

4. How long did the symptoms last?		
5. Please advise the last time you suffered from this medical condition and confirm the nature and extent of any resulting disability?		
6. What advice and/or treatment were you given ?		
7. Did you require any time off work ?	Yes <input type="radio"/> No <input type="radio"/> If "yes" please give details	Yes <input type="radio"/> No <input type="radio"/> If "yes" please give details
8. Have you made a complete recovery resulting in cessation of treatment and are no longer attending or waiting follow up appointments	Yes <input type="radio"/> No <input type="radio"/> If "No" please give details	Yes <input type="radio"/> No <input type="radio"/> If "No" please give details

Section 5 - Declaration

I have been informed of my statutory rights under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991, as explained below, and I agree that a copy of this consent shall have the validity of the original.

I consent to any insurer seeking information from any doctor or medical adviser who at any time has attended me concerning anything which affects my physical or mental health or seeking medical information from any insurance company to which an application has been made for insurance on my life. I authorise the giving of such information and such authority will continue beyond my death.

I agree to the Insurer holding personal information on me for the purposes of underwriting, administration and claims management associated with this policy.

I declare that to the best of my knowledge and belief, the statements provided in this declaration and any associated declarations are true and complete, and all material facts have been disclosed. I authorise the payroll department to deduct the appropriate subscription from my salary.

I wish to see the report before it is sent to the insurer

I do not wish to see the report before it is sent to the insurer please tick one only

Signature of the person whose life is to be insured	Date
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Rights and Procedures

Access to Medical Reports Act 1988, Access to Personal Files and Medical Reports (Northern Ireland) Order 1991
 We need your consent before we can approach any doctor for a medical report about you. This is given by signing the declaration in Section 5 of this form. Before you sign, you should read this section carefully. It details your rights under the Act.
 1. You do not have to give your consent. If you do not give your consent, we may be unable to proceed with your application.
 2. You can request to see the report before it is sent to us. We will inform the doctor that you want to see the report before it is sent to us and confirm your request to you in writing. You will then have 21 days to arrange with the doctor to see the report. If you haven't arranged to see the report within this period the doctor will send it to us.
 3. If you indicate that you don't want to see the report, we don't have to tell you if we apply for one. You can, however, ask to see a copy of the report within six months of it being sent to us.
 4. The doctor may charge you a reasonable fee if you ask to see a copy of the report.
 5. If you have seen the report before it is sent to us, the doctor will require your written consent to send it to us. You have the right to ask the doctor to change anything that you consider to be incorrect or misleading. The doctor can, however, refuse to make any alterations. If the doctor refuses to change the report you may attach a note giving your views.
 6. The doctor can refuse to let you see all or part of the report if, in their opinion, it is likely to:
 > adversely affect your physical or mental health or that of others,
 > indicate the doctor's intentions to you,
 > reveal the identity of a third party who has given information about you unless they have consented to its disclosure or it has been supplied by a health professional involved in caring for you.

In such cases the doctor must notify you. You will only be able to see the remaining part of the report. If the whole report is affected the doctor will advise you and not send it to us without your written consent. If you refuse to give your consent we may be unable to proceed with your application.
 A terms of business letter is included with this application form. If it has not been included please contact Philip Williams & Co on 01925 604421 for a copy.

PLEASE COMPLETE AND RETURN TOGETHER WITH THE DIRECT DEBIT FORM TO :
 Philip Williams and Company, 35 Walton Road, Stockton Heath, Warrington, Cheshire WA4 6NW
 Philip Williams & Company are authorised and regulated by the Financial Conduct Authority

04/14 v2

Philip Williams & Co
 INSURANCE MANAGEMENT
SUPPLEMENTARY INSURANCE SCHEME

SUPPLEMENTARY LIFE INSURANCE

ADDITIONAL £50,000 £13.95 per calendar month
ADDITIONAL £75,000 £19.95 per calendar month

SUPPLEMENTARY CRITICAL ILLNESS

ADDITIONAL £30,000 £14.00 per calendar month
ADDITIONAL £50,000 £20.00 per calendar month

The listed illnesses are:-

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

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. Please note cover is payable by direct debit and will only commence following acceptance from the underwriters. COVER AVAILABLE TO AGE 60

Please complete this form in block capitals and tick answers as applicable.

