



RISK  
ASSURANCE  
MANAGEMENT

# Group Life Assurance

Discretionary Entrant Form





**Scheme Name:** .....

**Policy Number:** .....

**Employee Name:** .....

**Employee Date of Birth:** .....

**Date First eligible to Join scheme:** .....

**Date of Joining Scheme:** .....

**Scheme Salary:** .....

**Scheme Benefit:** .....

**To Be Completed by the Employer:**

I confirm that .....was Actively at work on  
..... (Date of Joining Scheme)

Actively at work means that at the intended date on which cover commences, the individual must be at work and be mentally and physically able to carry out their normal occupation for their normal contracted number of hours at their usual place of work and has not received medical advice to refrain from working.

**Signed:** ..... **Date:** .....

**Full Name:** .....  
(Print in BLOCK CAPITALS)

**Position in Company:** .....



**To be completed by the Employee:**

**Statement of Health:**

I am not suffering from any medical condition. I am not currently awaiting referral to a medical practitioner or specialist/consultant and I am not awaiting the results of any tests or medical investigation.

I confirm that I have not had more than 10 working days absence through illness and/or injury during the last 12 months.

I confirm I have not had any application for Life Insurance declined, postponed or subject to an increased premium or other special terms.

*(If you are unable to confirm any of the above, a full Personal Declaration form will be required. If you are in any doubt, please declare details in the space provided)*

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**Important Notes**

- Please note that information you provide on this form will be used to assess the risk involved in providing you with the proposed level of cover. If you are unsure whether a particular fact is important you should disclose it.
- Cover will not start until we have assessed and accepted the information you have provided on this form.
- It may be necessary for us to send your form and relevant medical reports to the participating Lloyd’s Underwriters or their reinsurers for their opinion or agreement of terms offered.



- Risk assurance Management Limited has a confidentiality practice in place which means that your medical information is held securely and access is limited to authorised individuals who need to see it.
- You must inform us of any changes in your health or other circumstances during the period between this form being completed and in us notifying the terms on which cover will be offered.

### **Statement Practice on Genetics**

In accordance with the Association of British Insurer's (ABI) policy on genetics and insurance, you do not need to tell us about any genetic test you have had if the proposed level of cover, taken with any other insurance cover you already have, totals £500,000 or less for life assurance.

Above these limits you may need to tell us about certain genetic test results when applying for certain types of insurance. We will only be interested in genetic test results which have been approved by the Government's Genetic and Insurance Committee for Insurers' use.

If you think this may apply to you, please ask for details of the current position. These details are also available from the ABI website: [www.abi.org.uk](http://www.abi.org.uk) under 'Insurance & Savings/Topics and issues/Genetics'.

You must tell us if you have a family history of, are experiencing symptoms of or are having treatment for a medical condition including any genetically inherited condition.

### **Data Protection act 1998**

I understand and consent to the use of any information provided by me for the operation of this insurance. This includes the process of underwriting, administration, claims management, rehabilitation and handling customer concerns.

I understand that in order to do this the information may be shared with other insurers, reinsurers, insurance intermediaries and service providers who are involved in either the operation of insurance which covers employees or the employee benefit arrangements provided by the company.

I understand the data will be processed fairly and securely in accordance with the Data Protection Act 1998 and the details will be stored on computer but will not be kept for longer than necessary.

I confirm that the data in relation to this insurance has been obtained and passed to Risk Assurance Management Limited in accordance with the requirements of the Data Protection Act 1998 and confirm that I give my consent to forward such information to the insurer.



**Personal Declaration:**

I hereby acknowledge and accept that if any of the statements made by me in this form are untrue or deliberately misleading, any payment of benefit may be declined.

I agree that a copy of this signed Declaration will be legally valid.

I understand that this form will be passed to or used by member companies of Risk Assurance Management Limited for the purpose of my insurance. This includes underwriting, processing, claims handling and fraud prevention, which could include passing details to agents of Risk Assurance Management Limited or other insurers. You may ask other insurers for information to check the information I have provided.

**Signed:** ..... **Date:** .....

**Full Name:**

.....

(Print in BLOCK CAPITALS)

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Coverholder at 

