

## Supplementary Insurance Scheme

Please refer to the scheme summary for full details of the cover available under the scheme.  
Cover is only available to members of an existing Group Insurance Scheme.  
A separate application form needs to be completed if you wish to take out cover for your spouse or partner.  
All applications will be subject to medical underwriting.  
Cover is payable by direct debit and will only commence following acceptance from the underwriters.  
Life Cover is available to age 70. Critical Illness Cover is available to age 65.

**Please Note:** Our Privacy Notice can be viewed on our website at [www.philipwilliams.co.uk](http://www.philipwilliams.co.uk)  
A hard copy can be provided upon request.

### 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.

Please tick this box to confirm that you are eligible for this scheme and have read the above terms

☐

#### Section 1: Details of the person to be covered:

Serving Officer

☐

Police Staff

☐

Partner of  
Serving Officer

☐

Partner of  
Police Staff

☐

Police Force: \_\_\_\_\_

Employer name (If different): \_\_\_\_\_

|                                |  |            |  |                                       |           |  |  |
|--------------------------------|--|------------|--|---------------------------------------|-----------|--|--|
| Serving Members Name           |  |            |  | Serving Members Collar/Payroll Number |           |  |  |
| Serving Members Date of Birth  |  |            |  | Serving Members Email                 |           |  |  |
| <b>Applicant Details: -</b>    |  |            |  |                                       |           |  |  |
| Title (Mr., Mrs., Miss, other) |  | Surname    |  |                                       | Forenames |  |  |
| Address                        |  |            |  |                                       |           |  |  |
|                                |  |            |  |                                       |           |  |  |
| Postcode                       |  |            |  | Contact telephone number              |           |  |  |
| Email                          |  |            |  | Date Member joined Force              |           |  |  |
| Date of birth                  |  | Sex (M, F) |  | Marital status                        |           |  |  |
| Nationality                    |  |            |  | Normal Country of Residence           |           |  |  |

**Top Up Cover Required: – (tick options required)**

|                                                                    |                                                                                                                                                                 |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Additional Life Cover Required – Serving member</b>             | <input type="checkbox"/> £50,000 (£5.00 per month)<br><input type="checkbox"/> £75,000 (£6.75 per month)<br><input type="checkbox"/> £100,000 (£8.00 per month) |
| <b>Additional Critical Illness Cover Required – Serving member</b> | <input type="checkbox"/> £25,000 (£9.00 per month)<br><input type="checkbox"/> £50,000 (£15.00 per month)                                                       |
| <b>Additional Life Cover Required – Partner</b>                    | <input type="checkbox"/> £50,000 (£5.00 per month)<br><input type="checkbox"/> £75,000 (£6.75 per month)<br><input type="checkbox"/> £100,000 (£8.00 per month) |
| <b>Additional Critical Illness Cover Required – Partner</b>        | <input type="checkbox"/> £25,000 (£9.00 per month)<br><input type="checkbox"/> £50,000 (£15.00 per month)                                                       |

**The covered critical illness are (subject to policy terms & conditions):-**

• Alzheimer's Disease • Aorta Surgery • Bacterial Meningitis • Benign Brain Tumour • Cancer • CJD • Coma • Coronary Artery (By-Pass) Surgery • Heart Attack • Heart Valve Replacement/Repair • H.I.V. and Hepatitis B Virus (Contracted in a documented duty related situation) • Total Loss of Hearing • Total Loss of Sight • Total Loss of Speech • Total Loss of Hands or Feet • Major Organ Transplant • Motor Neurone Disease • Multiple Sclerosis • Parkinson's Disease • Paralysis • Irreversible Renal Failure • Severe Burns • Stroke • Traumatic Head Injury

**Beneficiary Nomination Details: (continue on separate sheet if required)**

As a member of the Federation Group Insurance Life scheme, please provide details of the person(s) that you wish to receive the money in the event of your death. Scheme trustees are not bound to follow the nomination, but will consider it. It is your responsibility to ensure that in the event of your circumstances or wishes changing you keep the information up to date.

| Name | Date of Birth | Relationship to member | Percentage of Benefit |
|------|---------------|------------------------|-----------------------|
|      | / /           |                        |                       |
|      | / /           |                        |                       |
|      | / /           |                        |                       |

**Section 2: G.P. details**

|                                                                                                                                   |  |
|-----------------------------------------------------------------------------------------------------------------------------------|--|
| Name of doctor who currently holds your medical records                                                                           |  |
| Address and telephone number                                                                                                      |  |
| If you have changed doctors within the last 3 months, please give the name, address and telephone number of your previous doctor. |  |

### Section 3: Occupation

|                                                                                                                                                                                                                               |     |    |                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|----------------------------------|
| Employer's name:                                                                                                                                                                                                              |     |    |                                  |
| Nature of business or occupation in which you are engaged (if more than one, please state all):                                                                                                                               |     |    |                                  |
| Do your duties involve you in any way (other than clerical) with:                                                                                                                                                             | Yes | No | If yes, please give full details |
| 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?<br>(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) |     |    |                                                   |

