

Business name

Franchise type

Postal address

Weekly gross income for the franchise

(This is all of the money your franchise is expected to make, before any expenses are deducted)

Weekly franchise fees for the franchise

(This is your total franchise fees, including brand/IT levies)

PERSON 1 – FULL NAME

PERSON 2 – FULL NAME

Weekly personal income expected from working in the franchise

(This is the amount expected to be earned by each person individually, after expenses are deducted)

Weekly personal income expected from working in the franchise

(This is the amount expected to be earned by each person individually, after expenses are deducted)

Phone

Phone

Email

Email

Have you or anyone else intended to be covered by this insurance:

1. Been involved in any motor vehicle accident? ☐ Y ☐ N
2. Received any fine or infringement notice involving a vehicle? ☐ Y ☐ N
3. Been disqualified from driving? ☐ Y ☐ N
4. Been convicted for, charged with or committed any criminal offence? ☐ Y ☐ N
5. Had a drivers licence, cancelled, suspended or endorsed? ☐ Y ☐ N

6. Had any insurance refused or cancelled? ☐ Y ☐ N
7. Had any insurance claim declined? ☐ Y ☐ N

Also, please advise if:

8. The vehicle/s have any modifications? ☐ Y ☐ N
9. Your business employs any people other than those named above? ☐ Y ☐ N
10. A current Full New Zealand Drivers Licence is held by the main driver/s of the vehicle/s? ☐ Y ☐ N

If the answer to any of the questions is YES (except question 10 – if you answer NO), please provide all details (date, cost, description) below or on a separate sheet.

FranchiseBiz insurance includes cover for:

Public Liability \$2 million

Commercial Vehicle/s

Tools of Trade up to \$4,000

Franchise Fees

Statutory Liability

Roadside Assistance

Loss of Income

Would you like to:

- ☐ Increase Public Liability cover to \$5 million? ☐ Increase my Tools of Trade cover to: \$ _____ ☐ Yes please! Talk to me about personal insurances.
- ☐ Increase Public Liability cover to \$10 million? ☐ Add cover for tree-felling and/or arborist work?

Please tell us about your business vehicles (be sure to include any trailers or ride-on mowers)

My vehicle is a:

☐ Car/wagon/van/small truck ☐ Trailer ☐ Ride-on mower

Year

Make and model

Registration

Main driver

Market value (excl GST)

Date of birth

My vehicle is a:

☐ Car/wagon/van/small truck ☐ Trailer ☐ Ride-on mower

Year

Make and model

Registration

Main driver

Market value (excl GST)

Date of birth

DECLARATION AND SIGNATURE

Name

Date

Signature

SIGN HERE

We declare that: All answers and statements made in this proposal are correct and complete in every respect and that no information has been withheld which is likely to affect acceptance of this Proposal. If accepted by the Insurer, this Proposal and Declaration shall form the basis of and be incorporated into the Contract of Insurance now being applied for. I/We understand that the Broker and Insurer requires this information (which will be retained by the Broker) in order to decide whether to accept this Proposal. The Broker and Insurer are authorised to disclose information contained herein or pertaining to the Contract of Insurance to their business partners, advisers, insurers, reinsurers and to other insurers. I/We authorise the Broker or Insurer to obtain, from any other party, information that is, in the Broker or Insurer's view, relevant to this Proposal. I/We understand that the insurance will not be in force until this Proposal has been accepted and cover is confirmed by the Broker or Insurer.

Insurance Package – Health Questionnaire

Important! Please complete one questionnaire for each person working in the business

Person to be Insured	Height
Date of Birth	Weight
Doctor's Name	
Doctor's Address	

Details of Insured Person's Health

If insufficient space, please use separate sheet of paper and attach with application

Yes	No	1	Are you currently receiving any form of medical treatment? <i>If yes, please provide details and the period of the treatment</i>	
<input type="checkbox"/>	<input type="checkbox"/>			
Yes	No	2	Have you ever had any of the following:	
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Abnormal blood pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Hernia <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Paralysis	<input type="checkbox"/> Arthritis <input type="checkbox"/> Rheumatism <input type="checkbox"/> Any disorder of the back, spine, or heart <input type="checkbox"/> Any disorder or disease of the mental, nervous, genitourinary, coronary artery, respiratory, digestive systems
<i>If yes, please describe the nature and period of the illness, the name of the treating doctor and your results.</i>				
Yes	No	3	Are you on a waiting list for any surgery? <i>If yes, please provide details</i>	
<input type="checkbox"/>	<input type="checkbox"/>			
Yes	No	4	Have you ever had investigation for or received advice about any form of hepatitis B, C or D, human immune-deficiency virus (HIV) or acquired immune deficiency syndrome (AIDS)? <i>If yes, please provide details of the treating doctor and your results.</i>	
<input type="checkbox"/>	<input type="checkbox"/>			
Yes	No	5	Are there any reasons you would not consider yourself in good health? <i>If yes, please describe.</i>	
<input type="checkbox"/>	<input type="checkbox"/>			

DECLARATION AND SIGNATURE

Name	Date
Signature	

SIGN HERE

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