

Scheme Member's Application

Application to Unum Limited ("Unum", "we", "us")
 Registered Office: Milton Court, Dorking, Surrey RH4 3LZ
 Registered number: 983768



Scheme details

To be completed by the financial adviser, employer or trustee in BLACK INK and in BLOCK CAPITALS

The completed original form should be sent to Unum at the above address.

1. Scheme name

2. Cover type

<input type="checkbox"/> Group Income Protection	Scheme Number	<input type="text"/>
<input type="checkbox"/> Group Life	Scheme Number(s)	<input type="text"/>
<input type="checkbox"/> Group Dependants	Scheme Number(s)	<input type="text"/>
<input type="checkbox"/> Group Critical Illness	Scheme Number	<input type="text"/>

3. Reason for completing this form

Application for new or increased benefit above free cover for eligible member

Application for discretionary member (please specify):

The applicant does not meet scheme eligibility

Late entry

Early entry

GL/GD switch: The previous insurer's acceptance terms were adverse and additional benefit is now required

4. Member details

If you have not already provided this information, please complete this section. If you prefer, you may provide these details under separate cover.

Member's full name

Date of birth

Marital status

	Group Income Protection	Group Life	Group Critical Illness
Date of joining scheme			
Scheme-defined salary			
Membership category			

Note to financial adviser/employer/trustee: Please do not have this form completed in full unless you know that underwriting will be required. To notify us of a new joiner to the scheme, you may choose to send us this page on its own, giving us the scheme name and numbers and the new joiner details. We shall then confirm our underwriting requirements to you.

Important information for the member

- **We ask you to complete this application carefully.** It is the basis of our agreement to consider cover that is not automatically granted by your scheme membership. Please answer all our questions in **BLACK INK**, writing in **BLOCK CAPITALS**.
- **We rely on the information you give us to make our decision about insuring you.** We believe we can assess most risks successfully without medical evidence - after all, you're best placed to tell us about yourself and it's actually not that common for medical reports to tell us much more. We ask you for information that we may in the past have obtained from your GP or have checked at a medical examination, believing that time spent now making clear and complete application statements gets your cover in place sooner. We only ask you to tell us what we think it's reasonable for you to know and we don't expect you to have to check facts with your employer or GP. If you are in any doubt about the need to tell us something, please give us the information in full as it's better to tell us a fact that turns out not to be relevant to the risk than to miss out something that later causes a problem.
- **We guide you through the form.** To assist you, we explain alongside many of the questions how we'd like you to answer them. We ask you to take this guidance into account when you make your statements to us and we require you to confirm you have done this when you sign the form at the end.
- **You need to tell us about changes.** If something you have told us changes before your full cover is in place, we expect you to write in to update us. We are particularly interested in changes to your state of health, lifestyle, occupation duties and potentially hazardous activities.
- **We regard you as entirely responsible for what is disclosed to us.** If you don't complete the form yourself, we expect you to read carefully all the statements and our guidance before you sign it. If at any time after you have submitted this application we find you have given us incomplete or false information, we may change our underwriting decision, we may refuse a claim and we may withdraw some or all cover.

Member details

1. Surname	<input type="text"/>			
2. Title (please tick one of these boxes or state another title)	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Miss <input type="checkbox"/>	Ms <input type="checkbox"/>
	Other	<input type="text"/>		
3. Forename(s)	<input type="text"/>			
4. Date of birth	<input type="text"/>	5. Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>
6. Home address	<input type="text"/>			
	<input type="text"/>			
	<input type="text"/>			
	Postcode			

We can often sort out unclear application details with a quick call or e-mail. If you are happy for us to contact you between 9am and 6pm Monday to Friday, please give us details. We shall not use this information for any other purpose.

7. What is a good time to contact you?	Between	<input type="text"/>	and	<input type="text"/>	Don't contact me directly	<input type="checkbox"/>
Telephone number and/or e-mail address	<input type="text"/>					
	<input type="text"/>					

Member details (continued)

8. Who is your GP?

Surgery address

 Postcode

Telephone number and/or e-mail address

9. Have you registered with this surgery within the last six months? Yes No

If **Yes**, who were you registered with before?
(Please tell us the doctor's name, surgery address and telephone number here.)

If we require medical evidence in support of your application, we may be able to use a health screen report on you dated within the last 12 months. You will need to supply a copy of the report, which you can attach to the form in a sealed envelope.

10. Have you supplied a medical report? Yes, attached No

If **Yes**, what is the date of the report?