## 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?                                                                                              |     |    |                                                                                                         |  |
| (c) back problems, arthritis, bone joint, muscle or limb conditions?                                                                                              |     |    |                                                                                                         |  |
| (d) asthma bronchitis or other respiratory disorders?                                                                                                             |     |    |                                                                                                         |  |
| (e) any stomach, bowel complaint, liver disorder(including bladder disease, gastric or duodenal, Colitis or Crohn's disease)                                      |     |    |                                                                                                         |  |
| (f) diabetes, gout, kidney, liver, prostate or bladder problem?                                                                                                   |     |    |                                                                                                         |  |
| (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 or gout?                                                                                                                                       |     |    |                                                                                                         |  |

|                                                                                                                                                                                                                      | Yes | No | If yes please provide details, including name of doctor or hospital, dates, duration, test results etc.                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|--------------------------------------------------------------------------------------------------------------------------------|
| (j) Multiple sclerosis, Parkinson's disease, paralysis, epilepsy, Alzheimer's disease, dementia or cerebral palsy?                                                                                                   |     |    |                                                                                                                                |
| (k) eye, ear nose or throat conditions, skin or allergic conditions?                                                                                                                                                 |     |    |                                                                                                                                |
| (l) any operation, X-rays or special investigations?                                                                                                                                                                 |     |    |                                                                                                                                |
| 7) Have you had any numbness, dizziness or any disease or disorder affecting your balance or your eyes or vision (not corrected by spectacle or lenses)?                                                             |     |    |                                                                                                                                |
| 8) Do you anticipate travel outside your normal country of residence, Western Europe, North America or Australasia? (other than for holiday)                                                                         |     |    |                                                                                                                                |
| 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?        |     |    | <i>If yes please provide details including relationship and age at time, and state if death resulted.</i>                      |
| 12) Has any application for assurance on your life been postponed, declined, withdrawn by yourself or accepted at special terms?                                                                                     |     |    | <i>If yes please give details of companies and dates.</i>                                                                      |
| 13) Have you ever tested positive for HIV/AIDS, hepatitis B or C or are you awaiting the results of such a test?                                                                                                     |     |    | <i>If yes please give details including dates - for confidentiality these may be sent direct to the Chief Medical Officer.</i> |
| 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.) |     |    | <i>If yes please give details including dates - for confidentiality these may be sent direct to the Chief Medical Officer.</i> |
| 15) Within the last 5 years have you tested positive or been treated for any sexual transmitted disease?                                                                                                             |     |    | <i>If yes please give details including dates - for confidentiality these may be sent direct to the Chief Medical Officer.</i> |
| 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.                   |     |    |                                                                                                                                |

## Section 6: Additional Information

| Question: | Additional Information |
|-----------|------------------------|
|           |                        |
|           |                        |
|           |                        |
|           |                        |

## SECTION 7: 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 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 application information with another company authorised by us. They will make the arrangements for the examination to take place.
- ☐ On occasion the faxing of medical reports may help to ensure a speedier assessment of your medical assessment. 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 in this form.
- ☐ All insurers have 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.

### DATA PROTECTION ACT 1998:

I understand and consent to the use of any information provided by us 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, re-insurers, insurance intermediaries and service and service providers who are involved in either the operation of insurance which covers employees or the employee benefits 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 data in relation to this insurance has been obtained and passed to insurers in accordance with the requirements of the Data Protection Act 1998.

### 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, total:

- £500,000 or less for life assurance.
- £300,000 or less for critical illness or income protection.

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 us for details of the current position. These details are also available from the ABI website at [www.abi.org.uk](http://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 8: 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.
  - ☐ 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 the insurers 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 do not\* wish to see the report before it is sent to the insurers. (\*Only delete the word “not” if you wish to see the report before it is sent.)

## SECTION 9: 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 I am notified of 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 the insurers obtaining medical information from any doctor whom I have consulted about my 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 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 the insurers 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.
- ☐ 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 the insurers 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 form I am allowing the insurers 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 that I have read the summary of cover and am aware of the cover afforded under this scheme.
- I consent to the information on this form being stored / processed electronically.
- I understand that if my payments stop, all cover under the scheme will cease.
- I will be notified when cover and payments will start and am aware that there is no cover prior to this date.
- I confirm that if I am applying for cover for my partner that the person meets the following criteria;
  - \* You are co-habiting
  - \* They are financially interdependent
- I understand that it is my responsibility that in the event of my circumstances or wishes changing that I keep my information up to date.

## LIFE TO BE ASSURED:

|           |  |      |  |
|-----------|--|------|--|
| Signature |  | Date |  |
|-----------|--|------|--|

Please complete this form and upload securely.

GC re PhilipWilliams  
35 Walton Road, Stockton Heath, Warrington, WA4  
6NW, GB

## Instruction to your bank or building society to pay by Direct Debit

Customer Name or Company name

Service User Number

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1 | 2 | 4 | 6 | 2 | 4 |
|---|---|---|---|---|---|

Name(s) of account holder(s)

Reference

Bank/Building Society account number

### Instruction to your Bank or Building Society

Please pay GC re PhilipWilliams Direct Debits from the account detailed in this Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this instruction may remain with GC re PhilipWilliams and, if so, details will be passed electronically to my bank/building society.

Branch sort code

Signature(s)

Name and full postal address of your Bank/Building Society

Date

Banks and building societies may not accept Direct Debit Instructions for some types of account.

## The Direct Debit Guarantee



- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits.
- If there are any changes to the amount, date or frequency of your Direct Debit GC re PhilipWilliams will notify you 3 working days in advance of your account being debited or as otherwise agreed. If you request GC re PhilipWilliams to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your Direct Debit, by GC re PhilipWilliams or your bank or building society, you are entitled to a full and immediate refund of the amount paid from your bank or building society
  - If you receive a refund you are not entitled to, you must pay it back when GC re PhilipWilliams asks you to.
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.