



Life Insurance

SYNDICATE 779

**1ST FLOOR
47 MARK LANE
LONDON
EC3R 7QQ**

**TELEPHONE NUMBER INTERNATIONAL: +44 20 7280 6000
TELEPHONE NUMBER: 020 7280 6000
FAX NUMBER: 020 7280 6010**

Term Life Proposal

Underwritten by Syndicate 779 at Lloyd's of London

Syndicate 779 Term Life Proposal

IMPORTANT NOTICE

We will use the information you give on this Proposal Form to decide whether we are able to offer you cover, and if so at what terms, or if additional information is required.

- ☐ You must answer the questions fully and truthfully to the best of your knowledge. If you do not do so, your insurance cover may not protect you in the event of a claim, and your insurance may be invalidated. If you are in any doubt about whether to provide information when filling in the Proposal Form, please provide the information.
If you are unsure about any medical information, you may wish to consult your doctor before completing the Proposal Form.
- ☐ It remains your responsibility to complete the Proposal Form properly. You cannot assume that your doctor will provide the information we need. Consultations for “colds”, “coughs” and “sprains” can be ignored.
- ☐ You should keep a record of all information supplied with this Proposal Form (including copies of correspondence).
- ☐ A copy of this Proposal Form can be supplied upon request, within 3 months from the date of completion.

The Life Assured should fully complete the Proposal Form themselves. Where this is not possible, the Life Assured must read, agree, and if necessary amend any disclosures so that they are accurate and complete. If the Life/Lives Assured wishes, they may return the whole form or specific information to us confidentially, marked ‘Private & Confidential’ for the attention of our Chief Medical Officer to the address stated on the front page.

Disclosure of any changes since completion of this proposal for the following areas continues until Insurers have issued Acceptance Terms.

- Personal health;
- Family history;
- Occupation;
- Travel or Residence;
- Hazardous pastimes;
- Alcohol consumption;
- Smoking habit
- Use of recreational drugs (eg cocaine, heroin)

PERSONAL INFORMATION

FULL NAME OF LIFE TO BE ASSURED (SURNAME LAST)

Mr / Mrs / Miss / Ms

Address

Telephone No (day)..... (eve).....

Date of Birth Place of Birth Age Next Birthday

Marital Status (Please state if divorced or separated)

Nationality Number of Years resident in the UK (If applicable)

Give your profession or full details of your occupation (e.g. if Company Director, please elaborate):

POLICY REQUIRED

Do you require Personal or Business cover ?(please state)

Type of Assurance (level, decreasing, increasing, inheritance tax etc.)
(please state)

Life Sum Assured required (and currency)(please state)

Policy Term requiredyears/months
(please state)

Frequency of Payment (Single or Annual)(please state)

PERSONAL DETAILS

ALL YOUR ANSWERS WILL BE TREATED IN THE STRICTEST CONFIDENCE

Do you smoke cigarettes? YES / NO	Do you smoke Cigars or pipes? YES / NO				
If YES, please state type and daily consumption					
If NO, please state how long you have been a non-smoker					
What is your alcohol consumption ?units per week. If a total abstainer, for how long?					
<i>(1 unit = approximately 125ml glass of wine, 1 measure of spirit or 33cl (½ pint) of beer/lager)</i>					
Have you ever been medically advised to reduce your consumption of tobacco or alcohol? YES / NO					
Please give medical histories for your close relatives including details of any heart disease, stroke, raised blood pressure, diabetes, cancer or kidney disease, including age at onset of disease if known.					
Relation	Age	Living Present state of health	Age at death	Deceased Cause of death	Duration of illness
Father					
Mother					
Brother(s)					
Sister(s)					
<p>Give the full name and address of your usual Medical Attendant</p> <p>.....</p> <p>.....</p> <p>Tel: Fax:</p>					
ADDITIONAL PERSONAL DETAILS					
Please answer all questions and if you answer YES give full details. Incomplete answers may delay acceptance.					
			YES / NO	If YES, please give full details and dates.	
Does your current occupation involve, or is it likely to involve,					
<input type="checkbox"/> any extra risk to accident? <input type="checkbox"/> or exposure to the risk of contracting a disease?			Yes / No Yes / No		
Do you engage in, or have any intention of,					
<input type="checkbox"/> flying (other than as a passenger on recognised airlines)? <input type="checkbox"/> engaging in any hazardous pursuit including diving, mountaineering, or racing of any kind?			Yes / No Yes / No		
Has any proposal for Life or Disability cover on your life ever been :-					
<input type="checkbox"/> deferred <input type="checkbox"/> accepted on special terms <input type="checkbox"/> declined			Yes / No Yes / No Yes / No		
Have you effected or proposed for any Life or Disability cover on your life with any Insurer within the last 2 years? Is it your intention to do so in the foreseeable future? If so, when and to which offices?			Yes / No Yes / No		
Do you anticipate travel outside your normal country of residence, Western Europe, North America or Australasia in the next 5 years?			Yes / No		
<p>Life Assured's height:ftins Weightstlbs</p> <p>OR in height: Centimetres Weight:Kgs</p>					
1) Have you ever suffered from, or been asked to have any investigation for:					

