

Welcome to GreenGuard: the most competitive insurance package for Green Acres franchisees - guaranteed!

It is a bold statement, but it is one we stand by. "If you can provide us with a cheaper written quote for the full GreenGuard package from any insurance company, we will pay you double the difference in cash."

At Rothbury Insurance Brokers, we know insurance is about more than competitive rates - it is also about service.

We have been working alongside Green Acres since the 1990's to tailor an insurance package specifically for the needs of Green Acres franchisees

Here's what our Green Acres clients say...

"The Green Acres' package provides the best value insurance for franchisees - most of our 50 plus owner/operators are covered by it. Using a broker such as Rothbury's is also convenient when you are busy trying to run a business - and frankly, the price they offered couldn't be beaten."

"Having a Green Acres' package takes the hassle out of insurance. It's cost-effective and well-run. I know I can ring the team at Rothbury's and tell them to increase my cover or that I have changed my car and they will act on it quickly."

GreenGuard offers you a tailor-made insurance package which includes cover for:

- Commercial Vehicles
- Tools and equipment
- Public and statutory liability
- Personal disability (loss of income)

Some of the benefits of GreenGuard:

- Tailor-made covers, with special benefits and low excesses that you won't find on standard insurance policies
- Low Costs
- Convenient monthly payments
- Specialist customer service and claims management staff for Green Acres franchisees



ROTHBURY INSURANCE BROKERS

Business insurance can be complicated - let us make it easy for you!

Call our GreenGuard specialist today on

Ph: (AK) 09 526 8324
Ph: 0800 326 753
Fax: 09 579 9532

www.rothbury.co.nz

Green Acres Franchise Group.

Telephone 0800 803 200 • Facsimile 0800 803 201

Email admin@greenacres.co.nz • Website www.greenacres.co.nz



Green Acres Insurance Package - Quote Request

Full Name/s: _____
 Date of Birth: _____
 Height: _____ Weight: _____
 Occupation (Franchise): _____
 Franchise Number _____
 Physical Address: _____

 Postal Address: _____

 Home & Mobile Phone Number _____
 Cover to start from: _____

Vehicle Details:

Year _____	Year _____
Make & Model _____	Make & Model _____
Registration _____	Registration _____
*Value _____	*Value _____
Main Driver _____	Main Driver _____
Date of Birth _____	Date of Birth _____
Business Use? Y/N _____	Business Use? Y/N _____

*NB – Values for Business Use vehicles are to be exclusive of GST & rounded to the closest thousand, values for private use vehicle are to be inclusive of GST & round to the closest thousand

Covers included in package;

<input checked="" type="checkbox"/> Public Liability \$2,000,000	<input checked="" type="checkbox"/> Tools of Trade \$8,000
<input checked="" type="checkbox"/> Disability \$500 per week	<input checked="" type="checkbox"/> Motor Vehicle
Preferred payment method	<input type="checkbox"/> Annual <input type="checkbox"/> Monthly

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

- | | |
|--|----------|
| 1. Had any insurance refused or cancelled? | YES / NO |
| 2. Had any insurance claim declined? | YES / NO |
| 3. Been convicted for, charged with or committed any criminal offence? | YES / NO |
| 4. Had a drivers licence, cancelled, suspended or endorsed? | YES / NO |
| 5. Been disqualified from driving? | YES / NO |
| 6. Received any fine or infringement notice involving a vehicle? | YES / NO |
| 7. Been involved in any motor vehicle accident? | YES / NO |
| 8. Does the vehicle have any modifications? | YES / NO |
| 9. Do you hold a current Full New Zealand Drivers Licence | YES / NO |

If the answer to any of the above questions is YES (except question 9 – if you answer NO), please provide all details (date, cost, description...) below – if insufficient space below, please use a seperate sheet.

For the Loss of Income Insurance: please fully complete the Health Declaration over page, sign, date & return to Rothbury Insurance Brokers.

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Ph: (AK) 09 526 8324
Ph: 0800 326 753
Fax: 09 579 9532

DECLARATION AND SIGNATURE

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 Insurer requires this information (which will be retained by the Insurer) in order to decide whether to accept this Proposal. The insurer is authorised to disclose information contained herein to the Insurer's advisers, reinsurers and to other insurers. I/We authorise the Insurer to obtain, from any other party, information that is, in the 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 confirmed by the Insurer.

Signature _____

Date / / _____



Personal Disability questionnaire

Details of Insured Persons Health:

	Yes	No
1. Are you at present insured against accident or illness? If yes (a) give details of name of company and amount of insurance (lump sum & weekly benefit) (b) is this cover to remain in force?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever made a claim under any accident or illness policy? If yes, give details of name of company, date of claim, nature of disability and period of disability.	<input type="checkbox"/>	<input type="checkbox"/>
3. Has any company declined a proposal from you or cancelled or refused to renew or required specials terms to issue or renew any: (a) accident or illness policy? (b) other kind of policy? If yes to either, give details of name of company, reason & date	<input type="checkbox"/>	<input type="checkbox"/>
4. Has any insurance company rejected a claim made by you under any: (a) accident or illness policy? (b) other type of policy?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had any abnormal blood pressure, stroke, tuberculosis, hernia, varicose veins, diabetes, cancer, paralysis, arthritis, rheumatism, any disorder or disease of the mental, nervous, genito urinary, coronary artery, respiratory, digestive systems, back, spine or heart? If yes, give nature, date, period of disability, name of doctor and result.	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you during the last five years: (a) been referred to any hospital or clinic for treatment, surgery, specialist tests or investigations? (b) suffered from any illness lasting or requiring treatment for more than 14 days? (c) suffered from or had investigation for or received advice about any form of hepatitis B, C or D, human immuno-deficiency virus (HIV) or acquired immune deficiency syndrome (AIDS)? If yes, give nature, date, period of disability, name of doctor & result.	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you at present receiving any form of medical treatment? If yes, please give details and period of treatment.	<input type="checkbox"/>	<input type="checkbox"/>
8. Have any of your parents, brothers or sisters died or suffered from heart disease, stroke, high blood pressure, diabetes, kidney disease or cancer before the age of 60?	<input type="checkbox"/>	<input type="checkbox"/>
9. Are there any circumstances connected with your occupation or other activities which render you susceptible to accident or illness?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you anticipate making any flights in charter aircraft or private aircraft?	<input type="checkbox"/>	<input type="checkbox"/>
11. Are there any reasons that would cause you to consider yourself not presently in good health?	<input type="checkbox"/>	<input type="checkbox"/>
12. Has your weight varied more than 7kg in the last year?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you play any contact sports?	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>

Please give details of all questions where the answer is yes:

If insufficient space above, please give details on separate sheet of paper and attach to same.

15. Please supply name and address of your family doctor

Doctor's Name

Address



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Name

Signature

Date / /

