

4. How long did the symptoms last?		
5. Please advise the last time you suffered from this medical condition and confirm the nature and extent of any resulting disability?		
6. What advice and/or treatment were you given ?		
7. Did you require any time off work ?	Yes <input type="radio"/> No <input type="radio"/> If "yes" please give details	Yes <input type="radio"/> No <input type="radio"/> If "yes" please give details
8. Have you made a complete recovery resulting in cessation of treatment and are no longer attending or waiting follow up appointments	Yes <input type="radio"/> No <input type="radio"/> If "No" please give details	Yes <input type="radio"/> No <input type="radio"/> If "No" please give details

Section 5 - 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 any insurer seeking information from any doctor or medical adviser who at any time has attended me concerning anything which affects my physical or mental health or seeking medical information from any insurance company to 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 purposes 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 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 one only

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 5 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 want 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 a copy of 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 doctor's intentions to you,
 > reveal the identity of a 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.
 A terms of business letter is included with this application form. If it has not been included please contact Philip Williams & Co on 01925 604421 for a copy.

PLEASE COMPLETE AND RETURN TO :

**Northamptonshire Police, Police Federation Office, The Lodge
 Wootton Hall Park, Wootton, Northampton NN4 0JA**

06/17 v1

**NORTHAMPTONSHIRE POLICE FEDERATION
 SUPPLEMENTARY INSURANCE SCHEME** 

Underwritten Application Form With effect from 1 September 2018
SUPPLEMENTARY LIFE INSURANCE

ADDITIONAL £25,000	£3.60 per calendar month
ADDITIONAL £50,000	£6.20 per calendar month
ADDITIONAL £100,000	£11.20 per calendar month

SUPPLEMENTARY CRITICAL ILLNESS (NOT AVAILABLE TO PARTNERS)
ADDITIONAL £5,000 **£2.60 per calendar month**

All benefits cease at age 65

Please complete this form in block capitals and tick answers as applicable.

The answers you give on this declaration form will be used to assess the proposal for insurance and must be answered fully to the best of your knowledge and belief. All questions should therefore be carefully answered. If you are unsure whether a particular fact is relevant then this information should be disclosed. Any change in your circumstances following the completion of this declaration form should be notified to the Insurer. Part or all of the policy benefits may be forfeited if relevant information is withheld.

Please tick appropriate option

Serving Member **Partner of Serving Member** (Member name _____)

Police Staff Member **Partner of Police Staff Member** (Member name _____)

**(Payable by Direct Debit, please complete additional Direct Debit form)*

Section 1 - Personal Details

Name of employer		
Full name Mr/Mrs/Miss/Ms		
Home Address		
Postcode	Email	
Home tel no.	Work tel no.	
Exact description of occupation		
Marital status	Date of birth	Place of birth
Members Work / Pay number.		
Nomination of Beneficiary (Name and relation)		

