

# International Decreasing Term Assurance

## Application form

**Financial professional use only**

Agency number
Bank/Broker name
External reference number

**Completing this form**

Please write clearly in **BLOCK CAPITAL** letters and complete the form in English.

**1. Policy owner(s)**

**Policy owner 1**

**Title**  Mr  Mrs  Miss  Ms  Dr

Other (please give details) \_\_\_\_\_

Family name \_\_\_\_\_

Forename(s) \_\_\_\_\_

*Please give details of any previous names or alias used, including maiden name (if applicable)*

Date of birth 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

**Gender**  Male  Female

Nationality \_\_\_\_\_

Do you hold nationality in another country?  Yes  No

If 'Yes', please confirm the country

**Marital status**

Single  Married  Other (please give details)

Occupation \_\_\_\_\_

Job title \_\_\_\_\_

**Policy owner 2**

**Title**  Mr  Mrs  Miss  Ms  Dr

Other (please give details) \_\_\_\_\_

Family name \_\_\_\_\_

Forename(s) \_\_\_\_\_

*Please give details of any previous names or alias used, including maiden name (if applicable)*

Date of birth 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

**Gender**  Male  Female

Nationality \_\_\_\_\_

Do you hold nationality in another country?  Yes  No

If 'Yes', please confirm the country

**Marital status**

Single  Married  Other (please give details)

Occupation \_\_\_\_\_

Job title \_\_\_\_\_

## Policy owner(s) continued

### Policy owner 1

#### Contact details

Current residential address  
(please indicate if flat or villa, and include flat/villa number, property name, street name, landmarks if any, area, city, and country)

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Is the above address permanent or temporary?

Permanent  Temporary

If temporary, please state the reason for this

---

**Correspondence address** (if different from residential address)  
(please include PO Box number, city and country)

---

Please provide a reason why you are using a correspondence address that is different from your residential address. Depending on the answers given we may ask for further information.

---

Telephone number

---

Mobile number

---

Email address

Who will be the life/lives insured? (tick which apply)

Policy owner 1      Have you smoked or used any form of tobacco or nicotine product within the last 12 months?\*

Yes  No

Policy owner 2      Have you smoked or used any form of tobacco or nicotine product within the last 12 months?\*

Yes  No

Other – please complete the 'Lives/Additional lives insured application form'

**Note:** when there are two lives insured, the policy will be issued on a joint life first death basis.

\* for example cigarettes, cigars, pipe or chewing tobacco, shisha or nicotine products such as patches, gum or ecigarettes.

### Policy owner 2

#### Contact details

Current residential address  
(please indicate if flat or villa, and include flat/villa number, property name, street name, landmarks if any, area, city, and country)

---

Is the above address permanent or temporary?

Permanent  Temporary

If temporary, please state the reason for this

---

**Correspondence address** (if different from residential address)  
(please include PO Box number, city and country)

---

Please provide a reason why you are using a correspondence address that is different from your residential address. Depending on the answers given we may ask for further information.

---

Telephone number

---

Mobile number

---

Email address

## 2. Beneficiary nomination

**Complete this section to nominate a beneficiary to receive the amount payable on death. You should take legal advice before completing this section.**

If your policy is joint life or you require more than one beneficiary, please complete the 'Appointment of beneficiary form'.

Subject to any future revocation or appointment, I hereby appoint the following person as beneficiary.

Title  Mr  Mrs  Miss  Ms  Dr  Other (please give details) \_\_\_\_\_

Family name \_\_\_\_\_

Forename(s) \_\_\_\_\_

Please give details of any previous names or aliases used (including maiden name) \_\_\_\_\_

Date of birth

Gender  Male  Female

Relationship to policy owner \_\_\_\_\_

Current residential address \_\_\_\_\_

## 3. Third party payor (only to be completed if payor is different from policy owner)

### About the person making the payments

Is the policy owner making the payments from their own funds?  Yes  No

If 'No' please complete the remainder of this section. There are restrictions on who can make the payments. Please contact your local Zurich office for further guidance. For acceptable third party payors we will require full evidence of their identity and origin of wealth.

**Title**  Mr  Mrs  Miss  Ms  Dr  Other (please give details) \_\_\_\_\_

Family name \_\_\_\_\_

Forename(s) \_\_\_\_\_

Please give details of any previous names or aliases used (including maiden name) \_\_\_\_\_

Date of birth

Nationality \_\_\_\_\_

Do you hold nationality in another country?  Yes  No

If 'Yes', please confirm the country \_\_\_\_\_

Occupation \_\_\_\_\_

Job title \_\_\_\_\_

Residential address \_\_\_\_\_

## Third party payor (only to be completed if payor is different from policy owner)

Relationship to policy owner \_\_\_\_\_

Reason for individual other than policy owner(s) making payments \_\_\_\_\_

#### 4. Proof of identity

Policy owners and/or third party payors must provide one of the following valid primary documents that has been suitably certified (please tick to confirm document is attached).