a) Cancer, leukaemia, Hodgkins disease, lymphoma, brain or spinal tumour? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date
b) Lumps or growths? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date
c) Heart attack, angina, heart defects and heart surgery? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date
d) Stroke, circulatory problems, brain haemorrhage or permanent brain injury? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date
e) Multiple Sclerosis, Parkinson's disease, paralysis, epilepsy or Cerebral palsy? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date
f) Alzheimers's disease or dementia? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date
2) In the last 5 years have you:	
a) Had any raised blood pressure? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date
b) Had raised cholesterol? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date
c) Had any chest pain, irregular heart beat? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date
b) Had any kind of medical attention for depression, anxiety, stress or nervous breakdown, including any form of suicide attempt or self harm? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date
c) Had any disorder of the digestive system, liver, stomach, pancreas, or bowel (including gastric or duodenal ulcer, hepatitis, colitis or Crohn's disease)? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date
e) Diabetes or sugar in the urine? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date
f) Musculoskeletal disorders, such as any form of arthritis or back trouble? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date

g) Respiratory conditions including asthma and bronchitis? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date
3) Are you currently taking prescribed drugs, medicines, tablets? YES <input type="checkbox"/> NO <input type="checkbox"/> Are you currently on any other treatment? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date
4) Are due to have any form of check up in the next 12 months in connection with any medical condition? YES <input type="checkbox"/> NO <input type="checkbox"/> Are you waiting for the result of any medical investigation? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date
5) Do you currently have any symptoms for which you might seek medical attention? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date
6) Have you in the last 5 years consulted any doctor, received or have been advised to have any investigations, scans or blood tests in connection with any medical condition? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date
7) Have you tested positive for <input type="checkbox"/> HIV/AIDS Yes / No <input type="checkbox"/> Hepatitis B Yes / No <input type="checkbox"/> Hepatitis C Yes / No Are you awaiting the result of any such test? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date
8) Have you taken any type of recreational drug, for example, cannabis, cocaine, heroin, etc? YES <input type="checkbox"/> NO <input type="checkbox"/>	Details & Date

Access to Medical Reports Act 1988
(Access to Personal Files and Medical Reports (Northern Ireland) Order 1991)

We may need to apply for a medical report from your doctor but before doing so we need your consent, you should know you have certain rights under the above Acts. They are:-

- You can withhold your consent BUT we may be unable to proceed without it.
- You have the right to see the report before it is returned by the doctor. Please indicate if you wish to do so.
- If you indicate that you wish to see the Medical report and we decide that one is required we will inform you of our intention to obtain a report. We will also notify the doctor that you wish to see the report. You will then have 21 days to make arrangements with the doctor to see the report. The doctor can charge a reasonable fee for this service.
- If you indicate that you do not wish to see the report, you can change your mind but you must inform the doctor immediately. You will then have 21 days to make arrangements to see it before the report is returned to ANV Syndicate 779.
- You can also see the report up to six months after it has been provided to ANV Syndicate 779, even if you elected not to see it initially.
- If you consider the report (or any part of it) to be misleading you can add a statement of your own.
- The doctor can withhold the report (or part of it) from you if he feels it is in your interests to do so.

Data Protection

The 1998 Data Protection Act places responsibilities on people and organisations who use personal information. The Act has particular regard to the right of the individual. It includes the right for individuals to have their information protected and imposes special conditions and rights if this information is classified as "sensitive". "Sensitive personal information" is defined by the Act as comprising information about racial or ethnic origin, health, religious beliefs, sexual life, convictions or sentences, and trade union membership. Our interest is restricted to the categories of health and sexual life for underwriting purposes. Any information collected from you by our Underwriters will be carefully protected and any details which could be defined as "sensitive" as above will receive extra protection. We may, however, pass on information to our reassurers, and other individuals or groups, for example, medical practitioners, who may be involved in the processing of this proposal for assurance.

"Sensitive" information relating to your proposal for assurance may not be processed without your explicit consent. Should your consent of the processing of sensitive information not be given, it may not be possible to underwrite your proposal. Therefore would you please indicate your consent to such processing by signing the declaration section. All information provided may be retained for up to seven years from the date of your proposal or when you cease to be a policyholder with us.

