Global Connections

BANNER

LIFE INSURANCE APPLICATION FORM

Please complete this form in block capitals and it is important that all questions are answered truthfully and accurately. Please disclose all relevant facts that could influence or affect the assessment and/or acceptance of the application of insurance. If you are unsure whether a particular fact is relevant, then this information should be disclosed. If a policy is issued without all relevant information being provided, the Insurer may avoid payment of a claim under the policy. If you are in doubt as to whether certain information is relevant you should disclose it. If you consider that the responses to any of the questions in the application form require any expert or third party knowledge that you do not have, please indicate this in your answer. The Insurer must be notified in writing of any changes to the details provided on the application form, including those relating to health, pastimes, travel or country of residence that occur before the policy is issued.

SECTION 1 – PERSONAL DETAILS

Please tick one MEMBER Application ☐ SPOUSE/PARTNER Application ☐

Members name: Members Reference/Agency:

Name of Employer:

FULL NAME

Surname:

First name(s):

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Marital Status: Date of Birth: / / Place of Birth:

Home Address:

Postcode:

Home Telephone number: Work Telephone number:

Mobile number: E-mail Address:

Exact description of occupation:

Name, address and telephone number of your current GP

Name:

Address:

Postcode: Telephone number:

Name, address and telephone number of any other GP consulted in the last 5 years

Name:

Address:

Postcode: Telephone number:

SECTION 2 – INSURANCE HISTORY

1. Has any application for life or critical illness insurance on your life ever been declined, postponed, withdrawn or deemed unacceptable at ordinary rates, or accepted at an extra premium, subject to a debt or other special terms?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**☐ (select one only)

IF YES, please provide full details and dates and name of insurance company.

2. Have you applied for any form of insurance on your life to any insurance company within the past six months, or are you expecting to do so in the next six months?

YES ☐ **NO** ☐ (select one only)

IF YES, please provide full details and advise if a medical examination was performed.

SECTION 3 – HEALTH AND 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 alcohol?

Units*

(*A unit is a single pub measure of a small glass of wine, spirits or half pint of beer, lager or cider)

3a. Have you used any form of tobacco products (including nicotine replacement products) in the past 12 months?

Yes ☐ **No** ☐ (select one only)

If yes, please give details

3b. If you smoke /smoked cigarettes, cigars or a pipe please indicate how many per day.

4. 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** ☐ (select one only)

If yes, please give full details including symptoms, dates and nature of treatment. If necessary please use a separate sheet of paper.

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

Yes ☐ **No** ☐ (select one only)

If yes, please give full details including symptoms, dates and nature of treatment.

6. Have you EVER suffered from any of the following:-

a. High Blood Pressure, Stroke, or any other disease of the heart/circulatory system **Yes** ☐ **No** ☐

b. Any cyst, growth, tumour or cancer? **Yes** ☐ **No** ☐

c. Any form of kidney (renal) disease? **Yes** ☐ **No** ☐

d. Any disease or disorder of the eyes **Yes** ☐ **No** ☐

e. Any disease or disorder of the respiratory system including Asthma, Bronchitis or Emphysema? **Yes** ☐ **No** ☐

f. Any musculoskeletal disorder, including Back Pain, Sciatica, Whiplash, Rheumatism or Arthritis? **Yes** ☐ **No** ☐

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** ☐

h. Diabetes? **Yes** ☐ **No** ☐

i. Any disease/disorder not listed above? **Yes** ☐ **No** ☐

j. Are you currently taking any medication? **Yes** ☐ **No** ☐

Please see over the page.

If the answer to any of the questions in 6 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.

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** ☐ (select one only)

If yes, please give full details

8. Have either 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 the age of 65?

Yes ☐ **No** ☐ (select one only)

If yes, please give 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 or Mountaineering).

Yes ☐ **No** ☐ (select one only)

If yes, or you are uncertain about any activity, please give details.

When you have signed and ticked section 4 below please return the form to

By email:

info@bannergroup.com

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 the Insurer seeking information from any doctor or medical advisor who at any time has attended me concerning anything which affects my physical or mental health or seeking medical information from any insurance company 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 purpose 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 premium 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 only one box.

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 wish 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 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 doctors intentions to you,
- Reveal the identity of the 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.