**Declaration:**

Have you the proposer, any director/partner of the business, either personally or in any business capacity:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ◦ Been bankrupt, insolvent, subject to bankruptcy/ insolvency proceedings | Yes |  | No |  |
| ◦ Had a proposal refused or declined | Yes |  | No |  |
| ◦ Had insurance cancelled or special terms imposed | Yes |  | No |  |
| ◦ Had any convictions for criminal offences | Yes |  | No |  |

**Proposers Details:**

|  |  |
| --- | --- |
| ◦ Legal Trading Status |  |
| ◦ Business Name |  |
| ◦ Nature of Business/Trade/Type |  |
| ◦ Title |  |
| ◦ Forename |  |
| ◦ Surname |  |
| ◦ Telephone Number |  |
| ◦ Email |  |
| ◦ Website | www. |
| ◦ Street Number/Name |  |
| ◦ Town/City |  |
| ◦ County |  |
| ◦ Postcode |  |
| ◦ Year Business Established |  |
| ◦ Years at Current Address |  |
| ◦ Claims Made in The Last 5 Years | Yes  No  (if yes, please give details) |
|  |  |
|  |  |

**Personal Accident:**(select only one)

1. Multiple of Salary (if selecting this option, please complete the Insured Persons section)
2. Fixed Benefits

(only complete this section if you have chosen option 2 above)

**Personal Accident Section - Required Cover:**

(select one of the 4 options below)

1. All Employees of the Insured
2. Directors only
3. Directors and Clerical Workers only
4. Named Employees only (if selecting this option, please complete the Insured Persons section)

**Insured Persons:**

(only complete this section if you have chosen option 4 above)

|  |  |  |
| --- | --- | --- |
|  |  | **Multiple of Salary**  (salary disclosure is required) |
| ◦ Forename |  | Yes  No |
| ◦ Surname |  | Salary £        Multiple of Salary |
| ◦ Date of Birth |  |
| ◦ Gender | Female  Male |
| ◦ Forename |  | Yes  No |
| ◦ Surname |  | Salary £        Multiple of Salary |
| ◦ Date of Birth |  |
| ◦ Gender | Female  Male |
| ◦ Forename |  | Yes  No |
| ◦ Surname |  | Salary £        Multiple of Salary |
| ◦ Date of Birth |  |
| ◦ Gender | Female  Male |
| ◦ Forename |  | Yes  No |
| ◦ Surname |  | Salary £        Multiple of Salary |
| ◦ Date of Birth |  |
| ◦ Gender | Female  Male |
| ◦ Forename |  | Yes  No |
| ◦ Surname |  | Salary £        Multiple of Salary |
| ◦ Date of Birth |  |
| ◦ Gender | Female  Male |
| ◦ Forename |  | Yes  No |
| ◦ Surname |  | Salary £        Multiple of Salary |
| ◦ Date of Birth |  |
| ◦ Gender | Female  Male |

**Cover Options:**

|  |  |
| --- | --- |
| ◦ Insurable Time | 24 Hours  Other (please advise) |
| ◦ Death | Yes  No |
| ◦ Permanent Total Disablement | Yes  No |
| ◦ Temporary Total Disablement | Yes  No |
| ◦ Temporary Partial Disablement | Yes  No |
| ◦ Loss of an Eye or both Eyes | Yes  No |
| ◦ Loss of a Limb or both Limbs | Yes  No |
| ◦ Medical Cover | Yes  No |
| ◦ Other (please list your requirements) |  |
| ◦ Limits (please list your requirements)  (do not complete this section if Multiple of Salary) | Death £  PTD £  TTD £  TPD £  Eye/Eyes £  Limb/LimbsDeath £  Medical £  Other (please list)       £  Other (please list)       £ |

**Please email the completed form to** [**admin@tcfellis.co.uk**](mailto:admin@tcfellis.co.uk) **and we will respond within 48 hours.**

**Any Additional Information**

|  |
| --- |
|  |