Proposal Form

UK Form for Loss of Commercial Flying Licence Insurance

Part 1 - Instructions and Undertakings:

1 All sections of this proposal form **MUST** be completed in full in **ENGLISH**.

2 The Insurer relies on the proposal form containing all material information about you and that the information is true and complete. Material information is **anything** that may influence the Insurers decision to issue a policy or not or to decide on what terms a policy will be offered to you. If you are unsure if something is material, you **must** disclose it.

3 If there is any change in the information declared after the date you sign this proposal form and before any cover offered by the Insurer commences, you must advise the Insurer immediately. The Insurer may alter the terms quoted to you in such circumstances.

4 If you do not make a true and complete disclosure of material information, the Insurer may at their election cancel your policy or modify the terms on which it was issued. It will also prejudice your ability to claim under the policy.

Data Protection

Catlin includes Catlin Underwriting Agencies Limited and Catlin Insurance Company (UK) Ltd. ("the Insurer")

The information provided on this form, together with medical and any other information obtained from you or from other parties about you in connection with this policy, will be used by the Insurer for the purposes of determining your application, the operation of insurance (which includes the process of underwriting, administration, claims management, rehabilitation and customer concerns handling) and fraud protection and detection.

Information may be transferred overseas for these purposes.

Information may be shared by the Insurer for these purposes with group companies and third party insurers, reinsurers, insurance intermediaries and service providers. Such parties may become data controllers in respect of your personal data.

By completing and submitting this form, you consent to the processing of any personal data about you, including sensitive personal data, the transfer of such personal data about you overseas for these purposes as set out in this notice by the Insurer and such third parties and any other data controllers to which the personal data are transferred or disclosed for these purposes.

Your personal data will only be available to those who need to see it. For example, sensitive data, such as medical records will be used for the purposes of underwriting or claim management and rehabilitation only.

You are entitled to a copy of all your personal data upon receipt of a written request to the following address:

The Compliance Officer, Catlin Insurance Company (UK) Ltd., 20 Gracechurch Street, London, EC3V 0BG.

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Part 2 - Personal Information:

1. Surname:

2. First name(s):

3. Rank:

4. Date of birth: (dd/mmm/yyy)

5. Main employer:

6. Date cover to commence: (dd/mmm/yyy)

7. Annual taxable earned income from your main employer:

8. Any other earned income from flying:

9. During a period of disability, does your employer provide contractual sick pay?

☐ Yes ☐ No If **Yes**, how much and for how long:

10. During a period of disability are you entitled to benefit from any other loss of licence, disablement or accident insurance policy which pays a temporary benefit?

☐ Yes ☐ No If **Yes**, how much and for how long:

11 During a period of disability will you receive any other regular income?

☐ Yes ☐ No If **Yes**, how much and for how long:

12 Are you entitled to benefit from any other loss of licence, disablement or accident insurance policy which pays a lump sum benefit only?

☐ Yes ☐ No If **Yes**, please give name of insurer(s), policy number(s) and benefit payable.

13 Type of aircraft flown: (please tick all which apply):

Fixed Wing ☐

Rotor Wing (On Shore) ☐

Rotor Wing (Off Shore) ☐

14 All current licences held: (Please specify type, number, country of issue and whether any limitations apply or have applied previously)

Type	Number	Country of Issue	Limitations (yes or no)

Please give details of any licence limitations in **Part 6 - Supplementary Information**

Part 3 - Basis Of Cover:

15. Sum to be insured:

Loss of Licence £ ☐

(Maximum - £ 200,000)

16. Please state if this Proposal is: (Please tick which applies)

(a) Your first proposal to the Insurer ☐

Or

(b) An additional amount to an existing insurance ☐

(If b) state existing Policy No. and amount insured and insurer)

Part 4 - Medical Information:

17. Do you hold a current medical certificate?

☐ Yes ☐ No

18. What is your height: (cm)

What is your current weight: (kg)

19. Has there been any significant change in weight in the last year? (± 6.5kg)

☐ Yes ☐ No If **Yes**, please give details:

20. Date of last aircrew medical examination: (dd/mmm/yyy)

Were you advised of any abnormality, referred for additional tests, specialist examination or asked to follow any treatment or diet plan?

