

Supplementary Insurance Application Form



Please refer to the scheme summary for full details of the cover available under the scheme.

You must be a subscribing member of the Police Federation to be eligible to join this scheme.

Cover is only available to members of an existing Group Insurance Scheme.

Cover is available to age 70 or the serving members retirement date, whichever is earlier.

Please ensure you have reviewed and can agree to the declarations overleaf before completing this form

Please Note: Our Privacy Notice can be viewed on our website at www.philipwilliams.co.uk.

A hard copy can be provided upon request.

Please tick this box to confirm that you are eligible for this scheme and have read the terms above

Details of the person to be covered:

Serving Officer Police Staff Partner of Serving Officer Partner of Police Staff

Police Federation: _____

Employer name: _____
(If different)

Serving Member Details (required in all cases):

Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Miss <input type="checkbox"/>	Ms <input type="checkbox"/>
Surname:		Forename/s:	
Address:			
			Postcode:
Email:			Tel No.:
Date of Birth: / /		Date Joined Force: / /	
Collar No.:		Nationality:	

Top Up Cover Required: - (tick options required)

Additional Life Cover Required – Serving member	<input type="checkbox"/> £50,000 (£5.50 per month) <input type="checkbox"/> £100,000 (£8.50 per month)
Additional Critical Illness Cover Required – Serving member	<input type="checkbox"/> £25,000 (£9.50 per month) <input type="checkbox"/> £50,000 (£15.50 per month)
Additional Life Cover Required – Partner	<input type="checkbox"/> £50,000 (£5.50 per month) <input type="checkbox"/> £100,000 (£8.50 per month)
Additional Critical Illness Cover Required – Partner	<input type="checkbox"/> £25,000 (£9.50 per month) <input type="checkbox"/> £50,000 (£15.50 per month)

The covered critical illness are :- • Alzheimer’s Disease • Aorta Surgery • Bacterial Meningitis • Benign Brain Tumour • Cancer • CJD • Coma • Coronary Artery (By-Pass) Surgery • Heart Attack • Heart Valve Replacement/Repair • H.I.V. and Hepatitis B Virus (Contracted in a documented duty related situation) • Total Loss of Hearing • Total Loss of Sight • Total Loss of Speech • Total Loss of Hands or Feet • Major Organ Transplant • Motor Neurone Disease • Multiple Sclerosis • Parkinson’s Disease • Paralysis • Irreversible Renal Failure • Severe Burns • Stroke • Traumatic Head Injury

Beneficiary Nomination Details:

As a member of the Federation Group Insurance Life scheme, please provide details of the person(s) that you wish to receive the money in the event of your death. Scheme trustees are not bound to follow the nomination but will take it into account. It is your responsibility to ensure that in the event of your circumstances or wishes changing you keep the information up to date.

Beneficiary Details:

Name	Date of Birth	Relationship	Percentage of Benefit
	/ /		
	/ /		
	/ /		

To be completed by your spouse/civil partner/partner if they are to be insured for the Life or Critical Illness benefits:

<p>Name of Spouse/civil partner/partner: _____</p> <p>Date of Birth: _____ / _____ / _____</p>
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In the event of my death, my nominated beneficiaries are:

Name	Date of Birth	Relationship	Percentage of Benefit
	/ /		
	/ /		

Please read and then sign the declarations below:

- I understand that the premium rates may vary from time to time as agreed with the Insurer.
- I confirm that I have read the summary of cover and am aware of the cover afforded under this scheme.
- I consent to the information on this form being stored / processed electronically.
- I understand that if my payments stop, all cover under the scheme will cease.
- If my application to join is successful, I will be notified when cover and payments will start and am aware that there is no cover prior to this date.
- I confirm that if I am applying for cover for my partner that the person meets the following criteria:
 - * You are co-habiting
 - * They are financially interdependent
- I understand that it is my responsibility that in the event of my circumstances or wishes changing that I keep my information up to date.

<p>Serving Member Signature: (Required in ALL cases)</p>	<p>Date: / /</p>
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Health Declaration (applicable to ALL applicants):

I confirm I have been actively at work in my usual occupation for a period of 8 consecutive weeks prior to my intended commencement of cover date (normal annual holiday entitlement may be ignored) and that I have not had more than 14 days absence through illness and/or injury during the last 12 months.

I confirm I am in good health and not aware of any condition or symptoms which may give rise to a claim under this insurance and I confirm I am not in receipt of any ongoing treatment or care (including checkups or regular medication) for any accident, illness or medical condition.

I confirm that I am not currently awaiting referral to a medical practitioner or specialist/consultant and I am not awaiting the results of any tests or medical investigation.

I confirm I have not had any application for insurance declined, postponed or subject to an increased premium or other special terms, and that I have not previously made any claim for Critical Illness or Sickness insurance.

I confirm that I have not previously been refused entry into the group insurance scheme.

I understand that if this declaration is found to be untrue then my insurance will be invalidated and scheme membership cancelled with no return of premiums.

Member Signature:	Date: / /
Partner Signature (if required):	Date: / /

Please note: If you are unable to confirm the above statements you may still be able to join the Scheme, but you will need to complete a full medical questionnaire for evaluation by our underwriters.

Payment of Premium:

If your application is accepted the 1st monthly payment will be collected by Credit/Debit card payment.

The remaining payments will be collected on a monthly basis by direct debit.

Please complete the direct debit mandate on page 4 of this form along with your Debit/ Credit details below: -

1st Payment Details:

Credit/Debit card: **VISA DEBIT / MASTERCARD / VISA CREDIT (delete as applicable)**

Cardholder Name: _____

Card Number: _____

Valid From: _____ / _____ / _____

Expiry Date: _____ / _____ / _____

Issue No*: _____ **(*if applicable)**

Security Code: _____

Cardholder signature: _____ **Date:** _____

Please return this completed form to:
Philip Williams and Company, 35 Walton Road, Stockton Heath, Warrington, WA4 6NW
or email: schemes@philipwilliams.co.uk