GENETIC TESTING GUIDELINES

In accordance with the Association of British Insurers' policy on genetics and Insurance, you do not need to tell us about any genetic test result you have had if this application for insurance taken together with any other insurance policies you already have for this type of insurance totals:

£ 500,000 or less for life insurance

£ 300,000 or less for critical illness, income protection or long-term care insurance

Above these limits you may need to tell us about certain genetic test results when applying for insurance. We will only be interested in genetic test results where the Government's Genetics and Insurance Committee (GAIC) has approved them 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/consumers/disclosure.htm

DECLARATION

I the Life to be Assured, and (if different) the Grantee, declare that the answers given in the Proposal Form are honest and to best of my knowledge true and that I have not withheld any information which may influence the acceptance of my proposal. I agree that this Proposal Form will form part of my proposal for assurance and understand that the terms of the Certificate to be issued in respect of this proposal shall be dependent upon the answers given and statements made in this proposal and made by the Life to be Assured to any medical examiner appointed by the Insurers. I undertake to inform the Insurers of changes to these statements which occur after the proposal form has been completed and signed by me, up to the date it is accepted by Insurers.

If Insurers require any further information from me/us, I undertake to inform the Insurers of changes to these statements which occur until that additional information is received from me/us and accepted by Insurers. I understand that failure to do so may affect the validity of the contract. In respect of joint life cases this obligation continues until both lives have been accepted by Insurers.

I the Life to be Assured consent to the Insurers seeking medical information, including the result of any HIV test, from any Insurance Office to which a proposal has been made for assurance on my Life and I authorise the giving of such information.

I do not* wish to see the report before it is sent to Insurers.

Please delete the word "not" if you wish to see the report.

Signature of the Life to be Assured Date

If the Proposer is other than the Life to be Assured, please complete below:

Full Name

Full Company Name (if applicable)

Address

Relationship to the Life to be Assured

Insurable Interest

I/We, the proposer of this Assurance and therefore the Grantee have read all the statements made herein and declare that to the best of my/our knowledge they are true. I/We agree that this proposal and declaration and any which have been or shall be made to the Medical Examiner of the Insurers with reference to this proposal and subscribed to by the person whose life is to be assured, shall form the basis of my/our contract with the Insurers. I/We understand that should any information contained in the statements within this proposal change prior to the commencement date, then I/we must inform the Insurers. I/We understand that such changes in information may affect acceptance of this proposal.

I/We have read and understand the 'IMPORTANT NOTICE' contained in this Proposal Form.

Signature of Grantee: Date:

Full name and position of person signing on behalf of the Grantee:

Συγκατάθεση για τη χρήση πληροφοριών

Η General Cover insurance Brokers θα χρησιμοποιήσει τις πληροφορίες που παρέχονται στο παρόν για τη διαχείριση του ασφαλιστηρίου συμβολαίου, συμπεριλαμβανομένων των αναδοχών και των απαιτήσεων Χειρισμός, ή Αντιμετώπιση. Αυτό μπορεί να περιλαμβάνει τη γνωστοποίησή του σε άλλους ασφαλιστές, ρυθμιστικές αρχές ή στους πράκτορες του ασφαλιστή για λογαριασμό τους.

Ο ασφαλιστής μπορεί να παράσχει, κατόπιν αιτήματος, περισσότερες λεπτομέρειες μέσω των βάσεων δεδομένων στις οποίες έχει πρόσβαση ή συνεισφέρει .

Δήλωση

Ο κάτωθι υπογεγραμμένος επιβεβαιώνω ότι είμαι δεόντως εξουσιοδοτημένος και δίνω συγκατάθεση για τη χρήση των πληροφοριών όπως ορίζεται ανωτέρω .

Επίσης δηλώνω ότι είμαι εξουσιοδοτημένος να ολοκληρώσω αυτήν την πρόταση εξ ονόματος του προτείνοντος. Αναλαμβάνω να ενημερώσω τον ασφαλιστή για οποιασδήποτε ουσιώδη τροποποίηση ή προσθήκη σε αυτές τις δηλώσεις ή στοιχεία που εμφανίζονται πριν από την έναρξη της περιόδου ασφάλισης. Αναγνωρίζεται και συμφωνείται ότι οι όροι υπόκεινται σε περιορισμούς και οι εξαιρέσεις από την πολιτική ενδέχεται να υποστούν αλλαγές οποιαδήποτε στιγμή πριν από την έναρξη της περιόδου ασφάλισης αν θα πρέπει να προκύψουν τέτοιες υλικές τροποποιήσεις ή προσθήκες. Η υπογραφή αυτής της πρότασης δεν δεσμεύει τον ασφαλιστή να δώσει προσφορά, ούτε ο αιτών να δεχθεί την ασφάλιση.

Υπογραφή *

Όνομα

Θέση της εταιρείας

Ημερομηνία

* ο υπογράφων θα πρέπει να είναι διευθυντής ή ανώτερος υπάλληλος της εταιρείας ή ο ασφαλιζόμενος

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