	Policy owner 1	Policy owner 2	Third party
• Passport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Government issued ID card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### 5. Proof of residential address

In order to verify the policy owner's and/or third party payor's current residential address, please attach either an original or suitably certified copy of one of the following documents (the document seen must be less than three months old upon receipt by us, unless advised otherwise). The document must be issued in the name of the policy owner or third party payor and show the address appearing on the application or held in our records as the current residence.

	Policy owner 1	Policy owner 2	Third party
• Utility bill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Tenancy contract*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Letter from employer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Local tax bill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Driving licence (certified copy only)*†	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Electoral register search	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Bank statement/Bank credit card statement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* These documents do not need to be less than three months old – just valid and currently in force. †Certified copies of all parts of the license must be provided. In certain circumstances, other forms of ID and/or address verification may be accepted; please contact your local Zurich office for further guidance.

**Note: UAE clients only** proof of address is not required for policy owner(s) in the UAE. Where payors are different to policy owner(s), proof of address is required.

#### 6. Protection benefits

The amount and type of protection can only be selected at a policy level and will apply to both lives insured on a joint life case. All benefits to be expressed in the policy currency.

##### Benefit

(i) Life cover	Amount	
(ii) Additional benefits		
(a) Critical illness	Amount	
(b) Permanent and total disability	Amount	
(c) Waiver of premium	Life to be insured 1 <input type="checkbox"/> Yes <input type="checkbox"/> No	Life to be insured 2 <input type="checkbox"/> Yes <input type="checkbox"/> No

**Note:** the additional benefits must be the same as the life cover amount and cannot exceed the maximum additional benefits levels which are available on request.

#### 7. Policy term and interest rate applicable to the reduction in life cover sum insured (and critical illness and permanent and total disability benefit where applicable)

Please specify the period of cover required \_\_\_\_\_ years

- Minimum five years, maximum 35 years.
- Maximum termination age of life insured is 80 next birthday.
- The term must be in whole years.

Please indicate the interest rate to be used in calculating reductions in life cover sum insured (please tick one only).

0%  7%  9%  11%

## 8. Temporary life cover

Upon receipt of this application in conjunction with the first premium or valid method of payment form by Zurich International Life, the life/lives insured will be provided with immediate life cover of up to a maximum of USD250,000/AED1,000,000 (or currency equivalent) or the amount of life cover applied for, whichever is lower. This cover will remain in force for a maximum of 60 days or until the cover applied for on the term policy is in place, whichever is earlier.

Please refer to the 'Temporary life cover terms and conditions' on pages 23 and 24.

## 9. Payment details

Premiums for this policy will be paid from my salary

Yes  No

If you answer 'No', please complete an 'Origin of wealth questionnaire'. If you answer 'Yes', please advise approximate annual salary, including currency.

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**Policy currency** (please tick one only)

USD  GBP  AED  EUR  BHD  QAR

**Premium type and frequency**

Single premium  Yes  No

OR Regular premium frequency (please tick one only)

Monthly  Quarterly  Half-yearly  Yearly

Premium amount

---

## 10. Health and lifestyle questionnaire

### Life insured 1

Please ensure all questions are answered fully and truthfully as failure to disclose any fact may invalidate your insurance. We may require special questionnaires to be completed, which will be provided by your relevant financial professional.

1. a If you have smoked or used any form of tobacco or nicotine product in the last 12 months, please provide type, frequency and quantity (for example, 20 cigarettes per day, shisha once a week).

- b If you no longer use tobacco or nicotine products when did you stop using them and what was your previous consumption (for example, stopped January 2011 – used to smoke 20 cigarettes a day)?

2. Do you consume alcohol?  Yes  No

If 'Yes', please provide the number of units consumed each week. \_\_\_\_\_ units  
(1 unit = single measure of spirits or 125ml glass of wine or 250ml of beer).

3. Have you ever been advised to give up tobacco and/or alcohol for a specific reason?  Yes  No

If 'Yes' please provide details

4. What is your height and weight? \_\_\_\_\_ cms \_\_\_\_\_ kgs

5. a In which industry are you employed and what is your job title?

Industry \_\_\_\_\_ Job title \_\_\_\_\_

- b What percentage of your occupation involves manual work and what is the nature of these duties? If your occupation includes activities that may be considered hazardous (for example – aviation, working at heights or underground or with explosives), please complete the relevant 'Oil and natural gas', 'Aviation' or 'General occupation' questionnaire as appropriate.

\_\_\_\_\_ % \_\_\_\_\_ Duties \_\_\_\_\_

- c Please state your earnings in the last 12 months from employment or business operations.

Please include the currency.

- d Do you participate in any sport or activity that may be considered hazardous? For example, motor racing, diving, mountaineering, private flying, etc.

If 'Yes', please complete the relevant questionnaire or, if a specific questionnaire does not exist, please provide us with full details of frequency of activity, level of participation, any qualifications, details of competitions in which you take part, etc. in the 'Additional information' section at the end of this form.

