

PUBLIC SERVICE FRIENDLY SOCIETY(PSFS) GROUP SPECIFIED ILLNESS COVER PLAN

Standard Application Form

Group Policy Number: 9929

Please complete this form fully using BLOCK CAPITALS. If any item is blank or illegible, this will cause a delay in processing your form.

Before you give us your personal information it is important that you know what your data protection rights are and how and why we use your personal information. This is set out in the Irish Life Data Privacy Notice which is always available on our website at www.irishlife.ie/privacy-notice or you can ask us for a copy.



Section 1: Personal Details

Use both first name and surname in your employee records.

Please provide mobile phone number and email address, both are needed in case we need to contact you regarding your application.

Litle	Mr	Mrs	Miss	Ms	Other	
First Name					Surnam	е
Staff Number						
Phone	Home					Mobile
Email Address						
Home Address						
Date of Birth				Ма	le	Femal

Section 2: Partner Details

Partner is defined as a spouse or civil partner or a person living in a spousal type relationship with the member for 12 months or more at the date application for cover is made.

Note: If you are including your partner, you must make them aware that you are providing Irish Life with their details. You must also inform them about the Irish Life Data Privacy Notice and where to find it.

Please complete the following details if you wish to cover your partner under the Plan.

Partner's First Name Partner's Surname

Partner's Date of Birth

To be completed by those who want their partner covered: I wish to include my partner for cover under the PSFS Group Specified Illness Cover (SIC) plan. This is referred to as Partner throughout the rest of this form. I understand that my partner, as stated above, is covered under the plan, unless I notify my employer of a change in circumstances.

Note: A person can become a member of the PSFS Group Specified Illness Cover (SIC) Plan either as a PSFS member or the partner of a PSFS member, but not both i.e. only one amount of Benefit will ever be paid to, or in respect of any given person under the PSFS Group SIC Plan, even if that person is both a PSFS member and also the partner of another PSFS member.

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Section 3: Cover Options

Please confirm your current benefit cover: Member Partner'

Benefit		Cost	Tick option
1A	€16,000 for member only	€3.96 per week	
1B	€16,000 for member and partner	€7.93 per week	
	Children (age 0 - 25) are automatically covered for €8,000	Free of charge	
2A	€9,600 for member only	€2.37 per week	
2B	€9,600 for member and partner	€4.75 per week	
	Children (age 0 - 25) are automatically covered for €5,000	Free of charge	
3A	€20,000 for member only	€4.95 per week	
3B	€20,000 for member and partner	€9.90 per week	
	Children (age 0 - 25) are automatically covered for €10,000	Free of charge	
4A	€25,000 for member only	€6.19 per week	
4B	€25,000 for member and partner	€12.38 per week	
	Children (age 0 - 25) are automatically covered for €10,000	Free of charge	

Warning: The current premium may increase after the next review of the scheme at 01/05/2024.

Section 4: Declaration - You must read this carefully before signing

Any words in the singular also mean the plural as applicable (e.g. 'I' means 'we' and 'my' means 'our' etc.)

Tick each statement

Plan Declaration

You must tick each statement to confirm you have read and understand the Declaration.

I understand and agree that my cover with Irish Life Assurance plc (Irish Life) will be based on the declarations on this form, my completed application form (online or otherwise), any supplementary questions answered, any statements made to Irish Life in writing or by telephone, and all terms and conditions given to me by Irish Life.

I confirm that I am eligible to join this plan as I have read and fully understand the corresponding booklet in relation to PSFS Group Specified Illness Cover plan including the sections on pre-existing conditions and the six month cancer moratorium. I also confirm that I understand the key features of the Plan and accordingly I now apply to join this Plan.

I understand that where I have a medical history, previous medical conditions or symptoms described in the pre-existing conditions clause, Irish Life will not pay a claim and I may encounter difficulty in obtaining cover elsewhere. I also understand that this is a reviewable scheme and the benefits and/or costs can change at the next review date.

I declare that all information, statements and answers I have provided, are true and complete, and answered honestly and with reasonable care.

I understand that Irish Life can use my personal information for any subsequent applications to Irish Life.

I confirm I have been informed about the Irish Life Data Privacy Notice and where to find it and where I am including my partner I have informed them about the Irish Life Data Privacy Notice and where to find it.

Please sign and date

Applicant's Signature

Date



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Section 5: Salary Deduction Mandate - Please Sign

Employer's Name

Employer's Address

Staff Number Date of Birth

I instruct my employer to deduct from my salary the appropriate premium under the Specified Illness scheme and pay to Irish Life Assurance. I recognise that these deductions, being made solely as a measure of convenience to me, may be terminated at any time. I also recognise that the ultimate responsibility for ensuring that the deductions have, in fact, been made from my salary rests with myself, and that, beyond making remittances direct to Irish Life Assurance plc in accordance with the arrangements approved, the employer accepts no responsibility of any kind in that matter. Once you have been accepted for cover, premiums will be taken at the next available payroll date.

Please sign and date

Applicant's Signature

Date

Please return the completed application form to: Lyons Financial Services. Office 1, Dunboyne Business Park, Dunboyne, Co Meath. Tel: 01 801 5808 Fax: 01 825 1183 Email: grouprisk@LFS.ie. Website: www.lyonsfinancial.ie