☐ Yes ☐ No If **Yes**, please give details:

21. Date of last electrocardiograph taken as required by the Licensing Authority: (dd/mmm/yyy)

Were you advised of any abnormality, referred for additional tests, specialist examination or asked to follow any treatment plan?

☐ Yes ☐ No If **Yes**, please give details:

22. Have you been investigated, diagnosed or treated for any of the following:

(a) Cancer, leukaemia, Hodgkin's disease, lymphoma, or any tumour of the brain or spine?

☐ Yes ☐ No

(b) A mole or freckle that has bled, caused pain or changed in appearance or any lump or growth?

☐ Yes ☐ No

(c) Heart disease (including heart attack, angina, valve defect, heart defects from birth or heart surgery)?

☐ Yes ☐ No

(d) Chest pain, irregular heart beat, raised blood pressure or raised cholesterol?

☐ Yes ☐ No

(e) Any other chest complaint?

☐ Yes ☐ No

(f) Disease or disorder of the arteries (including disease in the legs or of the aorta)?

☐ Yes ☐ No

(g) Stroke, Transient Ischaemic Attack [TIA], brain haemorrhage or brain injury?

☐ Yes ☐ No

(h) Asthma, bronchitis, lung or any other respiratory disorder?

☐ Yes ☐ No

(i) Multiple Sclerosis, optic or retrobulbar neuritis, Parkinson's disease, paralysis, epilepsy, Alzheimer's disease, dementia, bell's palsy or cerebral palsy?

☐ Yes ☐ No

(j) Any other disorder of the central nervous system not already mentioned?

☐ Yes ☐ No

(k) Numbness, loss of feeling or tingling of the limbs or face, loss of balance or coordination?

☐ Yes ☐ No

(l) Seizures, fits, fainting, unexplained loss of consciousness or blackouts?

☐ Yes ☐ No

(m) Mental illness or psychological problems that have required any kind of medical attention, time off work, hospital treatment or referral to a psychiatrist?

☐ Yes ☐ No

(n) Depression, anxiety, stress, insomnia, fatigue (including chronic fatigue syndrome [CFS] / myalgic encephalopathy [ME]) or nervous breakdown?

☐ Yes ☐ No

(o) Any disorder of the eyes or ears including blurred or double vision, or impaired hearing?

☐ Yes ☐ No

(p) Gout, arthritis, back pain, sciatica, neck, knee or wrist pain?

☐ Yes ☐ No

(q) Any other disorder of the joints, bones or muscles (including repetitive strain injury)?

☐ Yes ☐ No

(r) Diabetes, abnormal glucose tolerance or sugar in the urine?

☐ Yes ☐ No

(s) Disorder of the kidneys, bladder, or the genitourinary system (including blood or protein in the urine and urinary tract infections)?

☐ Yes ☐ No

(t) Any disorder of the digestive system, gall bladder, liver, stomach, spleen, pancreas, bowel (including ulcers, hepatitis, colitis or Crohn's disease or any other form of bowel disease)?

☐ Yes ☐ No

(u) Any blood disorder or anaemia?

☐ Yes ☐ No

(v) Thyroid or other glandular disorder?

☐ Yes ☐ No

(w) Any gynecological, menstrual or breast problems (e.g. breast lumps)? (female applicants only)

☐ Yes ☐ No

(x) Any prostate problems or problems relating to the breast tissue? (male applicants only)

☐ Yes ☐ No

(y) Have you ever tested positive for HIV, Hepatitis B or C or are you awaiting the results of such a test? If the result is negative the fact that you've had a test will not, of itself, have any effect on your acceptance terms for insurance.

