

New Intermediary Questionnaire



Full Trading Title:			
Full Address:			
Telephone Number:		Fax Number:	
Email Address:		Website Address:	

GENERAL INFORMATION

Trading Style:	<input type="checkbox"/> Sole Trader	<input type="checkbox"/> Partnership	<input type="checkbox"/> Private / PLC	<input type="text"/> Other :	
Company Registration Number:					
Nature of Business:					
Date Business Established:					
Have you ever had an agency (Insurer or Intermediary) cancelled or refused?				<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are any insurance activities outsourced to third Parties? If so, please provide full details.					
Do you have any Sub-Agents or third parties who introduce business to you in respect of healthcare insurance?					

PROFESSIONAL INSURANCE DETAILS

It is a requirement of our terms of business that you hold appropriate Professional Indemnity Insurance cover. Please ensure that you return a copy of your PI cover with this application. If this is not attached your application will not proceed.

Have you ever made a claim under the above policy or any other PI or E&O policy or are you aware of any circumstances that may give rise to a claim? If yes please provide details under separate cover.

 YES

 NO

PROFESSIONAL MEMBERSHIP

Of which Insurance regulatory body are you a member?	
Membership Number:	
Please give details of any other regulatory or trade body that you subscribe to e.g. BIBA:	

ACCOUNT PROFILE

What is your Annual Gross Written Premium for Healthcare insurance over the past 3 years?	Prior year	Prior year	Current to date	
What is your approximate Client Retention Rate for Healthcare Insurance over the past 3 years?	Prior year	Prior year	Current to date	
Please provide details of your percentage account split for your last financial year.	Car Rental	Personal Accident	Private Medical	Life Products
	Motor	Household	Other (Specify)	Other (Specify)

PERSONNEL

Please complete the following questions with regards to all Directors, Partners, Principals and Active Shareholders

1	Name:	<input type="text"/>	Date of Birth:	<input type="text"/>
	Business Title:	<input type="text"/>		
	Professional Qualifications:	<input type="text"/>		
	Criminal Convictions (past or pending):	<input type="text"/>		
2	Name:	<input type="text"/>	Date of Birth:	<input type="text"/>
	Business Title:	<input type="text"/>		
	Professional Qualifications:	<input type="text"/>		
	Criminal Convictions (past or pending):	<input type="text"/>		
3	Name:	<input type="text"/>	Date of Birth:	<input type="text"/>
	Business Title:	<input type="text"/>		
	Professional Qualifications:	<input type="text"/>		
	Criminal Convictions (past or pending):	<input type="text"/>		

Please attach a separate sheet of paper for additional principals of the company.

Have you or any of your personnel actively involved in general insurance activities:		
Ever been adjudged by a court liable for fraud, misfeasance, wrongful trading or other misconduct?	<input type="text" value="YES"/>	<input type="text" value="NO"/>
Ever knowingly been the subject of an investigation into misconduct or malpractice?	<input type="text" value="YES"/>	<input type="text" value="NO"/>
Ever been subject to a disciplinary proceeding by any professional body (e.g. C.I.I., I.B.R.C., G.I.S.C., F.S.A, etc.)	<input type="text" value="YES"/>	<input type="text" value="NO"/>

If any of the questions have been answered "YES" please attach a separate sheet of paper providing details

DECLARATION

- I/We confirm that the above information is accurate and truthful.
- I/We confirm that we have read, understood and accept Expatriate Healthcare's Terms of Business Agreement.
- I/We confirm that we understand that this application is part of Expatriate Healthcare's standard compliance procedure to verify the quality and security of the companies with whom we trade. This does not constitute an application to become an Authorised Agent of the Company in accordance with the terms as expressed by the FSA (Financial Services Authority).

Signed:	<input type="text"/>	Date:	<input type="text"/>
Print Name:	<input type="text"/>		
Position:	<input type="text"/>		

Please return your completed form and a copy of your current PI policy to admin@exphealth.com, post to Expatriate Healthcare 10 - 13 Lovat Lane, London EC3R 8DN or fax to +44 (0)870 428 5141. An incomplete application form will delay consideration of your application.

Expatriate Healthcare is a style of Strategic Insurance Services Limited a company registered in England under number 02968515 with its registered office at 10-13 Lovat Lane, London, EC3R 8DN.

Do you have any general or specialist insurance requirements which you think our parent London Broking house may be able to help you with?

Accidental Death
ATM Cover
Avalanche
Business Equipment
Capital Benefits
Catastrophe
Corporate Card Liability Waiver
Delayed Baggage
Drop-off Charges
Extended Warranty

Hijack
Holiday Abandonment
Hospital Benefit
Identity Theft
Key Man Cover
Legal Expenses
Lock-Out
Loss Damage Waiver
Lost or Stolen Credit Cards
Loyalty Card Cover

Medical Expenses (PA)
Medical Expenses (Travel)
Medical Expenses (PMI)
Missed Departure Money
Outstanding Balance Insurance
Permanent Disability
Permanent Total Disability

Personal Accident
Personal Effects
Personal Liability
Piste Closure
Plastic Card Insurance
Private Medical Insurance
Purchase Protection
Restitution of Holiday
Ski Equipment
Ski Hire

Ski Pack
Supplementary Liability Insurance
Temporary Total Disability
Travel Delay
Travel Insurance
Trip Cancellation
Trip Curtailment

Direct access to Lloyd's of London and general composite markets

For more information please visit www.sis-l.com or call +44 (0)845 345 6611