Personal Accident/Illness and/or Term Life Proposal Form

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expatriate GROUP

Before any question is answered, please read carefully the declaration at the end of this proposal, which must be signed and dated. Please ensure that the person to be insured answers all questions fully and correctly.

All material facts must be disclosed as failure to do so may nullify any policy or certificate issued. A material fact is one likely to influence the assessment and acceptance of the proposal by Underwriters. If you are in any doubt as to whether a fact is material it should be disclosed.

1. Details of the Proposer

a) Name and Address in full of the Proposer:
(if other than the person to be insured)

Postcode:

b) Relationship to the person to be insured:

c) Reason for affecting the Cover:

2. All the following questions relate to the person to be insured

Title: Mr/Mrs/Miss/Other (please specify)

First Name: Surname:

Address:

Postcode: Email:

Country:

Date of Birth: Day Month Year Place of Birth:

BMI Calculator:	Height		= H	H x H =		= H^2
	Weight		= W	W ÷ H^2 =		= Your BMI
Example:	Height	1 85	= H	H x H =	3.40	= H^2
	Weight	75.3	= W	W ÷ H^2 =	22	= Your BMI

3.

Nature of business or occupation in which you are engaged:
(if more than one, state all)

My occupation is mainly: (tick as appropriate) clerical ☐ clerical/light labour ☐ light labour ☐ manual labour ☐ heavy manual labour ☐

I am: (tick as appropriate) employed ☐ self employed ☐ retired ☐ other (please specify)

Annual Salary: Currency Gross Amount

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4.

Required commencement date: Day | Month | Year

Should anything about your health or other circumstances change before we have assumed risk for the Policy you have applied for, you must tell us immediately. We will then confirm whether any terms we have quoted will remain available. Failure to notify us of any such change may result in the Policy becoming void and the benefits not becoming payable.

5.

a) Personal Accident Cover

Death by Accident only — Currency _____ Sum Insured* _____

Permanent Total Disablement — Currency _____ Sum Insured* _____

Cover required for: (tick as appropriate) — Accident Only ☐ Accident & illness ☐

*maximum 10 times your gross annual salary

Temporary Total Disablement — Currency _____ Sum Insured** _____ per week

Cover required for: (tick as appropriate) — Accident Only ☐ Accident & illness ☐

Excess of: 30 ☐ 60 ☐ 90 ☐ 180 ☐ days Payable for: 52 ☐ 104 ☐ weeks

**maximum 75% of your gross weekly salary

b) Life Cover

Currency _____ Sum Insured _____ Term _____

c) Long Term Disability

Currency _____ Sum Insured* _____

*maximum 70% of your gross annual salary

Deferred period: (circle as appropriate) 13 weeks 26 weeks 52 weeks

If you have any questions about the level of cover, please call one of our advisors on +44 (0) 20 3551 6634.

6.

If you travel by air as a passenger in a licensed commercial aircraft, please state:

The number of annual flights _____

The anticipated destinations _____ _____ _____

_____ _____ _____

7.

Do you participate in any of the following activities? If YES, please give details:

Air Travel other than as described above	YES		NO		Details	
Winter Sports	YES		NO		Details	
Are competitions included?	YES		NO		Details	
Hazardous Pursuits (bungee, skydiving, jet skiing, etc)	YES		NO		Details	
Driving or riding in races or competitions	YES		NO		Details	
Riding Motorcycles or Motor Scooters	YES		NO		Details	State the vehicle's CC

8.

Are you in good health and currently free of injury and pursuing your normal occupation? (If "NO" please provide details on a separate sheet of paper)	YES		NO	

9.

Are you now insured against accident or illness?	YES		NO		Details	If so, with whom and for what benefits?
Have you at any time insured against accident or illness?	YES		NO		Details	If so, with whom?
What claims have you made in respect of accident or illness?						
Please state in each case the nature of the claim, amount and name of Company or Underwriter:						

10.

Have you ever been declined, deferred or accepted on special terms, for Life Insurance, Permanent Health Insurance or Insurance against accident or illness?	YES		NO	
If so, when and by whom?				

11.

Give the name and address of your usual GP and names and addresses of specialists seen for any accident or illness over the past 5 years:

12.