11. If a medical examination is required, in which town or postal district should this take place?

Occupation details

1. What is your occupation title?

2. Do you regularly work more than 60 hours each week? Yes No

3. Do you work entirely in an office environment? Yes No

You should say **No** and give full details in the box below if all or part of your duties require you to work in other environments, such as in a shop, on the factory floor, on a building site, at heights over 50 feet or offshore.

4. Do you need to drive to perform your duties? Yes No

You should say **Yes** if you need to drive on business at least once a week, for example to visit clients or make deliveries, and if you cannot perform those duties by taking alternative means of travel. You should say **No** if business use of your vehicle is only to get you to and from your normal place of work.

Travel details

1. Have your occupation duties required you to travel outside the European Union and North America in the **last** 12 months? Yes No

If **Yes**, please detail all your trips in the last 12 months including the cities or areas of each country.

Countries visited in last 12 months	Cities or areas visited	Total number of days spent there in the last 12 months

If you are expecting to travel on business in the next 12 months, please pay particular attention to the next question

2. Do your occupation duties require you to travel outside the European Union and North America in the **next** 12 months? Yes No

If **Yes**, please detail all the trips you know you will be making in the next 12 months including the cities or areas of each country.

Countries you will visit in next 12 months	Cities or areas to be visited	Total number of days you will spend there in the next 12 months

Fitness and lifestyle details

1. What is your height? **feet** **inches**
or **cm**

2. What is your weight today? **stones** **pounds**
or **kg**

3. Has your weight changed by more than 2 stones (or 13kg) in the last two years? Yes No

4. What is your waist measurement today? **inches** or **cm**

5. What is your typical WEEKLY alcohol consumption?

Beer, lager or cider up to alc 4.5% vol **pints**

Wine **175ml glasses**

Fortified wine **50ml glasses**

Beer, lager or cider alc 4.6% vol or more **pints**

or Wine **75cl bottles**

Spirits **35ml measures**

Fitness and lifestyle details (continued)

6. Has a healthcare practitioner ever advised you to reduce your alcohol intake? Yes No

If **Yes**, when was the advice given and what was your average weekly alcohol intake at that time?

Month/year (the year only is sufficient if more than two years ago).

Beer, lager or cider
up to alc 4.5% vol **pints**

Wine **175ml glasses**

Fortified wine **50ml glasses**

Beer, lager or cider
alc 4.6% vol or more **pints**

or Wine **75cl bottles**

Spirits **35ml measures**

7. Have you smoked tobacco in the last 12 months? Yes No

If **Yes**, what is your typical DAILY consumption?

(if you stopped smoking in the last 12 months, please tell us your typical daily consumption before you gave up.)

 Cigarettes/cigars/tobacco (delete as appropriate)

Sickness absence details

Please answer the following questions on your work absence history to the best of your recollection. We do not expect you to have to check the details with your employer or your GP. More space is available at the end of the form for you to continue your answers if you need to.

1. Have you ever been absent from work for more than 2 consecutive months due to sickness or accident? Yes No

Reason for absence	Month/year first absent	Month/year returned to work

2. In the last 3 years, for how many days **in total** have you been absent from work due to sickness or accident?
 No absence Up to 15 days Up to 30 days More than 30 days

Please add together all your short and long term work absence. If you are unsure of the exact number of days, please tick the box that gives the closest indication.

3. In the last 3 years, have you been absent from work due to sickness or accident for more than 1 week at a time? Yes No

Reason for absence	Month/year first absent	Number of weeks absent

Sickness absence details (continued)

4. In the last 3 months, has your ability to perform your occupation duties been affected in any way by your health?

Yes

No

This question asks about any recent limitations or restrictions to your work capacity whether or not you took time off work because of it. You should say **Yes** if, for example, you have reduced your hours, adjusted your duties or required adaptations or special equipment to assist you, even if only temporarily.

If **Yes**, how has your ability to perform your occupation duties been affected?

What caused it?

Is your ability to perform your duties still limited?

Yes

No

Sports and pursuits details

1. Do you take part in, or do you intend to take part in, any hazardous sports?

Yes

No

You should say **Yes** if your sport requires you to adhere to formal safety standards or have your competence or fitness certified. Examples: all forms of aviation, caving, climbing, competitive horse riding, sports diving, martial arts, motor sport and competitive and/or offshore sailing. If your activity is not in this list and you are unsure if it is of interest to us, you should tell us about it. More space is available at the end of the form to continue your answers if you need to.

If **Yes**, what is your sport?