Yes  No

### 6. Family history

Please provide details of your family history. In particular whether your father, mother or any of your brothers or sisters has died of or suffered from heart disease, cancer, multiple sclerosis or diabetes before the age of 65 or from a familial/hereditary disorder.

Relation	Age now/age at death	State of health/cause of death	Age at onset of disease
Father			
Mother			
Brother(s)			
Sister(s)			

## Health and lifestyle questionnaire (continued)

- 7. a** Please confirm the purpose of this insurance application (for example, personal cover, family protection, mortgage cover, keyman insurance, partnership protection).

- b** Have you any existing life, disability or critical illness cover already in force with Zurich or any other insurance company?

Yes  No

If 'Yes', please complete the details.

Insurer	Benefits	Sum insured	Policy term	Start date	Reason for cover

- c** Are you intending to replace any of the above covers with this application?

Yes  No

If 'Yes', please advise which will be replaced.

- d** Are you currently applying to Zurich or any other insurance company for further cover?

Yes  No

If 'Yes', please complete the details.

Insurer	Benefits	Sum insured	Policy term	Date of application	Reason for cover

- e** Have you ever had an application for life, disability or critical illness insurance declined, postponed or accepted at other than normal terms?

Yes  No

If 'Yes', please state the company/ies, benefits and date of application.

Insurer	Benefits	Date of application	Decision

- 8. a** Have you been resident in your current country of residence for less than five years?

Yes  No

If 'Yes', please provide details.

Country	From	To

- b** Other than for vacations of less than 15 days in any 12 month period, do you visit or have any intention of visiting, living or working outside of your current country of residence?

Yes  No

If 'Yes', please complete the details.

Travel to (Country)	Duration of stay	Purpose of stay

**If you visit or intend to visit Iran, Iraq, Yemen, Afghanistan, Pakistan, Syria, any country of the former Soviet Union or any country in Africa, please complete our 'Travel and residency questionnaire'.**

## Health and lifestyle questionnaire (continued)

### 9. a Medical questions

If you answer yes to any of the questions in '9a. Medical questions', there are special questionnaires for each disorder that you will need to complete.

These will be provided by your relevant financial professional. Please ensure the relevant form(s) is/are attached with your application.

Do you have or have you ever been diagnosed as having:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a) high blood pressure?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) diabetes or impaired fasting glucose?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) asthma, chronic bronchitis or obstructive airways disease?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) spinal (back or neck) disorders, muscular or joint disorders?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e) digestive disorders (for example, Crohn's Disease, ulcerative colitis, gastric reflux, ulcers, hernia)?     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f) arthritis (for example, osteoarthritis, rheumatoid arthritis or gout)?                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g) growths, lumps, cysts, abnormal moles or skin lesions?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h) mental health issues (for example, depression, anxiety, schizophrenia, eating disorders, bipolar disorder)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### b Medical questions

If you answer yes to any of the questions in '9b. Medical questions' or in questions 10 or 11, please give details in the 'Additional information' section.

Do you have or have you ever been diagnosed as having:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| i) heart attack, murmur, palpitations, chest pain or high cholesterol?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j) paralysis, stroke or transient ischaemic attack?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| k) thyroid or other glandular disorders?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| l) skin disorders (for example, psoriasis, or sexually transmitted diseases)?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| m) epilepsy, fits, multiple sclerosis or other neurological complaints?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| n) impairment in speech, vision or hearing or other disorder of the ears or eyes?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| o) cancer or tumours (benign or malignant)?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| p) liver or gall bladder disorders (for example, hepatitis (including carrier state), fatty liver, haemochromatosis, cirrhosis, jaundice, gallstones)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| q) urinary or kidney disorders (for example, stones, pyelonephritis, blood or protein in urine)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| r) anaemia, haemophilia, malaria or other parasitic disease or blood disorders?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| s) prostate disorders, ovarian or cervical disorders (for example, hysterectomy, endometriosis)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| t) any other disability, illness, operation or injury causing bodily impairment?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### 10. Are you currently taking any medication?

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a) Are you currently taking any medication?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) Have you ever had any screenings where the results were abnormal (for example, mammograms, cervical smear tests, PSA screenings, chest x-ray)?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) Have you ever tested positive for HIV or Hepatitis B or C, or are you awaiting the results of such a test?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) Other than stated above, have you consulted a doctor in the last five years or have you, in that time, undergone any special investigations (for example, MRI scan, biopsy, colonoscopy, CT scan, sleep studies)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |



## Health and lifestyle questionnaire (continued)

e) Do you intend to seek a medical opinion within the next three months?

Yes  No

### For female clients

11.a Are you now pregnant?

Yes  No

If 'Yes', please confirm your due date and provide a statement from your obstetrician to confirm the pregnancy is proceeding normally.

Due date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

b Have you ever had any pregnancy related complications such as pre-eclampsia?

