



RISK  
ASSURANCE  
MANAGEMENT

**Please Return to:**

**Cumbria Police  
Federation Office  
12 The Green  
Carleton Hall  
Penrith  
CA10 2BA**

**Serving Member  
&  
Spouse/Partner of Serving Member**

**PERSONAL DECLARATION FORM**



# PERSONAL DECLARATION

## QUESTIONS TO BE ANSWERED BY THE PERSON WHOSE LIFE IS PROPOSED TO BE INSURED

Before any question is answered, please read carefully the Declaration at the end of this form, which must be signed and dated. Please ensure that all answers are complete and correct. Any question left unanswered or only answered with a dash will delay the assessment of this Proposal for assurance.

If you require additional space for any answers please use the further information section at the end of this form.

### Section 1: Details of the person to be Assured

Serving Member  Spouse/Partner of Serving Member

Serving Members Name		Serving Members Collar/Payroll Number	
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Title (Mr., Mrs., Miss, other)		Surname		Forenames	
Address					
		Postcode		Contact telephone number	
Date of birth		Sex (M, F)		Marital status (married, single, divorced, separated, widowed, in civil partnership)	
Nationality				Normal Country of Residence	

### Section 2: G.P. details

Name of doctor who currently holds your medical records	
Address and telephone number	
If you have changed doctors within the last 3 months, please give the name, address and telephone number of your previous doctor.	

### Section 3: Occupation

Employer's name:			
Nature of business or occupation in which you are engaged (if more than one, please state all):			
	Yes	No	If yes, please give full details
Do your duties involve you in any way (other than clerical) with:			
1) the licenced trade or entertainment industry?  2) working at heights, offshore, aviation (other than on scheduled flights), diving, or the fishing or mining industries, work requiring special safety precautions or any other activity which may be regarded as hazardous?			
Does your job require a licence, e.g. driving?			



#### Section 4: Smoking and alcohol details

	Yes	No	If yes, please state average consumption per week
Have you smoked or used any form of tobacco or nicotine product within the last 12 months?			
Do you drink alcohol? (if yes please state your average weekly consumption in units.(one unit is a pub measure of wine or spirits or a half a pint of beer, lager or cider))			

#### Section 5: Personal medical details

Height			Weight	
	Yes	No	If yes please provide details, including name of doctor or hospital, dates, duration, test results etc.	
1) Has your weight changed recently?				
2) Have you consulted any doctor, hospital or clinic within the last 5 years?				
3) Are you currently receiving any medical treatment?				
4) Are you taking any medicine or drugs, whether or not prescribed by a medical practitioner?				
5) Are you due to have any check-up in the next 12 months in connection with any medical condition, or are you waiting for the results of any medical inspection?				
6) Have you ever suffered from:				
(a) any chest or lung disorder?				
(b) anxiety, stress, depression or other mental or nervous disorder?				
(c) back problems, arthritis, bone joint, muscle or limb conditions?				
(d) asthma bronchitis or other respiratory disorders?				
(e) any stomach, bowel complaint, liver disorder(including bladder disease, gastric or duodenal, Colitis or Crohn's disease)				
(f) diabetes, gout, kidney, liver, prostate or bladder problem?				
(g) heart attack, angina or heart disease?				
(h) high blood pressure, raised cholesterol, stroke circulatory problems, brain haemorrhage or permanent brain injury?				
(i) cancer, tumour or gout?				