How often do you take part, e.g. how many annual dives, races, climbs or flying hours?

Where do you do it, e.g. which countries, mountains, waters or caves?

Which sports bodies, associations or clubs do you belong to or are you registered with?

Sports and pursuits details (continued)

What is your experience, e.g. how many years, which qualifications or licence, type of craft or vehicle, engine capacity?

What is the extent of your activity, e.g. maximum height or depth, type of race or competition, special or extreme activity?

2. Do you exercise regularly or take part in any sport you have not told us about above? Yes No

You should say **Yes** if during the last 12 months you have regularly taken exercise (such as at a gym, circuit training or running) or played any type of sport (football, rugby, tennis, squash, golf, etc).

If **Yes**, what is each activity and how often do you do it?

Medical details

1. In the last 3 years, have you had pain or discomfort persisting for more than 3 days in your muscles, joints or bones? Yes No

You should say **Yes** and give full details if you have had pain in your back, neck, shoulders or upper or lower limbs, whether or not you consulted a healthcare practitioner.

A healthcare practitioner is anyone qualified to advise you about or treat you for an illness or injury.

If **Yes**, please give full details of each occurrence. If symptoms are ongoing, please say this under "duration of episode".

Month/year of onset	Condition, location and cause (if known)	Duration of episode	Treatment	Number of days off work

During episodes, how have your activities been limited and what have you done to manage the pain or discomfort?

Medical details (continued)

2. In the last 3 years, have you had stress, anxiety or low mood that has persisted for more than 3 weeks or for which you have sought medical advice or counselling? Yes No
3. Have you **ever** had depression or another psychiatric illness, according to a healthcare practitioner's diagnosis? Yes No

If **Yes to questions 2 or 3**, please give full details of each occurrence. If symptoms are ongoing, please say this under "duration of episode".

Month/year of onset	Condition and cause (if known)	Duration of episode	Treatment	Number of days off work

4. In the last 3 years, have you had irritable bowel syndrome or prolonged or unexplained abdominal pain? Yes No
5. In the last 3 years, have you had prolonged or unexplained fatigue, breathlessness, numbness or dizziness? Yes No

If **Yes to questions 4 or 5**, please give full details of each occurrence.

You should say **Yes** if you have had these symptoms, whether or not you consulted a healthcare practitioner. If symptoms are ongoing, please say this under "month/year of last symptoms".

Month/year of onset	Condition	Frequency of symptoms	Duration of episodes	Treatment	Number of days off work	Month/year of last symptoms

6. In the last 3 years, has a healthcare practitioner advised you that your cholesterol has been raised? Yes No
- In the last 3 years, have you been treated for high cholesterol? Yes No
- Have you been advised that your cholesterol is now normal? Yes No

Please tell us the three most recent cholesterol levels advised to you by a healthcare practitioner or say here if you don't know.

Don't know

Month/year:	Month/year:	Month/year:
Level:	Level:	Level:
On treatment? (Y/N)	On treatment? (Y/N)	On treatment? (Y/N)

If treatment is ongoing, please tell us what you are taking.

Medical details (continued)

7. In the last 3 years, has a healthcare practitioner advised you that your blood pressure has been persistently raised or have you been treated for high blood pressure? Yes No

If **Yes**, please tell us the three most recent blood pressure readings advised to you by a healthcare practitioner or say here if you don't know. Don't know

Month/year:	Month/year:	Month/year:
Reading:	Reading:	Reading:
On treatment? (Y/N)	On treatment? (Y/N)	On treatment? (Y/N)

8. Are you diabetic? Yes No

If **Yes**, please confirm the month/year of diagnosis:

Please also tell us your three most recent glycosylated haemoglobin (HbA1C) levels or say here if you don't know. Don't know

Month/year:	Month/year:	Month/year:
Level:	Level:	Level:

9. Have you ever had any form of heart disorder including murmur, a stroke, chest pain, palpitations or any problem with your blood circulation including haemorrhage or clots? Yes No

If **Yes**, please give full details here. If symptoms are ongoing, please say this under "month/year of last symptoms".

Month/year of onset	Condition	Frequency of symptoms	Duration of episodes	Treatment	Number of days off work	Month/year of last symptoms

10. Have you ever had any form of cancer including leukaemia or a tumour or growth including moles that a healthcare practitioner has advised may be cancerous? Yes No

If **Yes**, please give full details here.