Heart Disease information (tick as appropriate)

a) Your BMI is greater than 25 (see Section 2a) ☐

b) You are a smoker or have smoked in the last 12 months ☐

c) You have a family history of heart attack/angina/stroke ☐

IF YOU HAVE TICKED TWO OR MORE OF QUESTION 12 AS APPLICABLE TO YOU, THEN PLEASE COMPLETE THE FOLLOWING WITH YOUR DOCTOR:

12. (continued)

LDL cholesterol level:	mg/dl	HDL cholesterol level:	mg/dl
Fasting triglyceride level:	mg/dl	Systolic blood pressure:	mm/Hg
Doctor's Signature:		Date:	
Doctor's Official Stamp:			

Important Notes

- Please note that your answers to the questions on this form will be used to assess this Proposal. All material facts must be disclosed since part or all of the benefit might be forfeited if relevant information were to be withheld. A material fact is one that is likely to influence the assessment and acceptance of the Proposal. If you are unsure whether a particular fact is material you should disclose it. You must not assume that we shall be asking your doctor for confirmation of what you have told us.
- Cover will not start until we have assessed and accepted your application. If you have a birthday while your application is being processed, the terms may differ from those originally quoted.
- In most instances your payments will be as originally quoted. Revised terms may be offered to you, but occasionally we may be unable to offer any terms.
- We may ask you to contact your doctor to speed up the completion of reports that we have requested.
- If we ask you to attend a medical examination, it will be necessary for us to share the application information with another company authorized by us. They will make the arrangements for the examination to take place.
- It may be necessary to send your application and relevant medical reports to Underwriters Reassurers for their opinion or agreement of the terms offered, or to other Underwriters they are to participate in cover. You can obtain details of general reassurance principles from Underwriters, together with details of any company or Lloyd's Syndicate to whom this information may be sent.
- On occasion the faxing of medical reports may help to ensure a speedier assessment of your application. We only accept faxed information direct to a fax machine in a secure part of our building. This ensures that we maintain strict confidentiality. If you do not agree to allow the faxing of information, please indicate by deleting the appropriate section of the Declaration.
- Underwriters have a Confidentiality Policy in place which means that your medical information is held securely and access is limited to authorized individuals who need to see it.
- You are entitled to ask for a copy of Underwriters standard plan terms and conditions and a copy of your application form at any time.

Access to Medical Records

It may be necessary for us to obtain medical reports to support your application. Before we can ask any doctor that you have consulted to complete a report, we need your permission under the Access to Medical Reports Act 1988. Your rights under the Act are as follows:

- You do not have to give your consent, but if you do not we may be unable to proceed. This does not stop you from applying to other companies for insurance.
- You can ask to see the report before the doctor returns it to us. If you do, we shall tell the doctor to retain the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.
- If you choose not to see the report at this stage, you may ask the doctor for a copy within 6 months of it being sent to us. A duplicate report can be sent to your doctor on request should you wish to see it at a later date.
- If you consider any aspect of the report to be incorrect or misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him/her to attach a statement outlining your views, which will then accompany the report.
- Your doctor can withhold access to the report if he/she feels that it would cause physical or mental harm to you or others.
- Your medical report will contain details of relevant consultations, treatment, operations, investigations and test results that you have undergone at any surgery, hospital or clinic. Your consent will give Kiln access to this information.
- If you have any questions regarding your rights under the Act or any questions relating to the process of obtaining, assessing or storing medical information, please write to Strategic Insurance Services Ltd, Third Floor, 36-38 Botolph Lane, London EC3R 8DE and we will obtain information from Underwriters.
- I/We do not* wish to see the report before it is sent to Underwriters. (*Only delete the word "not" if you wish to see the report before it is sent.)

Genetic Testing Guidelines

In accordance with the Association of British Insurers' policy on Genetics and Insurance, you do not need to tell us about any genetic test result you have had if this application for insurance taken together with any other insurance policies you already have for this type of insurance totals:

£500,000 or less for life insurance

£300,000 or less for critical illness, income protection or long-term care insurance

Above these limits you may need to tell us about certain genetic test results when applying for insurance. We will only be interested in genetic test results where the Government's Genetic and Insurance Committee (GAIC) has approved them for Insurers' use.

If you think this may apply to you, please ask us for details of the current position. These details are also available from the ABI website at www.abi.org.uk.

Declaration

Please sign this Declaration once you have read it together with the Important Notes. If you are unsure as to whether any information should be given, you should provide it. If you are applying for insurance with other companies at the same time, by signing the Declaration you are consenting to copies of medical reports being sent to these other companies at their request. However, if we are approached by another company to provide copies of highly sensitive information we shall ask for your specific written permission before doing so.

- I will inform you immediately of any changes that occur before the plan starts. I understand that failure to do so may result in the contract being declared void, and that a claim for the proceeds may not be paid.
- To the best of my knowledge and belief all the statements made, which includes anything I may have said, have been recorded accurately in this application or are attached in a sealed Private and Confidential envelope, and are true and complete. This disclosure will form the basis of the contract.

☐ Please tick if you have attached a Private and Confidential envelope.

- I agree to Underwriters obtaining medical information from any doctor whom I have consulted about my physical or mental health, in order to assess my/our proposal. You may obtain relevant information from other insurers about previous or concurrent applications for life, critical illness, sickness, disability, accident or private medical insurance that I have applied for. I authorize those asked for such information to provide it on the production of a copy of this consent. This consent allows underwriters to obtain medical reports at any time during the life of the cover or after my death to support any claim made on the cover proceeds.
- This information can also be used to maintain management information for business analysis.
- I agree that a copy of the agreement given in this declaration will have the validity of the original.
- I agree to Underwriters accepting medical reports faxed directly to the company from my doctor's surgery.
- I also do not* object to copies of the report being faxed to any other company that I have applied to at their request. (*Delete the word "not" if you do not wish us to fax information.)