Yes  No

### 12. Details of doctor/clinic/hospital

Please give details of the doctor/clinic/hospital who is most familiar with your medical history (even if this is in a country other than your current country of residence).

Name of doctor/clinic/hospital

Telephone number

Address of doctor/clinic/hospital

### Additional information

Question number

Details of disease or disorder, treatment given, date of diagnosis, details of doctor consulted, ongoing symptoms, date of next consultation, etc. If you are in possession of copies of reports in relation to these matters, please submit copies with your application for our consideration.

If there is insufficient space, please continue on a separate piece of paper ensuring you sign and date any additional pages.

## Health and lifestyle questionnaire (continued)

### Life insured 2

Please ensure all questions are answered fully and truthfully as failure to disclose any fact may invalidate your insurance. We may require special questionnaires to be completed, which will be provided by your relevant financial professional.

- 1. a** If you have smoked or used any form of tobacco or nicotine product in the last 12 months, please provide type, frequency and quantity (for example, 20 cigarettes per day, shisha once a week).

- b** If you no longer use tobacco or nicotine products when did you stop using them and what was your previous consumption (for example, stopped January 2011 – used to smoke 20 cigarettes a day)?

- 2.** Do you consume alcohol?  Yes  No  
 If 'Yes', please provide the number of units consumed each week. \_\_\_\_\_ units  
 (1 unit = single measure of spirits or 125ml glass of wine or 250ml of beer).

- 3.** Have you ever been advised to give up tobacco and/or alcohol for a specific reason?  Yes  No  
 If 'Yes' please provide details

- 4.** What is your height and weight? \_\_\_\_\_ cms \_\_\_\_\_ kgs

- 5. a** In which industry are you employed and what is your job title?

Industry \_\_\_\_\_ Job title \_\_\_\_\_

- b** What percentage of your occupation involves manual work and what is the nature of these duties? If your occupation includes activities that may be considered hazardous (for example – aviation, working at heights or underground or with explosives), please complete the relevant 'Oil and natural gas', 'Aviation' or 'General occupation' questionnaire as appropriate.

\_\_\_\_\_ % \_\_\_\_\_ Duties \_\_\_\_\_

- c** Please state your earnings in the last 12 months from employment or business operations.

Please include the currency.

- d** Do you participate in any sport or activity that may be considered hazardous? For example, motor racing, diving, mountaineering, private flying, etc.

If 'Yes', please complete the relevant questionnaire or, if a specific questionnaire does not exist, please provide us with full details of frequency of activity, level of participation, any qualifications, details of competitions in which you take part, etc. in the 'Additional information' section at the end of this form.

Yes  No

### 6. Family history

Please provide details of your family history. In particular whether your father, mother or any of your brothers or sisters has died of or suffered from heart disease, cancer, multiple sclerosis or diabetes before the age of 65 or from a familial/hereditary disorder.

Relation	Age now/age at death	State of health/cause of death	Age at onset of disease
Father			
Mother			
Brother(s)			
Sister(s)			

## Health and lifestyle questionnaire (continued)

- 7. a** Please confirm the purpose of this insurance application (for example, personal cover, family protection, mortgage cover, keyman insurance, partnership protection).

- b** Have you any existing life, disability or critical illness cover already in force with Zurich or any other insurance company?

Yes  No

If 'Yes', please complete the details.

Insurer	Benefits	Sum insured	Policy term	Start date	Reason for cover

- c** Are you intending to replace any of the above covers with this application?

Yes  No

If 'Yes', please advise which will be replaced.

- d** Are you currently applying to Zurich or any other insurance company for further cover?

Yes  No

If 'Yes', please complete the details.

Insurer	Benefits	Sum insured	Policy term	Date of application	Reason for cover

- e** Have you ever had an application for life, disability or critical illness insurance declined, postponed or accepted at other than normal terms?

Yes  No

If 'Yes', please state the company/ies, benefits and date of application.

Insurer	Benefits	Date of application	Decision

- 8. a** Have you been resident in your current country of residence for less than five years?

Yes  No

If 'Yes', please provide details.

Country	From	To

- b** Other than for vacations of less than 15 days in any 12 month period, do you visit or have any intention of visiting, living or working outside of your current country of residence?

Yes  No

If 'Yes', please complete the details.

Travel to (Country)	Duration of stay	Purpose of stay

**If you visit or intend to visit Iran, Iraq, Yemen, Afghanistan, Pakistan, Syria, any country of the former Soviet Union or any country in Africa, please complete our 'Travel and residency questionnaire'.**

## Health and lifestyle questionnaire (continued)

### 9. a Medical questions

If you answer yes to any of the questions in '9a. Medical questions', there are special questionnaires for each disorder that you will need to complete.

These will be provided by your relevant financial professional. Please ensure the relevant form(s) is/are attached with your application.

