INGLE™ INTERNATIONAL

SPECIAL RISK INDIVIDUAL APPLICATION FORM

HOW TO APPLY

Specialty insurance products are provided through certain underwriters at Lloyds of London. Receiving a quote from London will normally take us up to 5 business days, but may vary. The more detailed information you are able to provide, the quicker and more favourable the process will be.

Please fill out the applicable form(s) and return to us by email at helpline@ingleinternational.com or by fax at +1 416.730.1878. If you require additional space to provide further details, please feel free to use a separate sheet.

If you have any questions prior to submitting an application, please contact us at helpline@ingleinternational.com.

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A. COMPANY INFORMATION

Name

Occupation

Phone Number

Email

Citizenship

Address Street

City

State/Province

Country

Zip/Postal Code

Date of Birth M M D D Y Y Y Y

Sex ☐ Male ☐ Female

B. REQUESTED COVERAGE

Effective Date M M D D Y Y Y Y

Expiry Date M M D D Y Y Y Y

Coverage Desired

- ☐ Out-of-Country Emergency Medical, Evacuation & Repatriation
- ☐ Accidental Death and/or Dismemberment
- ☐ Temporary Total Disablement
- ☐ Permanent Total Disablement
- ☐ Kidnap, Ransom & Extortion – *see separate application*

Include coverage for war and terrorism in the benefits selected above? ☐ Yes ☐ No

C. TRAVEL AND RESIDENCY INFORMATION

Required for all applicants. Please provide detailed information on where covered individuals will live, work or travel during this period, including security precautions to be taken, frequency of travel and lengths of visits in any high-risk country or region:

D. ANNUAL INCOME

Required if any benefits other than Emergency Medical are selected.

Annual Income $

Currency

Note: Disability and Accidental Death are dependent upon income.

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E. ACCIDENTAL DEATH AND DISMEMBERMENT

Required if AD&D is chosen in Section B.

Requested Sum Insured $

Currency

Scales of Benefits (percentages are of the Sum Insured) – insert your requirements under column F if A, D or E are not acceptable.

Please choose from one of the three benefit schedules listed below: ☐ A ☐ D ☐ E ☐ F

	A	D	E	F
Death	100%	100%	100%	
Total and irrecoverable loss of sight of both eyes	—	100%	100%	
Total and irrecoverable loss of sight of one eye	—	50%	100%	
Loss of two limbs	—	100%	100%	
Loss of one limb	—	50%	100%	
Total and irrecoverable loss of sight of one eye and loss of one limb	—	100%	100%	

F. DISABILITY

Temporary total disability provides for income replacement on a monthly basis for one to two years if you are totally disabled by cause of accident or sickness. Benefits are limited to 60.00% of gross monthly income. Do you require coverage for temporary total disability?

☐ Yes ☐ No

Monthly Sum Insured $

Currency

Waiting Period in days

Benefit Period in months

Permanent total disability provides for a single lump-sum payment if you are permanently disabled by cause of accident or sickness. Do you require coverage for permanent total disability?

☐ Yes ☐ No

Lump Sum Insured $

Currency

Waiting Period in months

Sickness Coverage: Do you require coverage for sickness, or for accident only?

☐ Accident Only

☐ Accident and Sickness
see supplemental form

G. ADDITIONAL DETAILS OR INFORMATION

Please provide any other details or information which may affect your insurability for the product(s) you have requested, including any risk management strategies or security arrangements. (If applicable)

H. DECLARATION

Required for all applicants.

To the best of my/our knowledge and belief, the information provided in connection with the proposal, whether in my/our hand or not, is true and I/we have not withheld any material facts. I/We understand that non-disclosure or misrepresentation of a material fact may entitle Underwriters to void the insurance. (NB. A material fact is one likely to influence acceptance or assessment of this proposal by Underwriters. If you are in any doubt as to whether a fact is material or not you must disclose it.)

I/We understand that Underwriters will determine their terms and conditions upon the information provided in connection with this proposal and I/we further understand that the signing of this proposal does not bind me/us to complete or Underwriters to accept this insurance.

Signature of the person to be insured (if other than the proposer)

Date M M D D Y Y Y Y

Signature of proposer

Date M M D D Y Y Y Y