By signing this declaration I am are allowing Underwriters to process my application using the information that I have provided. This information can also be used to process any claim made on this policy.

I/We have read the Declaration, Important Notes and information relating to my rights under the Access to Medical Reports Act 1988.

Signature: _____ Date: Day Month Year

The following declaration is to be completed in all instances where someone is effecting this insurance on behalf of the person to be insured.

I hereby warrant that to the best of my understanding and belief all the answers and statements herein contained are full, complete and true and have been correctly recorded and I do not know of any other material fact which is likely to influence the decision of the Underwriters in their assessment and acceptance of this risk and that I am willing to accept a Policy, subject to the terms and conditions of such Policy, to be insured on the basis of and in consideration of the proposal, which I understand shall be attached to and constitute a part of the contract of insurance.

I confirm that I have sought the permission of the person to be insured to share the information herein (and any additional information that may be supplied) and that they are aware of the provisions of 1) above which I sign on their behalf and for which I take full responsibility.

Signature: _____ Date: Day Month Year

Medical Questionnaire

Statement made by the person to be insured. Full details; including dates, duration, physicians or surgeons consulted. Use a separate page where necessary and note as such.

1. Have you ever suffered from or had symptoms of:

a)	Chest Pain, raised blood pressure or any other affection of the heart or circulatory system?	YES		NO		Details
b)	Rheumatism, rheumatic fever, gout or arthritis?	YES		NO		Details
c)	Asthma, bronchitis, pneumonia, pleurisy or any other disease of the lung or throat?	YES		NO		Details
d)	Glandular trouble, thyroid, cysts, swellings or tumours?	YES		NO		Details
e)	Any affection of the stomach, liver or bowel, including persistent or recurrent indigestion, gastric or duodenal ulcer, colitis or gallstones?	YES		NO		Details
f)	Diabetes or any affection of the kidneys, bladder or prostrate, or any urinary or venereal disease?	YES		NO		Details
g)	Depression, breakdown, epilepsy, fits or any mental or nervous disorder?	YES		NO		Details
h)	Ear discharge, deafness or any nose or eye trouble?	YES		NO		Details
i)	Any illness, operation or injury not previously mentioned?	YES		NO		Details

2. Injuries - have you ever suffered an injury to:

a)	Head	YES		NO		Details
b)	Neck	YES		NO		Details
c)	Back or Spinal Column	YES		NO		Details
d)	Shoulders	YES		NO		Details
e)	Elbows	YES		NO		Details
f)	Hands, Wrists or Arms	YES		NO		Details
g)	Chest	YES		NO		Details
h)	Hips	YES		NO		Details
i)	Left Leg or Left Knee	YES		NO		Details
j)	Right Leg or Right Knee	YES		NO		Details
k)	Ankle or Foot, Left	YES		NO		Details
l)	Ankle or Foot, Right	YES		NO		Details

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3.

Have you any physical defect or infirmity? YES ☐ NO ☐ Details

4.

Have you ever had an AIDS blood test or counselling/medical advice in connection with AIDS or sexually transmitted diseases? YES ☐ NO ☐ Details

5.

Are you taking any drugs or medicines at present? If so, state type and dosage. YES ☐ NO ☐ Details

6.

What is your weekly consumption of alcohol? Details

7.

What is your weekly consumption of tobacco? Details

8.

Have you ever attended any hospital, clinic or doctor for any reason not disclosed? If so, when, where and for what reasons? YES ☐ NO ☐ Details

9. Family History

	State of health if living	Age	Cause of death if no longer living	Age at death
Father				
Mother				
Brothers				
Sisters				
Children				

10. **Females only**

a) How many children do you have?

b) Are you now pregnant? YES NO

I declare that the above answers are true and complete to the best of my knowledge and belief and that they shall form part of the proposal for insurance now being made to Underwriters.

Signature: Date: Day Month Year

Nomination of Beneficiary

You may use this section to nominate a beneficiary to receive the death benefits (Term Life or Accidental Death covers).

Subject to any future revocation or appointment, I hereby appoint the following person or persons as Beneficiary in the share indicated below.

1. Full name and address of the Beneficiary — Share of Benefit (%)
2. Full name and address of the Beneficiary — Share of Benefit (%)
3. Full name and address of the Beneficiary — Share of Benefit (%)
4. Full name and address of the Beneficiary — Share of Benefit (%)
5. Full name and address of the Beneficiary — Share of Benefit (%)

Signature: Date: Day Month Year

Post: Third Floor, 36-38 Botolph Lane, London, EC3R 8DE, UK.

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