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- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a) high blood pressure?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) diabetes or impaired fasting glucose?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) asthma, chronic bronchitis or obstructive airways disease?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) spinal (back or neck) disorders, muscular or joint disorders?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e) digestive disorders (for example, Crohn's Disease, ulcerative colitis, gastric reflux, ulcers, hernia)?     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f) arthritis (for example, osteoarthritis, rheumatoid arthritis or gout)?                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g) growths, lumps, cysts, abnormal moles or skin lesions?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h) mental health issues (for example, depression, anxiety, schizophrenia, eating disorders, bipolar disorder)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### b Medical questions

If you answer yes to any of the questions in '9b. Medical questions' or in questions 10 or 11, please give details in the 'Additional information' section.

Do you have or have you ever been diagnosed as having:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| i) heart attack, murmur, palpitations, chest pain or high cholesterol?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j) paralysis, stroke or transient ischaemic attack?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| k) thyroid or other glandular disorders?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| l) skin disorders (for example, psoriasis, or sexually transmitted diseases)?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| m) epilepsy, fits, multiple sclerosis or other neurological complaints?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| n) impairment in speech, vision or hearing or other disorder of the ears or eyes?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| o) cancer or tumours (benign or malignant)?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| p) liver or gall bladder disorders (for example, hepatitis (including carrier state), fatty liver, haemochromatosis, cirrhosis, jaundice, gallstones)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| q) urinary or kidney disorders (for example, stones, pyelonephritis, blood or protein in urine)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| r) anaemia, haemophilia, malaria or other parasitic disease or blood disorders?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| s) prostate disorders, ovarian or cervical disorders (for example, hysterectomy, endometriosis)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| t) any other disability, illness, operation or injury causing bodily impairment?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### 10. Are you currently taking any medication?

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a) Are you currently taking any medication?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) Have you ever had any screenings where the results were abnormal (for example, mammograms, cervical smear tests, PSA screenings, chest x-ray)?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) Have you ever tested positive for HIV or Hepatitis B or C, or are you awaiting the results of such a test?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) Other than stated above, have you consulted a doctor in the last five years or have you, in that time, undergone any special investigations (for example, MRI scan, biopsy, colonoscopy, CT scan, sleep studies)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e) Do you intend to seek a medical opinion within the next three months?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

## Health and lifestyle questionnaire (continued)

### For female clients

**11.a** Are you now pregnant?

Yes  No

If 'Yes', please confirm your due date and provide a statement from your obstetrician to confirm the pregnancy is proceeding normally.

Due date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

**b** Have you ever had any pregnancy related complications such as pre-eclampsia?

Yes  No

### 12. Details of doctor/clinic/hospital

Please give details of the doctor/clinic/hospital who is most familiar with your medical history (even if this is in a country other than your current country of residence).

Name of doctor/clinic/hospital

Telephone number

Address of doctor/clinic/hospital

### Additional information

Question number	Details of disease or disorder, treatment given, date of diagnosis, details of doctor consulted, ongoing symptoms, date of next consultation, etc. If you are in possession of copies of reports in relation to these matters, please submit copies with your application for our consideration.

If there is insufficient space, please continue on a separate piece of paper ensuring you sign and date any additional pages.

## 11. Relevant financial professional's details and declaration

To be completed by your relevant financial professional.

Family name

Forename(s)

Job title

Brokerage name

Email address

Mobile number

Suitable certifier number (if applicable)

Regulatory body/Individual membership number

### Declaration

I declare that, to the best of my knowledge and belief, the information given is true and shall form the basis of the proposed contract with Zurich International Life Limited. I further declare that no unauthorised third parties have provided any advice or been involved in any stage of the sale.

Signed

Date

D	D	M	M	Y	Y	Y	Y
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## 12. Payment instructions

### Payment method

- Credit card\* – (please complete the details on page 16)
- Telegraphic transfer/standing order (please attach a copy of the bank instruction)
- UAE direct debit – for regular premiums only (please complete the UAE direct debit form)
- Direct debit (please complete 'Method of payment form')
- Cheque (please complete the details below)

\*Not available for AED, BHD and QAR denominated policies.

### Bank details for cheque payments

All cheques must be made payable to: 'Zurich International Life Limited'.

Bank name

Bank address

Country

Account name

Account number

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## Payment instructions (continued)

### Bank account details for telegraphic transfers and standing orders

#### Please pay to Zurich International Life Limited

##### Bank details for premium collection in Bahrain:

Bahraini Dinar	To: Ahli United Bank (Bahrain) B.S.C (c), Manama, Bahrain. SWIFT code: AUBBBHBM	In favour of:	Zurich International Life Limited IBAN number: BH97AUBB00001752655001
Euros	To: HSBC Bank Middle East Limited, Dubai, UAE., SWIFT code: BBMEAEAD Via correspondent bank: HSBC Bank plc, London. SWIFT code: MIDLGB22	In favour of:	Zurich International Life Limited IBAN number: AE580200000030123657213
Sterling	To: HSBC Bank Middle East Limited, Dubai, UAE., SWIFT code: BBMEAEAD Via correspondent bank: HSBC Bank plc, London. SWIFT code: MIDLGB22	In favour of:	Zurich International Life Limited IBAN number: AE850200000030123657212
US dollars	To: Ahli United Bank (Bahrain) B.S.C (c), Manama, Kingdom of Bahrain. Swift code: AUBBBHBM Via correspondent bank: J P Morgan Chase Bank N.A., New York, USA. Account number: 400937913, Swift code: CHASUS33	In favour of:	Zurich International Life Limited IBAN: BH70AUBB00001753667100

