RISK ASSURANCE MANAGEMENT

Group Life Assurance

Personal Declaration Form

Please Return to:
Risk Assurance Management Limited
Chancery House
Leas Road
Guildford
Surrey
GU1 4QW

PERSONAL DECLARATION/EVIDENCE OF HEALTH

QUESTIONS TO BE ANSWERED BY THE PERSON WHOSE LIFE IS PROPOSED TO BE INSURED

Before any question is answered, please read carefully the Declaration at the end of this form, which must be signed and dated. Please ensure that all answers are complete and correct. Any question left unanswered or only answered with a dash will delay the assessment of this Proposal for assurance.

If you require additional space for any answers please use the further information section at the end of this form.

Section 1: Details of the person to be Assured

Title		Surname	
Forename(s)			
Address			
		Postcode	
Contact telephone number		Mobile number	
Email address		Date of Birth	
Sex (M,F)		Marital Status (married/single/divorced/ separated/widowed/in civil partnership)	
Nationality		Normal Country of Residence	

Section 2: G.P. details

Name of doctor who currently holds your medical records	
Address and telephone number of doctor	
Name, address and telephone number of your previous doctor if you have changed doctors within the last 3 months	

Section 3: Occupation

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

		Yes	No	If yes, please give full details
Do your duties involve you in any way (other than clerical) with:	1) the licenced trade or entertainment industry?	☐	☐	
	2) working at heights, offshore, aviation (other than on scheduled flights), diving, or the fishing or mining industries, work requiring special safety precautions or any other activity which may be regarded as hazardous?	☐	☐	
Does your job require a licence, e.g., driving?		☐	☐	

Section 4: Smoking and alcohol details

	Yes	No	If yes, please state average consumption per week
Have you smoked or used any form of tobacco or nicotine product within the last 12 months?	☐	☐	
Do you drink alcohol? (if yes, please state your average weekly consumption in units (one unit is a pub measure of wine or spirits or a half a pint of beer, lager or cider).	☐	☐	

	Yes	No	If yes, please state average consumption per week
Have you ever been advised to reduce your smoking or alcohol consumption for medical reasons (if yes please provide further details).	☐	☐	

Section 5: Personal medical details

Height		Weight	

	Yes	No	If yes please provide details, including name of doctor or hospital, dates, duration, test results etc.
1) Has your weight changed recently?	☐	☐	
2) Have you consulted any doctor, hospital or clinic within the last 5 years?	☐	☐	
3) Are you currently receiving any medical treatment?	☐	☐	
4) Are you taking any medicine or drugs, whether or not prescribed by a medical practitioner?	☐	☐	
5) Are you due to have any check-up in the next 12 months in connection with any medical condition, or are you waiting for the results of any medical inspection?	☐	☐	
6) Have you ever suffered from: a) any chest or lung disorder?	☐	☐	
b) anxiety, stress, depression or other mental or nervous disorder (including referral to psychiatrist or other specialist)?	☐	☐	

	Yes	No	If yes please provide details, including name of doctor or hospital, dates, duration, test results etc.
c) back problems, arthritis, bone joint, rheumatism, gout, muscle or limb conditions?	☐	☐	
d) asthma bronchitis or other respiratory disorders?	☐	☐	
e) any stomach, bowel complaint, liver disorder (including hepatitis, bladder disease, gastric or duodenal, Colitis or Crohn's disease)?	☐	☐	
f) diabetes, kidney or bladder disorder including blood and/or protein in the urine, prostate and gland disorders?	☐	☐	
g) heart attack, angina or heart disease?	☐	☐	
h) high blood pressure, raised cholesterol, stroke, circulatory problems, brain haemorrhage or permanent brain injury?	☐	☐	
i) cancer, tumour, Hodgkins disease, Non-Hodgkins lymphoma, lymphoma or leukaemia?	☐	☐	
j) Multiple sclerosis, Parkinson's disease, paralysis, epilepsy, Alzheimer's disease, dementia or cerebral palsy?	☐	☐	

	Yes	No	If yes please provide details, including name of doctor or hospital, dates, duration, test results etc.
k) eye, ear nose or throat conditions, skin or allergic conditions?	☐	☐	
l) any operation, X-rays or special investigations?	☐	☐	
m) blood disorder or anaemia?	☐	☐	
n) a lump or growth of any kind?	☐	☐	
o) any gynaecological disorder including abnormal cervical smears or breast conditions which have needed referral to a doctor or specialist?	☐	☐	
7) Have you had any numbness, dizziness or any disease or disorder affecting your balance or your eyes or vision (not corrected by spectacles or lenses)?	☐	☐	
8) Do you anticipate travel outside your normal country of residence, Western Europe, North America or Australasia (other than for holiday)?	☐	☐	

		Yes	No	If yes please provide details, including name of doctor or hospital, dates, duration, test results etc.
9)	Within the last 10 years, have you lived for longer than 1 month in any country outside your normal country of residence, Western Europe, North America or Australasia?	☐	☐	
10)	Do you engage in hazardous sports, such as aviation, motor sports, diving, etc.?	☐	☐	
11)	Have either of your parents or any brothers or sisters died from or suffered from heart disease, stroke, diabetes, cancer, a nervous disorder or any hereditary disease or disorder before the age of 65? (If cancer please specify the type).	☐	☐	*If yes please provide details including relationship and age at time, and state if death resulted.*
12)	Has any application for assurance on your life been declined, withdrawn by yourself or accepted at special terms?	☐	☐	*If yes please give details of companies and dates.*
13)	Have you ever tested positive for HIV/AIDS, hepatitis B or C or are you awaiting the results of such a test?	☐	☐	*If yes please give details including dates - for confidentiality these may be sent direct to the Chief Medical Officer.*