Month/year of onset	Type of cancer, tumour or growth	Site	Type and start date of treatment	Month/year treatment ended	Are you still under follow up? (Y/N)

Medical details (continued)

11. Have you ever tested positive or been treated for HIV, hepatitis B, hepatitis C or any other sexually transmitted infection or are you waiting for test results relating to one or more of these diseases?

Yes

No

If the result is negative, the fact of having an HIV test will not, of itself, have any effect on your acceptance terms for insurance.

If **Yes**, please give full details here.

12. Within the last 5 years, have you been exposed to the risk of HIV infection?

Yes

No

HIV infection can be caught through unsafe sex, intravenous drug abuse or blood transfusion or surgery outside the European Union.

If **Yes**, please give full details here.

13. Have you ever had any of the following illnesses or impairments?

a) Digestive problems such as ulcer or colitis, or any disease or disorder of the liver, pancreas or bowel?

Yes

No

b) Fits, blackouts, migraine, multiple sclerosis, Huntington's disease, motor neurone disease or any disease of the nervous system?

Yes

No

c) Any disorder of the kidneys or any recurrent urinary problem?

Yes

No

d) Asthma, bronchitis or any disorder of the lungs or airways?

Yes

No

e) Any defect or disease of the eyes or ears?

Yes

No

If you have answered **Yes to any part of question 13**, please give full details here.

Condition	Month/year of diagnosis	Month/year of last symptoms	Time off work	Treatment given

Please ensure you have answered Yes or No to each part of this question

Medical details (continued)

14. How many times in the last twelve months have you consulted a healthcare practitioner about your health?

A healthcare practitioner is anyone qualified to advise you about or treat you for an illness or injury. You should count as one consultation every time you saw a practitioner. If you are in any doubt about whether to count a particular consultation, you should count it.

No consultations at all in the last 12 months 1 to 5 6 to 10 11 or more

If you have consulted a healthcare practitioner in the last 12 months, please give details in the table below.

You should tell us about all treatment, including any medication, therapy or other intervention given, prescribed or recommended by a healthcare practitioner, including repeat prescriptions, follow up therapy and complementary therapy such as, but not restricted to, acupuncture and chiropractic treatment. Please use the space available at the end of the form to continue your answers if you need to.

	Condition 1	Condition 2	Condition 3
Reason for consultation			
Month/year first consulted			
Month/year last consulted			
Treatment (say if ongoing)			
Number of days off work			
Full recovery? (Y/N)			

15. In the last 3 years, have you been x-rayed, had your blood or urine tested, had an ECG or any other specialist test? Yes No

If **Yes**, please give details.

Month/year	What was the test?	What was the reason for it?	What was the result?

In answering this question you should keep in mind that:

- We don't expect you to tell us about a negative HIV test result.
- If you're applying to us for income protection or critical illness insurance, we don't expect you to tell us about any genetic test result.
- For life insurance, we only require you to tell us the result of a genetic test you've had for Huntington's disease if your benefit is to be more than £500,000 above the scheme's free cover level or if you already have more than £500,000 of life cover with other insurers. If you're unsure about your cover level with us, your scheme trustees will be able to help you.

Medical details (continued)

16. Do you intend to consult a healthcare practitioner within the next twelve months?

Yes

No

This question covers pending consultations for new or existing medical conditions or symptoms. If you have an appointment to see a healthcare practitioner, you are waiting for an appointment, you expect to arrange one or you have symptoms or signs of illness for which you have considered making one, you should say **Yes** and tell us about it here.

If **Yes**, who will you consult and what is the reason for the consultation and the date, if known?

17. Have any of your parents, brothers or sisters had any of the following medical conditions before they reached age 65: heart disease, a stroke, persistently high blood pressure, diabetes, kidney disease, breast or ovarian cancer, bowel cancer, multiple sclerosis, Huntington's disease or any hereditary disease of the nervous system?

Yes

No

If your living or deceased parent, brother or sister was diagnosed before the age of 65 as having a serious illness or disease that may run in families, including any genetically inherited condition, we expect you to tell us as much as you know about that person's condition.

If you've told us about your family's medical history, you may decide to tell us of a genetic test result that shows you're not predisposed to a genetically inherited condition.

If **Yes**, please give details.

Relationship to you	Condition	Age at onset	Cause of death (if deceased)

Other insurance details

1. Has any life, critical illness or income protection insurer ever accepted your application on special terms or refused to cover you?

Yes

No

If **Yes**, which cover did the decision relate to, what was each adverse decision and when was it made?

Cover type	Decision	Month/year

Please check that you have answered every question.

Please read the following notes, declarations and consents carefully and then sign and date the form on page 14.

