Personal Accident & Illness Proposal Form

IMPORTANT NOTICE ALL QUESTIONS MUST BE ANSWERED IN FULL WHERE APPROPRIATE. PLEASE COMPLETE ALL DETAILS IN BLOCK CAPITALS AND INITIAL ANY ALTERATIONS. IT IS ESSENTIAL THAT YOU PROVIDE DETAILS OF **ALL RELEVANT FACTS.** A RELEVANT FACT IS ONE THAT WOULD BE LIKELY TO INFLUENCE THE UNDERWRITER'S ASSESSMENT AND/OR ACCEPTANCE OF YOUR PROPOSAL. IF YOU ARE IN ANY DOUBT AS TO WHETHER A PARTICULAR ITEM OF INFORMATION IS RELEVANT YOU SHOULD DISCLOSE IT. **FAILURE TO DISCLOSE ALL RELEVANT FACTS MAY INVALIDATE YOUR INSURANCE OR MAY RESULT IN THE INSURANCE NOT OPERATING FULLY.**

THIS INSURANCE EXCLUDES ALL PRE-EXISTING CONDITIONS UNLESS DECLARED TO AND ACCEPTED IN WRITING BY UNDERWRITERS.

YOU SHOULD KEEP A RECORD OF ALL THE INFORMATION THAT YOU SUPPLY IN CONNECTION WITH THIS INSURANCE (INCLUDING COPIES OF LETTERS). A COPY OF THE PROPOSAL WILL BE SUPPLIED TO YOU IF REQUESTED WITHIN THREE MONTHS OF ITS COMPLETION.

UNDERWRITERS RESERVE THE RIGHT TO DECLINE ANY PROPOSAL. NO COVER IS IN FORCE UNTIL ACCEPTANCE IS CONFIRMED BY UNDERWRITERS.

IF THE ANSWER TO ANY QUESTION IS "NOT APPLICABLE" OR "NONE" PLEASE STATE SO IN YOUR ANSWER. A DOT OR DASH OR LEAVING THE QUESTION BLANK IS NOT ACCEPTABLE AND MAY RESULT IN A DELAY IN THE ARRANGEMENT OF INSURANCE.

PART A

1. Proposer (if not the same person as the person to be covered by this insurance)

a) Full name

b) Address

c) Relationship to the person to be covered by this insurance

ALL REMAINING QUESTIONS IN THIS PROPOSAL FORM RELATE TO THE PERSON TO BE COVERED BY THIS INSURANCE.

2. a) Full name

b) Address

c) Date of birth **d)** National insurance no.

e) Height **f)** Weight

3. a) Occupation (if more than one, state all)

b) Is manual work involved? **YES** **NO** **c)** Are you self employed? **YES** **NO**

4. Requested period of insurance **FROM** **TO**

PART B

FOR QUESTIONS 5 TO 7 PLEASE ANSWER "YES" OR "NO" IN THE BOX PROVIDED. IF THE ANSWER TO ANY OF THESE QUESTIONS IS"YES", PLEASE PROVIDE FULL DETAILS IN THE SPACE PROVIDED OVERLEAF.

	YES	NO
5. Have you any physical defect or infirmity, or any defect of your sight or hearing or other senses or faculties?		
6. Do you intend to or anticipate that you might:		
a) travel extensively or reside outside the United Kingdom or Ireland?		
b) undertake more than 20 air flights per annum or fly other than as a fare paying passenger? (If "yes", please provide full details including expected number of flights)		
c) ride motorcycles or motor scooters? (If "yes", please advise cc)		
d) engage in football, rugby, equestrian or winter sports, or any other sport(s), pastime(s) or activity(ies) likely to involve extra risk of accident?		
7. Are there any additional facts affecting the proposed insurance which should be disclosed to underwriters?		

PART C

FOR QUESTIONS 8 TO 12 PLEASE ANSWER "YES" OR "NO" IN THE BOX PROVIDED. IF THE ANSWER TO ANY OF THESE QUESTIONS IS "YES", PLEASE PROVIDE FULL DETAILS IN THE SPACE PROVIDED OVERLEAF.

8. Have you ever suffered from:	YES	NO
a) clinical depression, anxiety, or any nervous or mental condition, fainting episode, blackout, fit or paralysis of any kind?		
b) high blood pressure, a heart condition, haemorrhoids, varicose veins or other circulatory disorder or diabetes?		
c) a "slipped disc", lower back strain or other spinal disorder, a hernia or any rheumatic or arthritic condition?		
d) asthma, bronchitis or any chronic respiratory disorder?		
e) any other condition or injury needing medical advice or treatment in the past three years, or that may require future treatment?		

PART C continued

	YES	NO
9. Are you currently taking any medication or do you have any medication prescribed? (If "yes", please provide reason including name of medication, daily dosage and length of treatment)		
10. Do you smoke any form of tobacco? (If "yes", please advise type and daily consumption. If "no", please advise how long you have been a non-smoker")		
11. Have any of your close relatives suffered heart disease, stroke, cancer, kidney disease, or other serious condition or disease? (If "yes", please provide brief details)		
12. Have you had any outpatients appointment or seen any doctor in the last 12 months for any condition you have not already described? (If "yes", please provide brief details)		

PART D

13. Please specify amount of cover required:

INSURED EVENT	**SUM INSURED**	
SECTION A: PERSONAL ACCIDENT	**£ Pounds Sterling**	**or € Euros Ireland**
1. Death	£	or €
2. Loss of a limb	£	or €
3. Loss of sight	£	or €
4. Permanent total disability	£	or €

a) Extended scale of benefits

Do you require permanent disability cover to include the Extended scale of benefits? (e.g. loss of use of fingers, shoulder, elbow, wrist, toes, hip, knee, ankle and the like). Please refer to your insurance adviser for further details.

