LANCASHIRE POLICE FEDERATION
CRITICAL ILLNESS INSURANCE SCHEME APPLICATION FORM

This scheme is open to any Police Staff or Serving Officer who is also a member of the Lancashire Police Group Insurance Scheme. To join this scheme an officer must complete the attached Declaration and Direct Debit Mandate and return it to:

Police Mutual
5th Floor
20 Chapel Street
Liverpool
L3 9AG

CRITICAL ILLNESS BENEFITS

Category (1) Serving Officers/Police Staff

Category (2) Retired Officers who are aged up to 55 years

Category (3) Retired Officers who are aged 56 to 60 years

Category (4) Retired Officers who are aged 61 to 64 years

Benefit Basis	Category (1)	Category (2)	Category (3)	Category (4)
Benefit basis 1	£15,000	£7,500	£4,350	£2,550
Benefit basis 2	£30,000	£15,000	£8,700	£5,100
Benefit basis 3	£45,000	£22,500	£13,050	£7,650
Benefit basis 4	£15,000 plus Spouse or Partner £15,000	£7,500 plus Spouse or Partner £7,500	£4,350 plus Spouse or Partner £4,350	£2,550 plus Spouse or Partner £2,550
Benefit basis 5	£30,000 plus Spouse or Partner £15,000	£15,000 plus Spouse or Partner £7,500	£8,700 plus Spouse or Partner £4,350	£5,100 plus Spouse or Partner £2,550
Benefit basis 6	£45,000 plus Spouse or Partner £15,000	£22,500 plus Spouse or Partner £7,500	£13,050 plus Spouse or Partner £4,350	£7,650 plus Spouse or Partner £2,550
Children's Benefit: 25% of the Member's Benefit plus (if applicable) 25% of Spouse's or Partner's Benefit				

Name: ______________________ Collar Number/Payroll Number: ______________________

I wish to apply for the following Benefit basis

Benefit basis (1) £9.34 per month ☐ Benefit basis (2) £18.68 per month ☐

Benefit basis (3) £28.02 per month ☐ Benefit basis (4) £14.94 per month ☐

Benefit basis (5) £24.27 per month ☐ Benefit basis (6) £33.61 per month ☐

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INSTRUCTION TO YOUR BANK OR BUILDING SOCIETY TO PAY BY DIRECT DEBIT
Please read the important notes regarding variable instructions listed below this form
Please fill in the whole form and return to :

Police Mutual
5th Floor
20 Chapel Street
Liverpool L3 9AG

9 8 5 6 9 0

Name of Account Holder(s)

Originator's Reference (office use only)

Name and full address of your Bank/Building Society

Bank /Building Society Account Number:

Branch Sort Code

Instructions to your Bank/Building Society
Please pay Roland Smith 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 Roland Smith and if so, details will be passed electronically to my Bank/Building Society.

Signature(s)

Date ____ / ____ / ____

Please cut here and retain bottom portion of the form for your records

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 Roland Smith will notify you 5 working days in advance of your account being debited or as otherwise agreed. If you request Roland Smith 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 Roland Smith or your Bank or Building Society you are entitled to a full and immediate refund of this amount paid from your Bank or Building Society.
  - If you receive a refund you are not entitled to, you must pay it back when Roland Smith 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.

IMPORTANT NOTES REGARDING VARIABLE INSTRUCTIONS

Notes

- Once your instruction cover commences and collection of the first premium becomes due, any delay will result in this and further premiums being collected as one amount. Subsequent premiums will be collected as they fall due.
- The amounts are variable and may be debited on or after the due date.
- I/We understand that Roland Smith may change the amounts and dates only after giving me/us prior notice.
- I/We understand that if any Direct Debit is paid which breaks the terms of the instruction, the Bank/Building Society will make a refund.

Please Return to:

Serving Member
&
Spouse of Serving Member

PERSONAL DECLARATION FORM

Chancery House, Leas Road,
Guildford, Surrey GU1 4QW
Tel: 0870 7200 780 Fax: 0870 7200 781
Email: group.risk@ram-ltd.co.uk Web: www.ram-ltd.co.uk

Risk Assurance Management Limited, insurances arranged at Lloyd's
Risk Assurance Management Limited is authorised and regulated by the Financial Conduct Authority
Registered Address: 35 Lavant Street, Petersfield, Hampshire GU32 3EL
Registered in England and Wales No: 1334065

Coverholder at LLOYD'S

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

Scheme Name						
Title (Mr., Mrs., Miss, other)		Surname		Forenames		
Address						
		Postcode		Contact telephone number		
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	
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):	

		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?				

Coverholder at LLOYD'S

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))			

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?			

Coverholder at LLOYD'S

	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?			*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.*
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 sexual 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.			

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.
- It may be necessary for us to send your form and relevant medical reports to the participating Lloyd's Underwriters or their Reassurers for their opinion or agreement of the terms offered.
- 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.
- 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.

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 Risk Assurance Management Limited 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** under 'Insurance & Savings / Topics & Issues/ Genetics'

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. 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 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 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 do not* wish to see the report before it is sent to Risk Assurance Management Limited. (*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 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 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 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.
- 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 Risk Assurance Management Limited 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 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 have read and understood the Important Notes (including the Data Protection section information relating to my rights under the Access to Medical Reports and Statement of Practice section) information relating to my rights under the Access to Medical Reports Act and the Declaration and Consent.

LIFE TO BE ASSURED:

Signature		**Date**	

The Group Life Assurance is administered by Risk Assurance Management Limited in its capacity as a Lloyd's Coverholder on behalf of certain Underwriters at Lloyd's where the risk is underwritten.