

Intermediary Application Form

Please complete all relevant sections of the form in BLACK INK and BLOCK CAPITALS.

1 About you

a. Contact name _____	
b. Contact address including postcode* _____ _____	
c. Full trading name _____	
Sole trader <input type="checkbox"/> Partnership <input type="checkbox"/> PLC <input type="checkbox"/> Ltd Co <input type="checkbox"/> LLP <input type="checkbox"/>	
d. Trading address including postcode* _____ _____	
Tel no _____	Fax no _____
email address: _____	Website address: _____
Type of premises (<i>please tick</i>)	Private <input type="checkbox"/> Office <input type="checkbox"/> Shop front <input type="checkbox"/> Other <input type="checkbox"/>

* If you have been at the above address for less than five years, please give all previous addresses in the last five years (*using a separate sheet if necessary*).

2 Membership details/FSA authorisation to advise on or arrange general insurance and pure protection contracts

Please provide details of your Financial Services Authority Registration, or your membership of a Designated Professional Body (if more than one please go to section 14).	
FSA Registration number	_____
Date of registration	_____
or Name of Designated Professional Body	_____
Designated Professional Body number	_____
Date of registration	_____

2b

Do your FSA permissions include insurance mediation activities in respect of non investment insurance contracts? YES <input type="checkbox"/> / NO <input type="checkbox"/>
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3 Networks

Are you part of a network? YES <input type="checkbox"/> / NO <input type="checkbox"/> If "NO", please ignore the rest of this question. If "YES", please state the name of the network. Are you directly authorised by the FSA? YES <input type="checkbox"/> / NO <input type="checkbox"/> If "NO", please complete section 4.
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4 Appointed representative

Are you an Appointed Representative of an authorised principal firm? YES / NO

If "YES"

Please provide the names of your Principal Firms, and their FSA registration number(s). | _____

Please provide your trading name as it appears on the FSA register. | _____

Please provide your FSA registration number. | _____

Have your Principals delegated their permission for you to conduct insurance mediation activity? YES / NO

5 Your BUPA commission agreement

Please state the agency you wish to have with BUPA:

- a. Recommend Private Medical Insurance and Long Term Insurance Policies c. Recommend Private Medical Insurance only
 b. Recommend Long Term Insurance Policies only

6 Other agencies

Please provide details of all commission agreements held with other insurance companies

7 Products

	Recommend Require more information (BUPA products only)	Recommend *Do you sell this product?	Recommend *Product speciality	Recommend Approx. number of customers per product area	Recommend Approx. turnover per product area
Personal PMI					
Community rated PMI					
Experience rated PMI					
Travel					
Personal critical illness					
Personal life cover					
Personal income protection					
Group critical illness					
Group life cover					
Group income protection					
Group dental cover					
Employee assistance programme					
Occupational health					
Health screening					
International products					
Cash Plan					
			*Total	*	*

All items marked * in this section are mandatory.

8 Principals / Partners

We want to ensure that when we contact your business, we always speak to the right people and offer information on the products most relevant to them.

Please provide full name, home address (including post code) and position in the company (using separate sheet if necessary) of any principals, partners (within a partnership) and client contact staff.

Please let us know the details of any other branches you may have, their product specialities and the name, phone number and position of the main contact.

9 Branches

Do you have any other branches? Yes No *(If ticking Yes, all the following information is mandatory.)*

Office	Postcode	Products	Contact and position	Telephone number

10 Additional information

Have you, or any of the directors/controllers of the firm ever: (please tick)

Become subject to an adverse finding, whether past or pending, by a regulatory, trade, professional, public, industry or consumer body, or by any tax or government authority?

Yes No

Been the subject of any bankruptcy or insolvency proceedings?

Yes No

Had refused, suspended, withdrawn, or made subject to a non standard conditions or restrictions any licence, permission or authorisation to do any type of business?

Yes No

Been a defendant in any civil proceedings, or party to any arbitration in relation to any financial business or the subject of any criminal proceedings?

Yes No

Ceased trading in circumstances in which one or more of your/their creditors did not receive full payment?

Yes No

Been disqualified from acting as a director of a company, or from acting on the management or conduct of affairs of any company, partnership or unincorporated association?

Yes No

Been convicted of a criminal offence, other than motoring, (1974 Rehabilitation Act applies)?

Yes No

Been charged with any offence involving violence, fraud, or other dishonesty?

Yes No

Had an application to represent an insurance office refused, or a previous agency cancelled?

Yes No

If the answer to any of these is yes, please provide details below, using the additional space in section 14 if necessary.

11 Professional Indemnity (PI) Insurance

Please state the name of the person(s) responsible for the firm's compliance with regulatory responsibilities, including Money Laundering Regulations 2003, the Proceeds of Crime Act 2002.

Name	Status
Name	Status
If applicable, please state name of money laundering reporting officer	
Do you hold professional indemnity insurance for the selling of PMI?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the cover meet the relevant regulatory requirements?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Date of most recent visit by the Financial Services Authority.	
Please state the name of this financial services body	
Have all actions recommended been addressed?	Yes <input type="checkbox"/> No <input type="checkbox"/>

12 Bank/Building Society Details

Please give the name and address of the bank into which to pay commission

Name	
Address	
Postcode	
Account Name	
Account Number	Sort Code

If you require your commission from BUPA Health Assurance Limited and BUPA Insurance Limited to be paid into separate bank accounts, please provide details on separate sheet.

13 Declaration

I/we declare that the information given is correct, and that all information relevant to this application has been disclosed. I/we hereby apply for a commission agreement in the UK for the introduction of General Insurance (including PMI) business to BUPA Insurance Limited and/or Long Term Insurance business to BUPA Health Assurance Limited. I/we understand that, if successful, this application together with the BUPA Commission Policy for Independent Intermediaries (General Business) and/or (Long Term Business) (both of which may change from time to time) will constitute the terms of business (the commission agreement) between me/us and the relevant BUPA company. Intermediaries must maintain P.I. cover in accordance with the levels prescribed by the Financial Services Authority.

I/we authorise BUPA Insurance Services Limited to make such other enquiries as deemed necessary in consideration of this application. I/we understand that the commission agreement, if granted, may be terminated by either party without reason subject to the relevant standard Commission Policy. The commission agreement will in any event be kept under review and may be terminated if the volume and standard of business is not acceptable to BUPA.

When operating as an independent intermediary, I/we undertake to maintain in force professional indemnity insurance cover in accordance with FSA Regulation, and to inform BUPA immediately if these requirements are no longer complied with. I/we agree that the insurer(s) providing the professional indemnity cover shall be free to pass information on my/our cover to the Financial Services Authority, Association of British Insurers.

I/we understand that information supplied to BUPA will become part of the data held by BUPA in accordance with the Data Protection Act 1998. Access to such data may be granted by the BUPA Group to others on a strictly confidential basis in the course and for the purposes of the efficient administration of the BUPA group of companies and the maintenance of the relationship with BUPA.

I/we confirm that we have read and understood the applicable FSA Regulations and/or ABI Codes of Practice and agree to comply with them/it. I/we have provided a copy of the applicable FSA Regulations and/or ABI Codes to any sub agents/employees who recommend BUPA policies on my/our behalf and will ensure their adherence to the above.

Signature	Position held
Name of Signatory	Date

14 Additional Information

Please use this space to provide additional information in respect of any of the preceding sections.

Financial references



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