YES	NO

5. Temporary total disability (see Notes overleaf). Maximum: 65% of your average weekly wage	£	or € per week
6. Temporary partial disability (see Notes overleaf). Maximum: 40% of weekly benefit under item 5	£	or € per week

SECTION B: ILLNESS		
1. Loss of sight in both eyes	£	or €
2. Permanent total disability by paralysis	£	or €
3. Temporary total disability (see Notes below). Maximum: 65% of your average weekly wage	£	or € per week

EXTRA BENEFIT: The insurance includes:

1. Medical expenses arising from insured events 5 and 6 of section A and insured event 3 of Section B, up to 15% of any claim that we pay for that insured event

2. Extra permanent disability cover
Cover is extended to include the following permanent disabilities an insured person suffers as a result of bodily injury. The amounts we will pay are shown as a percentage of the sum insured in the schedule for insured event 4 above.

- Severe brain damage which entirely prevents an insured person from performing at least four of the following activities of daily living without another person helping them or them using special equipment – 100%
  - Feeding and eating
    Cutting meat, buttering bread, getting food and drink to the mouth using fingers or utensils
  - Dressing
    Dressing, including fastening zips and buttons, and getting clothes from wardrobes and drawers
  - Bathing and grooming
    Turning on taps, getting in and out of a bath or shower, washing face, hands and so on, drying, combing hair
  - Toileting
    Moving into and out of the bathroom, getting on and off the toilet without help, recognising the need to go to the toilet in time to get there
  - Mobility and transfer
    Getting into and out of bed, transferring from one place to another (for example, a chair to bed, chair to standing, chair to chair)
  - Walking
    Moving from one place to another, including when using a wheelchair or walking frame
- Total bodily paralysis – 100%
- Permanent and total loss of hearing in both ears – 40%
- Permanent and total loss of hearing in one ear – 10%
- Permanent and total loss of speech – 40%

3. Hospitalisation
We will pay £50, or €50, for each full 24 hours of hospitalisation (after the first 72 hours) if an insured person suffers bodily injury during the period of insurance for which they need inpatient hospital treatment in the United Kingdom or Ireland, whichever country they have their permanent home in. The most we will pay is up to £1,500 or €1,500 in total.

PART D continued

NOTES APPLICABLE TO INSURED EVENTS AND SUMS INSURED:

- This insurance contains a restriction linked to your average earnings in respect of the maximum amount payable for **temporary total disability** and **temporary partial disability** (insured events 5 and 6 of section A and insured event 3 of section B). Please refer to your insurance adviser for further details.
- **Temporary partial disabilit**y cover is only available to persons in non-manual occupations.

	YES	NO
14. Do you have any other insurance which, along with this proposed cover, would provide more than 65% of your average weekly wage following accident or illness? (If "yes", please provide details below)		
15. Apart from any matter you have already described, are you in and do you generally enjoy good health? (If "no", please provide details below)		
16. Have you ever been declined or been accepted on special terms for life, accident, illness, medical, travel or any other health related insurance, or has any Insurer ever cancelled or refused to renew your Policy? (If "yes", please provide details below)		

DATA PROTECTION

The details you have provided will be used by Equity Red Star Services Limited to process your request in accordance with the Data Protection Act 1998 and other applicable laws. We share data with approved organisations for underwriting and fraud prevention purposes. Your data may also be processed outside the European Economic Area. In all instances we take steps to ensure an adequate level of protection is given to your information. In order to assess the terms of an insurance contract or administer claims that arise, we may need to collect data that the Data Protection Act 1998 defines as sensitive (such as medical data or criminal convictions). In order to process your information for the purposes of providing insurance and claims handling, it may be necessary to pass your information to carefully selected third parties and other Group companies. By proceeding with this application you signify your consent to such information being processed in this way.

If you have any queries, please contact the Company Secretariat at: Equity Insurance Group Limited, Library House, New Road, Brentwood Essex, CM14 4GD.

DECLARATION

DECLARATION I/We declare that to the best of my/our knowledge and belief all the information given on this proposal is true and complete and that nothing which might influence the Underwriters in accepting or assessing this Proposal has been withheld. I/We also declare that if any details or answers on this form have been computer generated or written by another person that person has acted as my/our agent. I/We hereby consent to any information that you may have about me/us being processed by you for the purpose of providing insurance and claims handling, which may necessitate your providing such information to third parties.

SIGNATURE(S) OF PERSON(S) TO BE COVERED BY THIS INSURANCE		**DATE**
SIGNATURE OF PROPOSER (IF NOT THE SAME PERSON AS THE PERSON(S) TO BE COVERED BY THIS INSURANCE)PARTNER'S		**DATE**

This proposal form provides only a summary of the features of the personal accident and illness insurance. It is not intended to be read as a full statement of cover. A specimen of the full wording is available on request from your insurance adviser.

PLEASE USE THE SPACE BELOW, TO SUPPLY FULL DETAILS WHERE YOU HAVE TICKED ANY OF THE SHADED BOXES.

Question Number	Dates and details in respect of questions answered "yes". (If additional space is required please continue on a separate sheet)
	(Note: in certain circumstances underwriters may request additional information and /or your permission to obtain a Private Medical Attendant's report to enable assessment of your proposal)