The answers you give on this declaration form will be used to assess the proposal for insurance and must be answered fully to the best of your knowledge and belief. All questions should therefore be carefully answered. If you are unsure whether a particular fact is relevant then this information should be disclosed. Any change in your circumstances following the completion of this declaration form should be notified to the Insurer. Part or all of the policy benefits may be forfeited if relevant information is withheld.

Section 1 - Personal Details

Name of employer		
Full name Mr/Mrs/Miss/Ms		
Home Address		
Postcode	Email	
Home tel no.	Work tel no.	
Exact description of occupation		
Marital status	Date of birth	Place of birth
Members Work / Pay number.		
Nomination of Beneficiary (Name and relation)		

Please tick one - **Member application** **Partner application**
 (Member Name _____)

Please indicate the level of additional cover you require (tick a maximum of one option in each category):

I APPLY FOR ADDITIONAL LIFE COVER OF:	£50,000 <input type="radio"/>	£13.95 per month
	£75,000 <input type="radio"/>	£19.95 per month
I APPLY FOR ADDITIONAL CRITICAL ILLNESS COVER OF:	£30,000 <input type="radio"/>	£14.00 per month
	£50,000 <input type="radio"/>	£20.00 per month

Statement of Fact

Are you aware of any reason that an insurer would regard as likely to influence the assessment and acceptance of this application? This may include, but not be exclusive to being posted overseas, undertaking hazardous duties or pastimes,

Yes No If "yes" please give details

Section 2 – Insurance history

1. Has any application for life, income protection (PHI) or critical illness insurance on your life ever been declined, postponed or withdrawn, or accepted at an extra premium, subject to a debt or on other special terms?

Yes No If "yes" please give details and dates and name of insurance company

2. Has any proposal for any form of insurance on your life been made to any insurance company within the past six months or are you expecting to do so in the next six months?

Yes No If "yes" please give details and advise if a medical examination was performed

Section 3 – Health & lifestyle (failure to complete this section in full will result in delays)

1. What is your height and weight?
 Height ft ins (or cms). Weight st lbs (or kgs)

2. What is your average WEEKLY consumption of :
 A) Alcoholic drinks ? units B) Tobacco ?
A unit of alcohol is a pub measure of wine or spirits, or half a pint of beer, lager or cider.

3a. Name and address of your current GP :	3b. Name and address of any other GP consulted in last 5 years
Tel :	Tel:

4. During the past 5 years have you attended or been advised to attend any medical practitioner for any form of medical consultation, investigation, treatment or advice, or are you awaiting these?

Yes No If "yes" please give medical reason(s) and complete section 4

5. Are you currently having treatment (eg diet, medicines, tablets or injections) whether prescribed or not for any medical or psychiatric condition?

Yes No If "yes" please give medical reason(s) and complete section 4

6. Have you EVER suffered from:

If "yes" please state type of treatment and complete section 4

A) Any disease of the heart/circulatory system, high blood pressure/stroke ?	Yes <input type="radio"/>	No <input type="radio"/>
B) Any cancer, growth or malignancy ?	Yes <input type="radio"/>	No <input type="radio"/>
C) Any form of kidney (renal) disease ?	Yes <input type="radio"/>	No <input type="radio"/>
D) Any disease or disorder of the eyes ?	Yes <input type="radio"/>	No <input type="radio"/>

7. Have you tested positive for HIV/AIDS or Hepatitis B or C, or been tested/treated for other sexually transmitted diseases or are you awaiting the results of such a test?

Yes No if "yes" then FULL details MUST be declared to avoid delay with your application.

8. Have any of your parents, brothers or sisters died or suffered from heart disease, stroke, high blood pressure, diabetes, kidney disease, cancer, multiple sclerosis, nervous disorder or any hereditary disease before age 65?

Yes No if "yes" then FULL details of age at diagnosis, relevant dates, and information about their current health MUST be declared to avoid delay with your application.

9. Do you currently, or do you intend, to take part in any hazardous leisure activities? (For example, Private Aviation, Motor Racing, Mountaineering)

Yes No If "yes" or you are in doubt about any activity, please give details.

Section 4 Further details of life to be insured

Only complete this section if you have disclosed a medical condition in Section 3. Please give full details in the boxes provided and continue on a separate sheet if necessary.

	Condition 1	Condition 2
1. Medical condition disclosed		
2. Please describe the symptoms you have suffered and give the date they started		
3. How frequent were the conditions ?		