##### Bank details for premium collection in Qatar:

Euros	To: HSBC Bank Middle East Limited, Doha, Qatar. SWIFT code: BBMEQAQX Via correspondent bank: HSBC Bank, London. SWIFT code: MIDLGB22	In favour of:	Zurich International Life Limited IBAN: QA73BBME00000000001012673053
Qatari riyals	To: HSBC Bank Middle East Limited, Doha, Qatar Swift code: BBMEQAQX	In favour of:	Zurich International Life Limited IBAN: QA22BBME00000000001012673001
Sterling	To: HSBC Bank Middle East Limited, Doha, Qatar. SWIFT code: BBMEQAQX Via correspondent bank: HSBC Bank, London. SWIFT code: MIDLGB22	In favour of:	Zurich International Life Limited IBAN: QA03BBME00000000001012673052
US dollars	To: HSBC Bank Middle East Limited, Doha, Qatar. Swift code: BBMEQAQX Via correspondent bank details: HSBC Bank, USA. Swift code: MRMDUS33	In favour of:	Zurich International Life Limited IBAN: QA57BBME00000000001012673050

##### Bank details for premium collection in United Arab Emirates:

Euros	To: HSBC Bank Middle East Limited, Dubai, UAE SWIFT code: BBMEAEAD Via correspondent bank: HSBC Bank plc, London. SWIFT code: MIDLGB22	In favour of:	Zurich International Life Limited IBAN: AE580200000030123657213
Sterling	To: HSBC Bank Middle East Limited, Dubai, UAE SWIFT code: BBMEAEAD Via correspondent bank: HSBC Bank plc, London. SWIFT code: MIDLGB22	In favour of:	Zurich International Life Limited IBAN: AE850200000030123657212
UAE dirhams	To: HSBC Bank Middle East Limited, Dubai, UAE SWIFT code: BBMEAEAD	In favour of:	Zurich International Life Limited IBAN: AE210200000030123657200
US dollars	To: HSBC Bank Middle East Limited, Dubai, UAE SWIFT code: BBMEAEAD Via correspondent bank: HSBC Bank USA NA, USA. SWIFT code: MRMDUS33	In favour of:	Zurich International Life Limited IBAN: AE150200000030123657211

## Payment instructions (continued)

### Payment instructions for credit card

Do not detach from main application.

Any additional charge made by your credit card company for collection of your premiums will be met by the payor.

Credit cards can only be used for regular payments. If you wish to make a lump sum payment, please use a different payment method.

### Special instructions for collection

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#### Authorisation

I authorise Zurich International Life Limited, until further notice in writing, to debit my credit card account, as detailed below, with unspecified amounts in respect of the premiums for my Zurich International Life Limited policy as and when they fall due.

Please note that Zurich International Life Limited is not liable for any losses arising as a result of action taken by the cardholder's credit card company.

#### Credit card type

Visa     Mastercard (we do not accept prepaid or exchange credit cards.)

Name of card issuer – such as HSBC

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Currency of card

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#### Preferred collection date\*

\*Your regular payment will be collected on this date or the nearest available collection date.

#### Credit card expiry date

#### Credit card number

#### Name on card

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\*Your regular payments will be collected on this date or the nearest available date.

Future payments will be collected in line with the premium frequency you have selected.

Any additional charge made by your credit card company for collection of your contributions will be met by you (the payor).

### Cancellation and refund policy

We do not offer premium refunds after the 30 days free look period. For more information, please refer to the 'Right to cancel' section of your policy terms and conditions.

Any changes to the credit card collection agreement will be communicated to you in advance.

**I understand that this authority in favour of Zurich International Life will remain in force until such time as I cancel it in writing.**

Signature of cardholder

Cardholder's address – as held by credit card company

Date

## 13. Privacy notice

This Notice is a summary of our Privacy Policy which describes how we collect and use personal information as Data Controller. For the full version please visit online <https://www.zurichinternational.com/en/zurich-international-life/about-us/privacy> or contact us for a copy.

### Personal information we use

We use personal information such as name and contact details ("Personal Data") and sensitive personal information such as medical details ("Special Category Data").

### What we do with personal information

We use personal information to provide financial services, for example processing in connection with:

- setting up and managing a contract of insurance
- providing marketing information with consent
- complying with our legal obligations
- running our business where we have a legitimate interest to do so.



Without accurate and sufficient personal information where required, we cannot offer financial services.

