

OFFICE USE ONLY	Introducer	PFA/IFA	Date of Entry	Prop Input Signed	Prop Doc Produced	New Bus Doc CHKD
PROP NO:	MEMBER NO:	POLICY NUMBER:	NOMINATION NO:	NOMINEE NO:		

FUNERAL EXPENSES POLICY GUARANTEED ACCEPTANCE

RED ROSE ASSURANCE
Making Mutuality Meaningful

PERSONAL DETAILS

Please complete fully in block capitals
Life Proposed

NOMINEE DETAILS

In the event of my death, the proceeds of this Policy (Subject to a maximum of £25,000 under Current nomination rules) are to be paid to:

TITLE:	SURNAME:		TITLE:	SURNAME:	
FORNAMES:	D.O.B.:		FORENAMES:		
ADDRESS:			ADDRESS:		
ADDRESS:	POST CODE:		ADDRESS:		
MARITAL STATUS:	OCCUPATION:		POST CODE:	TEL NO:	
TEL NO:	AGE NEXT BIRTHDAY AT ENTRY:		SUM ASSURED	PREMIUM Calendar Monthly	

Should you wish to change your nominee at a later date, simply
Write to us with the new details.

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DO YOU SMOKE OR HAVE YOU SMOKED CIGARETTES IN THE PAST 12 MONTHS?
If you intend to smoke cigarettes in the future tick "YES" - If you only intend to smoke cigars or a pipe tick "NO"

YES NO

General Data Protection Regulation (GDPR) We take your privacy seriously and will only use your personal data to administer the policy and provide products and services you have requested from us. Full details of our GDPR policy and the Privacy Statement can be found on the website. You must sign our GDPR Document before we can process your application.

A COPY OF THE POLICY CONDITIONS AND OF THIS PROPOSAL WILL BE AVAILABLE ON REQUEST

I declare that to the best of my knowledge and belief the above statements are true and no material facts have been withheld. I agree that these statements shall form the basis of the proposed contract of Assurance between me and The Red Rose Friendly Society Limited and that I will be bound by the terms and conditions of the Policy and the rules of the Society from time to time in force. I apply for membership Of the Society, on behalf of myself.

SIGNATURE: DATE :

FOR OFFICE USE ONLY

I accept this proposal on behalf of the Society under the rules of table OB A (93) guaranteed acceptance

C.C.T./B.D.M: DATE:

