Klapton Cash Back Plan
Application Form

Once you have filled out this form, you will get the most cost effective Insurance Quote, information about our payment methods and an e-mailed copy of your quote.

Starting Date

Your insurance should start on:
[1-Scroll down menu]
(Maximum 30 days in advance)

Applicant Information

Title	First Name	Middle Name	Last Name
[2-scroll down menu]			

Email Address

Mobile Phone Number

Phone Number

Home Address

Home Address Line 2

Town

Postcode

Country
[3-scroll down menu]

Plan Level	[5-scroll down menu]

The Details of Persons You Want Us to Insure

You can include in addition to yourself, your spouse and your children, as long as they live with you.

#	Last Name	Forename	Gender	Date of Birth	ID/Passport No.	Related to you
1	Yourself		O M O F			[4-scroll down menu]
2			O M O F			[4-scroll down menu]
3			O M O F			[4-scroll down menu]
4			O M O F			[4-scroll down menu]
5			O M O F			[4-scroll down menu]
6			O M O F			[4-scroll down menu]

Acknowledgement and Declarations

I authorise any medical practitioner, or any other person(s) concerned with providing healthcare, to provide Klapton Cash Back Plan with any information that may be relevant to this Cash Back Plan Cover.
If submitting any information on behalf of another person covered by my policy, I also confirm that I am doing so with their knowledge and permission.
I declare the information shown on this form and any accompanying documentation is true and complete.

☑ **I hereby confirm that I have read and agree with the above statement**

I, the undersigned declare that all answers in this application form are complete and accurate. I understand completely that the answers provided are the basis for the provision of Insurance Cover. Furthermore, I declare that I do not have any supplementary information, in respect of this application, which could influence the outcome of your decision regarding my application request. My signature warrants that my application is submitted in all good faith.

☑ **I hereby confirm that I have read and agree with the above statement and it applies both to me and to any additional professional/practitioner and administrative employee included in this application.**

Premium Payment Information: I hereby confirm that I understand that after completing and submitting this application form, I must pay the required premium before any cover will become effective.

Submitted by: Date:

[Date Inserted automatically]

Submit this form

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Comments about the Scroll Dow Menus:
1. 30 dates commencing at the actual date of filling of the form.
2. Mr, Mrs, Ms, Dr, Prof,
3. Countries menu – can be changed in the back office.
4. Yourself, Wife/Husband, Child.
5. Silver, Gold, Platinum