### Sharing of personal information

We obtain personal information from, and share personal information with other organisations such as:

- Zurich Insurance Group Ltd. or any of its affiliated companies
- companies who supply services to us such as administration
- healthcare service providers
- financial advisors and employers where appropriate.

### How we transfer personal information to other countries

As a global business we ensure that personal information is equally protected in all locations by complying with data protection laws of the EU, Isle of Man and of each location in which we operate.

### How long we hold personal information for

We retain personal information for as long as is necessary to meet the purposes for which it was originally collected or to satisfy our legal obligations.

### Data subject rights

The person who is the subject of the personal information (the "Data Subject") has the following legal rights:

- access to personal information
- data rectification where it is inaccurate or incomplete
- erasure of personal information
- to restrict the processing of personal information
- data portability – to obtain personal information in a digital format
- to object to the processing of personal information
- to not be subject to automated individual decision making processes.
- to withdraw consent at any time where processing is based on consent.

If you have cause for complaint regarding our processing of personal information, you can contact the Isle of Man Information Commissioner.

### Data Protection contact

- Email our Data Protection Officer at ZILLPrivacy@Zurich.com
- Write to our Data Protection Officer at Zurich International Life Limited, Zurich House, Isle of Man Business Park, Douglas, Isle of Man IM2 2QZ, British Isles.

## 14. Declaration/Consent

### Declaration

I/We apply for an International Decreasing Term Assurance policy as detailed in this application form and in accordance with Zurich International Life Limited (the "Company") standard terms and conditions.

I/We declare that I/we have reviewed the answers given in this application, whether in my/our handwriting or not, and that they are true and complete to the best of my/our knowledge and belief, and will form the basis of my/our contract of life insurance.

I/We will tell the Company, in writing, if anything happens between completing this application and the commencement date of the policy that alters any of the answers I/we have given in this application form. Specifically, I/we will advise on any changes to the details provided by me/us in the health and lifestyle questionnaire sections contained within the application or any other circumstances which happen before the policy commencement, if that change makes any of my/our answers wrong or incomplete.

I/We understand that failure to disclose any material fact may invalidate the contract resulting in the loss of benefits.

**Note: a material fact is one which may influence the assessment or acceptance of your application for insurance. If you are in any doubt as to the relevance of any information, please give details.**

I/We confirm that I/we understand that a change in my/our country of residence, or that of any life insured, could mean that the Company may no longer be able to provide all the benefits under this policy.

I/We declare that any premiums that I/we pay to the policy will not contravene any applicable exchange controls regulations or trade or economic sanctions and that any premium paid to the Company is not of criminal origin or directly or indirectly related to criminal activities or any actual or attempted money laundering or tax evasion.

### Contact details

I/We understand that for security purposes, the Company will regard the contact details provided as my/our authorised contact details and that it is important that I/we let the Company know if any of these details change.

### Marketing consent

The Company, or the Zurich group companies, may wish to contact you by mail, email, telephone or other appropriate means about carefully selected products, services or offers that may be of interest to you.

I/We consent to being contacted in this way for this purpose by ticking here

### Special category data consent

By signing below, I/we consent to the Company processing my/our medical and health information and authorise the seeking and processing of information from any medical practitioner who has attended me/us or from any insurer to which an application has been made for insurance. I/We confirm such authorisation shall remain in force after my/our death.

## Declaration/Consent (continued)

### Withdrawal of consent

I/We understand that where I/we have provided consent I/we have the right to withdraw the consent at any time and that such withdrawal will not affect the data processing carried out prior to such withdrawal.

I/We confirm that this/these signature(s) below is/are mine/ours or that/those of my/our appointed legal representative(s).

If your signature is different from the signature in your passport/ID, or does not exist on the passport/ID, you will need to complete a 'Certifying signature form'.

#### Country where this application is signed

#### Policy owner/Authorised signatory 1

Signature

Print name

Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

#### Policy owner/Authorised signatory 2

Signature

Print name

Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

#### Life to be insured 1 (if different to policy owner)

Signature

Print name

Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

#### Life to be insured 2 (if different to policy owner)

Signature

Print name

Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

We will let you know when cover on the benefits you have selected starts. This will be subject to:

- i) the final underwriting decision; and
- ii) receipt of the initial premium payment; and
- iii) receipt of satisfactory proof of identity and any other documentation we require.

### Important information

Zurich International Life is a business name of Zurich International Life Limited.

Zurich International Life Limited is fully authorised under the Isle of Man Insurance Act 2008 and is regulated by the Isle of Man Financial Services Authority which ensures that the company has sound and professional management and provision has been made to protect policy owners.

For life assurance companies authorised in the Isle of Man, the Isle of Man's Life Assurance (Compensation of Policyholders) Regulations 1991, ensure that in the event of a life assurance company being unable to meet its liabilities to its policy owners, up to 90% of the liability to the protected policy owners will be met.

Not for sale to residents or nationals of the United States including any United States federally controlled territory.

