged to accept and offer any Insurance coverage based on this Proposal and only when confirmation of cover has been issued by the Company in writing will any cover apply.

I declare that under the provisions of the General Data Protection Regulation (GDPR) (EE) 2016/679 or any other Law or other regulation amending or replacing it, Eurosure, as processors of personal data within the meaning of the GDPR, may collect and process personal data for the sole purpose of providing the services I request from the Company. Eurosure may process/pass on my personal data to third parties to the extent that this is required as a contractual necessity, on the ground of legal obligations, and legitimate interest.

I also declare that I understand that such personal, sensitive and confidential information which has been given or will be given in the future to Eurosure by me or has been provided by Third Parties to the Company or has been abstracted from other Insurances, other Companies or other information for the purpose of providing their services to me, may be given to Third Parties, other Insurers, Insurance and Reinsurance Intermediaries, such us Surveyors/Adjusters, Repairers, Legal Advisors, Doctors, Insurance Consultants, Auditors, Reinsurers in order to provide me with the services and fulfilment of tasks deriving.

Consent - Sensitive Personal Data

In accordance with the provisions of articles 5, 6, 7 and 9 of the General Data Protection Regulations, I declare that I understand that Eurosure Insurance Company Ltd needs to collect, evaluate and process personal data that is relevant to health in order to proceed with the preparation of the appropriate insurance program. The assessment of my personal data of this nature will allow Eurosure either to accept or not the insurance claim and to calculate the premium corresponding to the risk assumed.

I declare that I understand, that for the smooth operation of the insurance contract both at the risk assessment stage and especially at the time of the insured event, my consent covers both the reception and transmission of sensitive data to and from third parties (such as Insurance Funds, Hospitals, Diagnostic Centers, etc.).

Personal data will be retained for the minimum amount of time required under the Company's contractual or legal obligations.
I understand that if I do not wish to consent to the processing of my sensitive personal data, the insurance company may reject the application for insurance. I have the right to recall my consent at any time by informing the Data Protection Officer of the Company in writing, either by letter to the Company's mailing address or by email dpo@eurosure.com.

Statement of Consent

☐ I consent that Eurosure Insurance Company processes my Sensitive Personal Data for the purpose of providing insurance services

Signature of Proposer		**Date**	
Signature of Proposer		**Date**	
Name of the Insurance Intermediary		**Signature of the Insurance Intermediary**	

No liability is accepted by the Company until the proposal has been accepted and the first premium paid.