9. 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.

10. 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 - 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

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 4 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.

PLEASE COMPLETE AND RETURN TO : Philip Williams and Company,
35 Walton Road, Stockton Heath, Warrington, Cheshire WA4 6NW

National Crime Officers Association Insurance Benefits Trust (IBT)

Effective from 1 June 2017

Underwritten Application Form

Serving Member to age 65

Life Insurance	£100,000
Terminal Prognosis Advance on Life Insurance	20% of sum insured
Permanent Total Disablement (due to accident)	£100,000
Accidental Loss of Use Benefit	£20,000
Critical Illness	£15,000
Child Critical Illness	£3,000
Child Death Grant	£2,000
Hospitalisation Benefit up to five nights	
Accident/incident/emergency admission	£50 per night
Planned admission after first three nights	£50 per night
Sick Pay Benefit	
Half Pay up to 26 weeks	20% Scale Pay
No Pay up to 26 weeks	50% Scale Pay
Family Travel Policy	Worldwide
Mobile Phone Insurance	Member & Partner
Dental Emergency and Injury	Member & Partner
CALENDAR MONTHLY SUBSCRIPTION	**£31.95**

Cohabiting Partner to age 65

Life Insurance	£50,000
Terminal Prognosis Advance on Life Insurance	20% of sum insured
Critical Illness	£7,500
Child Critical Illness	£1,500
CALENDAR MONTHLY SUBSCRIPTION	**£9.95**

Upon Acceptance, the first 3 months of membership is Free of Charge

The benefits arranged under this Insurance Scheme are provided strictly under the terms of insurance policies taken out and owned by the Trustees. Copies of the policies are available to view upon request. Subscription to the scheme entitles the member to the benefits provided by the scheme but confers no ownership of any of the underlying policies, which are vested in the Trustees.

35 Walton Road, Stockton Heath, Warrington, Cheshire WA4 6NW
Tel: 01925 604421 Fax: 01925 861351

Philip Williams & Company are authorised and regulated by the Financial Conduct Authority

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 to ensure that all requested facts are disclosed. If you are unsure whether a particular fact is relevant then this information should be disclosed. As the duty of disclosure of material facts applies until cover commences, 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 **Member application** ◯ **Cohabiting Partner application** ◯ ______________________ (member name)

Section 1 - Personal Details Name of employer | Date Member joined NCOA

Title	Forename	Surname
Home Address		Postcode
Home tel no.	Work tel no.	Email.
Exact description of occupation		Date employment commenced
Marital status	Date of birth	Place of birth
Members Work / Pay number.		
Nomination of Beneficiary (Name and relation)		

Section 2 – Insurance history - 1. Has any application for life, income protection (P.H.I.) or critical illness insurance on your life ever been declined, postponed, withdrawn or deemed unacceptable at ordinary rates, or accepted at an extra premium, subject to a debt or other special terms? Please note this also includes any application to join this or any other insurance, individual or group scheme.

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.

3. Have you used any form of Tobacco (including nicotine replacement) in the past 12 months? Yes ◯ No ◯
If Yes, please give details of product and amount per day.

4a. Name and address of your current GP :	4b. Name and address of any other GP consulted in last 5 years
Tel :	Tel:

5. In the past 5 years have you been to your GP for any form of medical consultation, investigation, treatment or advice or are you awaiting these? (For females please include cervical smears/mammograms as applicable).

Yes ◯ **No** ◯ If yes, please give full details including symptoms, dates and nature of treatment. If necessary please use a separate sheet of paper.

6. Have you ever consulted your GP or any other medical professional for Anxiety, Stress, Depression or any other mental illness?

Yes ◯ **No** ◯ If yes, please give full details including symptoms, dates and nature of treatment.

7. Have you EVER suffered from:

a. High Blood Pressure, Stroke, or any other disease of the heart/circulatory system	Yes/No (delete as appropriate)
b. Any cyst, growth, tumour or cancer?	Yes/No (delete as appropriate)
c. Any form of kidney (renal) disease?	Yes/No (delete as appropriate)
d. Any disease or disorder of the eyes	Yes/No (delete as appropriate)
e. Any disease or disorder of the respiratory system including Asthma, Bronchitis or Emphysema?	Yes/No (delete as appropriate)
f. Any musculoskeletal disorder, including Back Pain, Sciatica, Whiplash, Rheumatism or Arthritis?	Yes/No (delete as appropriate)
g. Any disease/disorder of the digestive system, stomach, pancreas, liver including Gastric or Duodenal Ulcer, Irritable Bowel Disease, Colitis, Crohn's Disease, Indigestion, Hiatus Hernia or Hepatitis?	Yes/No (delete as appropriate)
h. Diabetes?	Yes/No (delete as appropriate)
i. Any disease/disorder not listed above?	Yes/No (delete as appropriate)
j. Are you currently taking any medication?	Yes/No (delete as appropriate)

If the answer to any of the questions in 7 a - j is YES, please give diagnosis of condition disclosed, dates and details of symptoms, including frequency of symptoms and nature of treatment and time off work. Please confirm whether or not you have fully recovered or if symptoms continue, in the space below. If necessary please use a separate sheet of paper.

8. 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.