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 ◯ No ◯ If "yes" please give details	Yes ◯ No ◯ 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 ◯ No ◯ If "No" please give details	Yes ◯ No ◯ 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 authorise the payroll department to deduct the appropriate subscription from my salary.

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 TOGETHER WITH THE DIRECT DEBIT FORM TO :

Philip Williams and Company, 35 Walton Road, Stockton Heath, Warrington, Cheshire WA4 6NW

04/14 v2

Philip Williams&Co INSURANCE MANAGEMENT

SUPPLEMENTARY INSURANCE SCHEME

SUPPLEMENTARY LIFE INSURANCE

ADDITIONAL £50,000	£13.95 per calendar month
ADDITIONAL £75,000	£19.95 per calendar month

SUPPLEMENTARY CRITICAL ILLNESS

ADDITIONAL £30,000	£14.00 per calendar month
ADDITIONAL £50,000	£20.00 per calendar month

The listed illnesses are:-

- Alzheimer's Disease
- Aorta Surgery
- Benign Brain Tumour
- Cancer
- CJD
- Coma
- Coronary Artery (By-Pass) Surgery
- Heart Attack
- Heart Valve Replacement/Repair
- H.I.V. (A.I.D.S.) and Hepatitis B Virus (Contracted in a documented duty related situation)
- Total Loss of Hearing
- Total Loss of Sight
- Total Loss of Speech
- Major Organ Transplant
- Motor Neurone Disease
- Multiple Sclerosis
- Parkinson's Disease
- Paralysis
- Irreversible Renal Failure
- Severe Burns
- Stroke

Available to members of an existing Group Insurance Scheme. A separate application form needs to be completed if you wish to take out cover for your spouse or partner. Please note cover is payable by direct debit and will only commence following acceptance from the underwriters. COVER AVAILABLE TO AGE 60

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.

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)

Please tick one - **Member application** ◯ **Partner application** ◯
(Member Name_____)

Please indicate the level of additional cover you require (tick a maximum of one option in each category):			
I APPLY FOR ADDITIONAL LIFE COVER OF:	£50,000	◯	£13.95 per month
	£75,000	◯	£19.95 per month
I APPLY FOR ADDITIONAL CRITICAL ILLNESS COVER OF:	£30,000	◯	£14.00 per month
	£50,000	◯	£20.00 per month

Statement of Fact
Are you aware of any reason that an insurer would regard as likely to influence the assessment and acceptance of this application? This may include, but not be exclusive to being posted overseas, undertaking hazardous duties or pastimes,

Yes ◯ **No** ◯ If "yes" please give details

Section 2 – Insurance history
1 . Has any application for life, income protection (PHI) or critical illness insurance on your life ever been declined, postponed or withdrawn, or accepted at an extra premium, subject to a debt or on other special terms?

Yes ◯ **No** ◯ If "yes" please give details and dates and name of insurance company

2 . Has any proposal for any form of insurance on your life been made to any insurance company within the past six months or are you expecting to do so in the next six months?

Yes ◯ **No** ◯ If "yes" please give details and advise if a medical examination was performed

Section 3 – Health & lifestyle (failure to complete this section in full will result in delays)

1. What is your height and weight?
Height ft ins (or cms). Weight st lbs (or kgs)

2. What is your average WEEKLY consumption of :
A) Alcoholic drinks ? units B) Tobacco ?
A unit of alcohol is a pub measure of wine or spirits, or half a pint of beer, lager or cider.

3a. Name and address of your current GP :

Tel :

3b. Name and address of any other GP consulted in last 5 years

Tel:

4. During the past 5 years have you attended or been advised to attend any medical practitioner for any form of medical consultation, investigation, treatment or advice, or are you awaiting these?

Yes ◯ **No** ◯ If "yes" please give medical reason(s) and complete section 4

5. Are you currently having treatment (eg diet, medicines, tablets or injections) whether prescribed or not for any medical or psychiatric condition?

Yes ◯ **No** ◯ If "yes" please give medical reason(s) and complete section 4

6. Have you EVER suffered from:

If "yes" please state type of treatment and complete section 4

A) Any disease of the heart/circulatory system, high blood pressure/stroke ?	**Yes** ◯	**No** ◯
B) Any cancer, growth or malignancy ?	**Yes** ◯	**No** ◯
C) Any form of kidney (renal) disease ?	**Yes** ◯	**No** ◯
D) Any disease or disorder of the eyes ?	**Yes** ◯	**No** ◯

7. Have you tested positive for HIV/AIDS or Hepatitis B or C, or been tested/treated for other sexually transmitted diseases or are you awaiting the results of such a test?

Yes ◯ **No** ◯ if "yes" then FULL details MUST be declared to avoid delay with your application.

8. Have any of your parents, brothers or sisters died or suffered from heart disease, stroke, high blood pressure, diabetes, kidney disease, cancer, multiple sclerosis, nervous disorder or any hereditary disease before age 65?

Yes ◯ **No** ◯ if "yes" then FULL details of age at diagnosis, relevant dates, and information about their current health MUST be declared to avoid delay with your application.

9. Do you currently, or do you intend, to take part in any hazardous leisure activities?
(For example, Private Aviation, Motor Racing, Mountaineering)

Yes ◯ **No** ◯ If "yes" or you are in doubt about any activity, please give details.

Section 4 Further details of life to be insured
Only complete this section if you have disclosed a medical condition in Section 3. Please give full details in the boxes provided and continue on a separate sheet if necessary.

	Condition 1	Condition 2
1. Medical condition disclosed		
2. Please describe the symptoms you have suffered and give the date they started		
3. How frequent were the conditions ?		

Philip Williams&Co
INSURANCE MANAGEMENT

DIRECT Debit

INSTRUCTIONS TO YOUR BANK OR BUILDING SOCIETY TO PAY DIRECT DEBITS

Originators Identification Number

7	5	3	2	9	4

PLEASE FILL IN PARTS 1 TO 5 AND RETURN TO:

Philip Williams & Company, 35 Walton Road, Stockton Heath, Warrington, WA4 6NW Tel 01925 604421

1. Name(s) of account holder(s)

2. Bank or Building Society Account number

3. Branch sort code
(from top right hand corner of your cheque)

\- \-

6. Philip Williams & Co REF.

For Philip Williams & Company official use only.
This is not part of the instruction to your Bank or Building Society.

4. Name and Full Postal Address of your Bank or Building Society branch

To: The Manager Bank or Building Society

Address

Postcode

5. Instructions to your Bank or Building Society

Please pay Philip Williams & Co. Direct Debits from the account detailed on this instruction subject to the safeguards assured by The Direct Debit Guarantee. I understand that this instruction may remain with Philip Williams & Co, and if so, details will be passed electronically to my Bank/Building Society.

Signature(s)

Date

Banks and Building Societies may not accept Direct Debit Instructions for some types of account.

This guarantee should be detached and retained by the Payer.

THE DIRECT DEBIT GUARANTEE

DIRECT Debit

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits
- If there are any changes to the amount, date or frequency of your Direct Debit Philip Williams & Co will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request Philip Williams & Co to collect a payment, confirmation of the amount and date will be given to you at the time of the request
- If an error is made in the payment of your Direct Debit by Philip Williams & Co or your bank or building society you are entitled to a full and immediate refund of the amount paid from your bank or building society
- If you receive a refund you are not entitled to, you must pay it back when Philip Williams & Co asks you to
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.