Please read these notes carefully - they outline your statutory rights concerning the processing and use of information relating to your application.

How we shall request reports about your medical history

We may require a report about your medical history from the doctor who holds your medical records, a doctor you have consulted or one who has treated you. In requesting this evidence, we shall always comply with the relevant law that sets out your statutory rights.

The Acts relevant to obtaining this type of medical report in the UK (except the Channel Islands) are the Access to Medical Reports Act 1988, the Access to Personal File and Medical Reports (Northern Ireland) Order 1991 and the Access to Health Records and Reports Act 1993 (Isle of Man). The Data Protection Act 1998 also governs the handling of medical reports.

We must have your written consent to obtain a report. We ask for this in the declarations and consents section at the end of this form.

You do not have to give your consent.

If you consent, you can say if you want to see the report before your doctor sends it to us.

If you want to see the report before it is sent to us, we shall inform the doctor and tell you when we have requested it. The doctor will hold the report for 21 days to allow you to see it. If you do see it before it is sent to us, the doctor will only release it to us with your permission.

You can ask the doctor to amend anything in the report you consider is incorrect or misleading.

You can ask the doctor to attach to the report a statement from you that sets out your disagreement with what the doctor has said.

The doctor does not have to let you see any part of the report that may harm your physical or mental health, or that of others, or that indicates the doctor's intentions towards you. If the report reveals information about someone else who has supplied information about you, other than information from another health professional involved in your care, the doctor may only release it to you with that person's consent. If this is the case, the doctor must tell you and you will only be able to see any remaining part of the report. If the whole report is affected, the doctor must not send it to us unless you give your consent.

If you want to see the report at any time up to 6 months after it is sent to us, you may ask the doctor to show you a copy. There may be a charge for this to cover the doctor's costs.

How we shall process information relating to you

We shall hold all information relating to you, including medical reports, electronically and/or in a manual system. We shall process all information fairly and lawfully in accordance with the principles of the Data Protection Act 1998.

Access to information concerning you will be limited to employees and contractors of Unum, for example independent health professionals, who need access in order to process and/or assess the application.

We may additionally share information and conduct checks with third parties for purposes relating to the application, for validation purposes and for other lawful purposes. Third parties (who may be situated either within or outside the European Economic Area) may include, but are not limited to, reinsurers, underwriters, the Financial Services Authority, the Financial Ombudsman Service, medical agencies, other insurance companies and sub-contractors and agents. By signing this application you agree that we may share information concerning you.

We will not discuss medical information about you with anyone other than you without your written consent. This includes your financial and legal advisers, the policyholder, your employer, your spouse and other relatives and friends. To help us assess the risk or administer the policy, we may discuss non-medical information about you with your financial adviser or with the policyholder.

We monitor telephone conversations and e-mail communications from time to time for the purposes of training and in the interests of continually improving the quality of service we provide.

Your declarations and consents

I understand and I agree that I am entirely responsible for the statements I have made or that have been made on my behalf in this application and I declare that to the best of my knowledge and belief those statements are true and complete. I have taken the guidance provided in the application into account in making or in verifying my statements.

I agree to inform Unum immediately in writing of any change to my statements in this application before Unum's acceptance of the risk.

I understand that if at any time after I have submitted this application Unum finds I have given incomplete or false information, Unum may change the underwriting terms, refuse my claim or withdraw my cover.

I have read and I understand my statutory rights concerning the processing and use of information relating to my application as set out in this form.

I consent to Unum seeking, only for the purpose of underwriting my application,

- information from my medical records or a medical report from any doctor who at any time has attended me and I authorise the giving of this information.

Please read and tick one of these boxes only.

I WISH to see medical reports from my GP and/or Consultant before they are sent to Unum.

I DO NOT WISH to see medical reports before they are sent to Unum.

- information from any insurance office to which an application has been made on my life and I authorise the giving of this information.
- information concerning this application, including but not limited to information concerning my physical and mental health, from any third party and I authorise the giving of this information.

I consent to Unum confirming the underwriting decision, including any exclusion wordings or other special terms, to the policyholder and to the policyholder's financial advisers.

I authorise Unum to release information, including but not limited to information concerning my physical and mental health, to my doctors, to doctors or specialists appointed by Unum in relation to my application and to any third party who requires this information for lawful purposes.

Your signature

Date

Your full name

unum.co.uk

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We monitor telephone conversations and e-mail communications from time to time for the purposes of training and in the interests of continually improving the quality of service we provide.

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