	Yes	No	If yes please provide details, including name of doctor or hospital, dates, duration, test results etc.
(j) Multiple sclerosis, Parkinson's disease, paralysis, epilepsy, Alzheimer's disease, dementia or cerebral palsy?			
(k) eye, ear nose or throat conditions, skin or allergic conditions?			
(l) any operation, X-rays or special investigations?			
7) Have you had any numbness, dizziness or any disease or disorder affecting your balance or your eyes or vision (not corrected by spectacle or lenses)?			
8) Do you anticipate travel outside your normal country of residence, Western Europe, North America or Australasia? (other than for holiday)			
9) Within the last 10 years, have you lived for longer than 1 month in any country outside your normal country of residence, Western Europe, North America or Australasia?			
10) Do you engage in hazardous sports, such as aviation, motor sports, diving, etc.?			
11) Have either of your parents or any brothers or sisters died from or suffered from heart disease, stroke, diabetes, cancer, a nervous disorder or any hereditary disease or disorder before the age of 65?			<i>If yes please provide details including relationship and age at time, and state if death resulted.</i>
12) Has any application for assurance on your life been declined, withdrawn by yourself or accepted at special terms?			<i>If yes please give details of companies and dates.</i>
13) Have you ever tested positive for HIV/AIDS, hepatitis B or C or are you awaiting the results of such a test?			<i>If yes please give details including dates - for confidentiality these may be sent direct to the Chief Medical Officer.</i>
14) Within the last 5 years have you been exposed to the risk of HIV infection? (Note: this can be caught through unsafe sex, intravenous (IV) drug abuse, blood transfusions or surgery undertaken outside the EU.)			<i>If yes please give details including dates - for confidentiality these may be sent direct to the Chief Medical Officer.</i>
15) Within the last 5 years have you tested positive or been treated for any sexual transmitted disease?			<i>If yes please give details including dates - for confidentiality these may be sent direct to the Chief Medical Officer.</i>
16) Are you using or have you ever used drugs other than those prescribed by a doctor or obtained over the counter from a pharmacy? i.e. recreational drugs such as ecstasy, cocaine, heroin, etc.			



## Section 6: Additional Information

Question:	Additional Information

## SECTION 7: IMPORTANT NOTES

- Please note that your answers to the questions on this form will be used to assess the risk involved in providing you with the proposed level of cover. If you are unsure whether a particular fact is important you should disclose it.
- Cover will not start until we have assessed and accepted your answers given in this form.
- We may ask you to contact your doctor to speed up the completion of reports that we have requested.
- If we ask you to attend a medical examination, it will be necessary for us to share your application information with another company authorised by us. They will make the arrangements for the examination to take place.
- It may be necessary for us to send your form and relevant medical reports to the participating Lloyd's Underwriters or their Reassurers for their opinion or agreement of the terms offered.
- On occasion the faxing of medical reports may help to ensure a speedier assessment of your medical assessment. We only accept faxed information direct to a fax machine in a secure part of our building. This ensures that we maintain strict confidentiality. If you do not agree to allow the faxing of information, please indicate by deleting the appropriate section in this form.
- Risk Assurance Management Limited has a confidentiality practice in place which means that your medical information is held securely and access is limited to authorised individuals who need to see it.
- You must inform us of any changes in your health or other circumstances during the period between this form being completed and in us notifying the terms on which cover will be offered.

## DATA PROTECTION

I understand that the use of any information provided by me for the operation of this insurance is for the process of underwriting, administration, claims management, handling customer concerns and the detection, prevention and investigation of fraud.

I understand that in order to do this the information may be shared with other insurers, reinsurers, insurance intermediaries and service providers who are involved in either the operation of insurance which covers members or the member's benefits arrangements provided by the Company in accordance with the Data Privacy Notice shown on our website: [www.ram-ltd.co.uk](http://www.ram-ltd.co.uk).

I understand the data will be processed fairly and securely and the details will be stored on computer but will not be kept longer than necessary.

I understand that the data I have provided in relation to this insurance will be processed in accordance with the requirements of the General Data Protection Regulation.



## STATEMENT OF PRACTICE ON GENETICS

In accordance with the Association of British Insurers ('ABI') policy on genetics and insurance, you do not need to tell us about any genetic test you have had if the proposed level of cover, taken together with any other insurance cover you already have, total:

- £500,000 or less for life assurance.
- £300,000 or less for critical illness or income protection.