Zurich International Life Limited is registered in Bahrain under Commercial Registration No. 17444 and is licensed as an Overseas Insurance Firm – Life Insurance by the Central Bank of Bahrain.

Zurich International Life Limited is authorised by the Qatar Financial Centre Regulatory Authority.

Zurich International Life Limited is registered (Registration No. 63) under UAE Federal Law Number 6 of 2007, and its activities in the UAE are governed by such law.

Calls may be recorded or monitored in order to offer additional security, resolve complaints and for training, administrative and quality purposes.

Zurich International Life Limited provides life assurance, investment and protection products and is authorised by the Isle of Man Financial Services Authority.

Registered in the Isle of Man number 20126C.

Registered office: Zurich House, Isle of Man Business Park, Douglas, Isle of Man, IM2 2QZ British Isles.  
Telephone +44 1624 662266 Telefax +44 1624 662038 www.zurichinternational.com

# International Decreasing Term Assurance

## Temporary life cover terms and conditions

### Qualifying conditions

- (a) A payment or payment instruction must be submitted with the application form to the value of the minimum initial regular premium payable under the policy applied for on the application form.
- (b) The proposed life or lives to be insured must not be older than 74 years attained as at the date of issue of this cover note.

### Life cover

The amount of life cover provided by this cover note is the lesser of the amount of life cover benefit applied for under the application form or USD250,000. This cover note is in respect of life cover benefit applied for only, and does not apply to any other benefit, other supplementary applications or additional or alternative policies for which application has been made.

### Period of cover

This cover note is valid from the date Zurich International Life receives a fully completed application form, in conjunction with the first premium or a valid payment instruction until the earlier of the following dates:

- (a) The date the policy becomes effective.
- (b) At midnight (local time) on the sixtieth (60th) day after risk commenced under this cover note.
- (c) The date of issue by the Company of a notice that cover has been declined or postponed.

Where the application is for a joint life policy and one of the proposed lives to be insured dies during the period of temporary life cover, cover on the other life will be cancelled with effect from the date of death of the deceased life.

If appropriate, a new application form will then be requested from the remaining life.

### Exclusions

Notwithstanding the above this cover note will not be valid if:

- (a) it has been altered or modified in any way or if the payment in respect of the initial premium under the policy is not honoured on the first presentation for payment;
- (b) there is any material misrepresentation in this cover note, the application form or any other supplementary forms;
- (c) the death of a proposed life to be insured during the period of cover is by suicide;
- (d) a proposed life to be insured has in the past five years had or been diagnosed as having, or has been treated by a physician or medical professional for:
  - cancer, or any malignant tumour or growth including melanoma, angina, heart attack, coronary artery disease, heart or brain surgery, stroke, diabetes, psychosis or other form of mental disease, alcoholism or drug addiction, Acquired Immune Deficiency Syndrome (AIDS), HIV virus infection, or any other disabling disease or condition;
- (e) a proposed life to be insured has ever been declined, postponed or accepted on special terms for life cover in the past;
- (f) death or disappearance is caused directly by or resulting from or in any way related to:
  - (i) war or warlike operations (whether war be declared or not) including invasion, act of foreign enemy, hostilities, mutiny, riot, civil commotion, civil war rebellion, insurrection, conspiracy, military or usurped power, martial law or state of siege, or any of the events or causes which determine the proclamation or maintenance of martial law or state of siege;
  - (ii) acts of terrorism including any related act or activity that is dangerous to human life or property, whether claimed or not.
- (g) the death of a proposed life to be insured occurs directly or indirectly as a result of any hazardous pursuit or pastime (for example, aviation other than as a fare paying passenger on a regular scheduled airline, motor racing, diving).

## International Decreasing Term Assurance (continued)

### Payment of claim

The life cover under this cover note becomes payable upon proof being provided to the satisfaction of the Company of the death of the proposed life to be insured or one of the joint lives to be insured. Payment will be by a single lump sum in the currency and location stipulated by the representative of the life insured's estate, or, if applicable, to the beneficiary named in an appropriate beneficiary nomination form lodged with Zurich International Life.

Notwithstanding any other terms under this agreement, no insurer shall be deemed to provide coverage or will make any payments or provide any service or benefit to any insured or other party to the extent that such cover, payment, service, benefit and/or any business or activity of the insured would violate any applicable trade or economic sanctions law or regulation.

### Important information

Zurich International Life is a business name of Zurich International Life Limited.

Zurich International Life Limited is fully authorised under the Isle of Man Insurance Act 2008 and is regulated by the Isle of Man Financial Services Authority which ensures that the company has sound and professional management and provision has been made to protect policy owners.

For life assurance companies authorised in the Isle of Man, the Isle of Man's Life Assurance (Compensation of Policyholders) Regulations 1991, ensure that in the event of a life assurance company being unable to meet its liabilities to its policy owners, up to 90% of the liability to the protected policy owners will be met.

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