

Irish Life Over 50s Life Insurance

Application Form

€20

€15

Please tick the box beside the monthly payment you want to make

€30

Please complete and in black ink	this form in BLOCK CAPITA	For office use only Seller code:												
1. Personal details	(this information should	d be bas	ed on the person t	o be cover	ed)	_								
Gender:	Male Female		Country of birth:											
Title:	Mr Mrs	Ms	Country of residence:											
First Name:														
Last Name:														
Date of birth:	d d / m m / y y y y	Age:												
Phone number	Home:	Work:		Mobile:										
Your Home Address:														
Your E-mail Address:														
Will the owner of this plan (pr	roposer) be different from the life cove	ered?		١	res No (
If the plan owner (proposer) is	s not the person to be covered please	complete the	e following:											
Plan owner name:														
Last Name:														
Date of birth:	d d / m m / y y y y	If comp	any - company name:											
Address of plan owner:														
Relationship to life covered:														
Reason for cover if relationshi	p not husband and wife:													
Funeral expenses	Outstanding loans on death	Taxati	on on death Oth	ner										
Is the plan to be written in trus	st?			١	res No (
If yes, please complete the ap	propriate trust form. A plan cannot be	written in tr	ust if the proposer is different	to the life assured	Ł									
2. Your regular pay	yments (please see the benefits	table provi	ded in the Over 50s Life Ir	 nsurance bookle	t)	_								

Other

If yes, please complete the appropriate trust form. A plan cannot be written in trust if the proposer is different to the life assured

€55

3. DECLARATION UNDER REGULATION 6(3) of the Life Assurance (Provision of Information) Regulations, 2001.

WARNING

If you propose to take out this policy in complete or partial replacement of an existing policy, please take special care to satisfy yourself that this policy meets your needs. In particular, please make sure you are aware of the financial consequences of replacing your existing policy. If you are in doubt about this, please contact your insurer or insurance adviser.

picase contact your moder or r	isdiance adviser.		
Declaration of customer All customers should tick the	relevant box and sign the customer of	declaration below	
No, the policy is not a replac	rement policy Yes, the p	policy is a replacement policy	
Existing Policy Number			
Your policy will not automa	ically be cancelled. Please notify you	ur provider if this is required.	
Customer Declaration (Cu	stomer to sign as indicated X)		
I confirm that I have received	n writing the information specified in th	he declaration below.	
Signature of Customer	X	Date dd/mm/yyyy	
	(plan owner)		
Signature of life covered	Х		Date dd/mm//yyyy
DECLARATION OF INS	URER OR INTERMEDIARY		
	lance with Regulation 6(1) of the Life A	Assurance (Provision of Information) F	Regulations, 2001,
X (Insert client name and addr			78
of replacing an existing policy	with this policy by cancellation or redu	_	·
Name of insurer or insurance	ntermediary		Date
X			d d / m m / y y y y
4. Declaration			
This form is my appl	ication for cover under Iris	sh Life's Over 50s Life Ins	urance plan conditions.
I understand that my contract	s) with Irish Life Assurance plc (Irish Li	ife) will be based on this declaration a	and my application form.
	all the questions in this application forr e exclusions that apply to the accident		ect.
	the level of payment I wish to make for se any medical information on this plar		d all the information supplied. I understand to reflect this.
I understand that cover shall r	ot commence until all of the following	events have taken place:	
(i) this application for cover	has been accepted by Irish Life,		
(ii) the first premium has bee	n charged to my account.		
includes any other information customer care and service pur with the above purposes, to re	poses. I agree that my personal data ca egulatory authorities or as required by I	eparately. Irish Life may hold and pro an be disclosed for the above purposi law, to reinsurers, to health profession	n with this contract or transaction. This cess this information for administrative, es and to persons necessary in connection nals, to any persons with whom the company group and to any person to whom the policy

X

X

Signature of Customer

Signature of life covered



5. SEPA Direct Debit Mandate

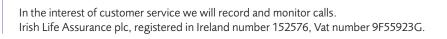
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UMR																											
Creditor Identifie														I	Е	3	0	Z	Z	Z	3	0	3	5	8		
Name and	l add	res	5 0	f t	he	e p	a	yeı	′:																		
* Debtor Name																											
Debtor Address																											
* Debtor Bank Ide	entifier C	ode (B	IC)																								
* IBAN																											
	(Accou	ınt Nun	nber)																							
Type of payment			Recu	ırrer	nt (0	r	(One	Off	Payı	mer	nt ()										
Creditor's name a	ınd addre	ess	1	R	S	Н		L	F	Е	1	S	S	U	R	Α	N	С	Е		P	L	C				
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			D	UE	3 L	I	N	-																			
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* Signature(s) For Irish Life	X X Inform	natio	from			ank.			nicr	T you	ar au								d	d	/[m	m	(pl	у	у	y
Statement that your signature (s) For Irish Life Plan Number (max)	X X Inform x 18 chara	nation	from			ank.													d	d	/[m	m	(pli	у	у	y y
* Signature(s) For Irish Life Plan Number (max) Person(s) on who	X Inform x 18 chara	nation	from			ank.													d	d	/[m	m	(pli	y	У	y y
* Signature(s)	X Inform x 18 chara se behali made	nation	from		ose	es o	onl												d	d	/[m	m	(pl	y	У	y y



Please sign and date

LA 7474 (REV 11-13

SEPA Direct Debit Mandate on reverse





Lower Abbey Street

Dublin 1 Ireland T: 01 704 2000

F: 01 704 1900