

Client Details

Full Name: _____ Date of Birth: _____

Address: _____ Postcode: _____

Existing Policy (to be replaced)

Provider: _____

Policy No: _____

Type: _____

Start Date: _____

Sum Assured: _____

Premium: _____

New Policy (Replacement)

Provider: _____

Policy No: _____

Type: _____

Start Date: _____

Sum Assured: _____

Premium: _____

Reason for Replacement

- Lower premium Increased sum assured Additional benefits (CI, etc.)
 Change in circumstances Policy no longer meets needs Better terms elsewhere

Other: _____

Important Considerations

- Do not cancel your existing policy until your new policy is fully in force
- New terms may apply based on your current health and lifestyle
- Premiums may be higher due to age or health changes
- There may be new exclusions or waiting periods on the new policy
- Any existing benefits or guarantees on your current policy may be lost

Client Declaration

I confirm that I have been advised of the potential disadvantages of replacing my existing policy, including: possible loss of existing benefits, new medical underwriting requirements, potential premium increases, and new exclusion periods. I understand that I should not cancel my existing policy until my new policy has been fully accepted and is in force. I confirm that I wish to proceed with the replacement of my existing policy as detailed above.

Adviser Name: _____

Signatures

Client Signature: _____ Adviser Signature: _____

Date: _____ Date: _____

Impact Financial Services Limited

Suite 15, Unit 4, Blenheim Court, Peppercorn Close, PE1 2DU | Email: office@impactfs.uk
FCA Number: 1025644 | Company No: 15712648