Above these limits, you may need to tell us about certain genetic test results when applying for certain types of insurance. We will only be interested in genetic test results which have been approved by the Government's Genetic and Insurance Committee 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](http://www.abi.org.uk)

However you must tell us if you have either a family history of, are experiencing symptoms of, or are having treatment for, a medical condition including any genetically inherited condition.

## SECTION 8: ACCESS TO MEDICAL REPORTS

It may be necessary for us to obtain medical reports to support your application for cover. Before we can ask any doctor that you have consulted to complete a report, we need your permission under the Access to Medical Reports Act 1988. Your rights under the Act are as follows:

- You do not have to give your consent, but if you do not we may be unable to proceed. This does not stop you from applying to other companies for insurance.
- You can ask to see the report before the doctor returns it to us. If you do, we shall tell the doctor to retain the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.
- If you choose not to see the report at this stage, you may ask the doctor for a copy within 6 months of it being sent to us. A duplicate report can be sent to your doctor on request should you wish to see it at a later date.
- If you consider any aspect of the report to be incorrect or misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him/her to attach a statement outlining your views, which will then accompany the report.
- Your doctor can withhold access to the report if he/she feels that it would cause physical or mental harm to you or others.
- Your medical report will contain details of relevant consultations, treatment, operations, investigations and test results that you have undergone at any surgery, hospital or clinic. Your consent will give Risk Assurance Management Limited access to this information.
- If you have any questions regarding your rights under the Act or any questions relating to the process of obtaining, assessing or storing medical information, please write to the Compliance Officer at our Head Office.
- **I do not\* wish to see the report before it is sent to Risk Assurance Management Limited. (\*Only delete the word "not" if you wish to see the report before it is sent.)**



**SECTION 9: DECLARATION**

Please sign this Personal Declaration once you have read it together with all of the sections. If you are unsure as to whether any information should be given, you should provide it. If you are applying for insurance with other companies at the same time, by signing the form you are consenting to copies of medical reports being sent to these other companies at their request. However, if we are approached by another company to provide copies of highly sensitive information we shall ask for your specific written permission before doing so.

- I will inform you immediately of any changes that occur before Risk Assurance Management Limited notify the terms on which cover will be offered. I understand that failure to do so may result in the loss or cancellation of the cover being assessed.
- To the best of my knowledge and belief all the statements made, which includes anything I may have said, have been recorded accurately in this form or are attached in a sealed Private and Confidential envelope, and are true and complete.

Please tick if you have attached a Private and Confidential envelope.

- I agree to Risk Assurance Management Limited obtaining medical information from any doctor whom I have consulted about my physical or mental health, in order to assess my application. You may obtain relevant information from other insurers about previous or concurrent applications for life, critical illness, sickness, disability, accident or private medical insurance that I have applied for. I authorize those asked for such information to provide it on the production of a copy of this consent. This consent allows Risk Assurance Management Limited to obtain medical reports at any time during the period of the cover or after my death to support any claim made on the cover proceeds.
- This information can also be used to maintain management information for business analysis.
- I agree that a copy of the agreement given in this Declaration will have the validity of the original.
- I agree to Risk Assurance Management Limited accepting medical reports faxed directly to the company from my doctor’s surgery. I also do not\* object to copies of the report being faxed to any other company that I have applied to at their request. (\*Delete the word “not” if you do not wish us to fax information.)

By signing this form, I am allowing Risk Assurance Management Limited to carry out my risk assessment using the information that I have provided. This information can also be used to process any claim made in respect of me on this policy.

I confirm I have read and understood the information in this form including the section relating to:

- Data Protection
- Statement of Practise on Genetics
- Access to Medical Reports Act 1988
- The Declaration

I understand that Risk Assurance Management Limited may ask other insurers for information to check the information I have given.

**LIFE TO BE ASSURED:**

<b>Signature</b>		<b>Date</b>	
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The Group Life Assurance is administered by Risk Assurance Management Limited in its capacity as a Lloyd’s Coverholder on behalf of certain Underwriters at Lloyd’s where the risk is underwritten.