		Yes	No	If yes please provide details, including name of doctor or hospital, dates, duration, test results etc.
14)	Within the last 5 years have you been exposed to the risk of HIV infection*? (Note: this can be caught through unsafe sex, intravenous (IV) drug abuse, blood transfusions or surgery undertaken outside the EU.)*	☐	☐	*If yes please give details including dates - for confidentiality these may be sent direct to the Chief Medical Officer.*
15)	Within the last 5 years have you tested positive or been treated for any sexually transmitted disease?	☐	☐	*If yes please give details including dates - for confidentiality these may be sent direct to the Chief Medical Officer.*
16)	Are you using or have you ever used drugs other than those prescribed by a doctor or obtained over the counter from a pharmacy? i.e. recreational drugs such as ecstasy, cocaine, heroin, etc.	☐	☐	
17)	Have you ever claimed a benefit under any income protection policy, critical illness policy or an accident or sickness policy?	☐	☐	

Section 6: Additional Information

Question:	Additional Information

SECTION 6: IMPORTANT NOTES

- Please note that your answers to the questions 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 your answers given in this form.
- We may contact you directly if we have any questions or require further information in respect of any answers provided or in respect of any other medical information received.
- 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 your medical information with another company authorized by us. They will make the arrangements for the examination to take place.
- It may be necessary for us to send your form and relevant medical reports to the underwriter or their Reassurers for their opinion or agreement of the terms offered.
- On occasion, the emailing of medical reports may help to ensure a speedier turnaround of your medical assessment. If you do not agree to the emailing of your information and you would prefer us to post any correspondence instead, please indicate by deleting the appropriate section of this form.
- Risk Assurance Management has 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 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.

DATA PROTECTION:

I understand that the use of any information provided by me for the operation of this insurance is for the process of underwriting, administration, claims management, handling customer concerns and the detection, prevention and investigation of fraud.

I understand that in order to do this the information may be shared with the underwriter (The Shepherds Friendly Society Limited), reinsurers, insurance intermediaries and service providers who are involved in either the operation of insurance which covers employees or the employee's benefits arrangements provided by the Company in accordance with their Data Privacy Notice shown on their website: www.ram-ltd.co.uk/privacy and the underwriter's Privacy Notice: www.shepherdsfriendly.co.uk/privacy-policy.

I understand the data will be processed fairly and securely and the details will be stored in line with UK Data Protection Law and will not be kept longer than necessary.

I understand that the data I have provided in relation to this insurance will be processed in accordance with the requirements of the General Data Protection Regulation.

STATEMENT OF 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 together 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 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 us for details of the current position. These details are also available from the ABI website www.abi.org.uk.

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

SECTION 7: ACCESS TO MEDICAL REPORTS

It may be necessary for us to obtain medical reports to support your application for cover. 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 them to attach a statement outlining your views, which will then accompany the report.
- Your doctor can withhold access to the report if they feel 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 Risk Assurance Management Limited 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 the Compliance Officer at our Head Office.

I wish to see the report before it is sent to Risk Assurance Management. ☐ Please tick if appropriate.

SECTION 8: DECLARATION

Please sign this Personal Declaration once you have read it together with all of the sections. 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 form 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 Risk Assurance Management Limited notify the terms on which cover will be offered. I understand that failure to do so may result in the loss or cancellation of the cover being assessed.

- 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 form or are attached in a sealed Private and Confidential envelope, and are true and complete.

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

- I agree to Risk Assurance Management Limited obtaining medical information from any doctor whom I/we have consulted about my/our physical or mental health, in order to assess my application. 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/we have applied for. I authorise those asked for such information to provide it on the production of a copy of this consent. This consent allows Risk Assurance Management Limited to obtain medical reports at any time during the period of the cover or after my death to support any claim made on the cover proceeds.

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

- I agree to Risk Assurance Management Limited accepting and sending medical reports and/or any other potentially sensitive personal information via email. I do not object to copies of my medical information being emailed to any other company that I have applied to, at their request.

  ☐ Please tick if you do not wish us to use email to send/receive your information.

By signing this form, I am allowing Risk Assurance Management Limited to carry out my risk assessment using the information that I have provided. This information can also be used to process any claim made in respect of me on this policy.

I confirm I have read and understood the information in this form including the section relating to:

- Data Protection
- Statement of Practice on Genetics
- Access to Medical Reports Act 1988
- Declaration

I understand that Risk Assurance Management Limited may ask other insurers for information to check the information I have given.

LIFE TO BE ASSURED:

Signature:		**Date:**	
Full Name: (Block Capitals)			

The Group Life Assurance is administered by Risk Assurance Management Limited and underwritten by The Shepherds Friendly Society Limited.



Risk Assurance Management Limited. Policies underwritten by The Shepherds Friendly Society Limited (FRN 109997)

Risk Assurance Management Limited is authorised and regulated by the Financial Conduct Authority (FRN 306891)

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Managing General Agents' Association

GRID Group Risk Development