☐ Yes ☐ No

(z) Any disease which was transmitted sexually?

☐ Yes ☐ No

(aa) Are you currently taking any form of medication, prescribed or otherwise or following any special diet or are you required to attend for follow-up or review?

☐ Yes ☐ No

(bb) Have you any current symptoms, medical disorder or abnormality for which you have not sought medical advise but intend to?

☐ Yes ☐ No

If you have answered **Yes** to any of the above, please provide further information regarding the condition, including treatment (whether proposed or received), medication (whether proposed or received) and prognosis in **Part 6 – Supplementary Information**

23. During the last 5 years have you been off work, unable to carry out your normal duties due to sickness or injury for more than 21 days at any one time, other than previously stated?

☐ Yes ☐ No If **Yes**, please give details:

24. Are you aware of any symptoms or complaints for which you have not consulted a doctor or received treatment?

☐ Yes ☐ No If **Yes**, please give details:

25. Have you ever been advised by your doctor or another medical practitioner to drink less alcohol?

☐ Yes ☐ No If **Yes**, please give details:

26. Have you used any form of tobacco or nicotine products in the last 12 months?

☐ Yes ☐ No If **Yes**, please give details of quantity per week:

27. Have you ever used recreational drugs (e.g. cocaine, heroin)

☐ Yes ☐ No If **Yes**, please give full detail including dates and state whether the drugs were injected If **Ye**

28. Have your parents, brothers or sisters, before the age of 65, died or suffered from, or had any investigations for Heart Disease, Stroke, Polycystic Kidney Disease, Cancer, Diabetes, Multiple Sclerosis, Polyposis of the Colon, Huntingdon's Disease or hereditary disorder?

☐ Yes ☐ No If **Yes**, please give details including age when diagnosed:

29. Have you ever had an application for loss of licence, life, critical illness or income protection insurance postponed, declined, accepted with an increased premium or on special terms?

☐ Yes ☐ No If **Yes**, please give details:

30. The Insurer may require additional medical information. If you have completed any section declaring medical history, please complete the following:

Usual Doctor or General Practitioner's name and contact address:

Consultant's name and contact address:

Part 5 - Declaration:

I hereby declare:

- that I have read the answers to the questions in this application form and, to the best of my knowledge and belief, the answers, whether in my own handwriting or not, are true and complete.
- that I have not withheld any material information which might influence the decision of the Insurer with regard to this proposal.

I agree that this proposal and declaration shall be the basis of the Contract between me and the Insurer if a policy is issued. I also consent to any information the Insurer may have about me being processed by them for the purposes of providing insurance and claims handling which may necessitate them providing such information to third parties.

Signed

Dated

(dd/mm/yyyy)

The Insurer reserves the right to impose special conditions or refuse to accept a proposal for insurance.

Notice of Statutory Rights Under the Access to Medical Reports Act 1988

Your Rights

(i) You can withhold your consent to the application of a medical report but without it, your cover may be restricted or your proposal for cover refused.

(ii) If you do give your consent you can indicate in the Declaration whether or not you wish to see the report before the doctor sends it to the Insurer.

(iii) If you wish to see any report the Insurer must tell you if they apply for one and notify the doctor of your wishes.

(iv) You will have twenty one (21) days to arrange with the doctor to see the report before it is sent to the Insurer.

(v) You have the right to ask the doctor, in writing, to amend any part of the report which you consider incorrect or misleading and you can ask him to attach a statement of your views on any part he refused to amend.

Exemptions

The doctor does not have to let you see any part of a report that he considers would be likely to cause serious harm to the physical or mental health of yourself or others, or that would indicate his intentions towards you. He also does not have to let you see any part that would be likely to disclose information about, or the identity of, another person who has supplied information about you, unless that person has consented or the information relates to, or has been supplied by, a health professional caring for you. If the doctor does not let you see any part of the report, he must notify you of that fact.

Time Limit

Once the report has been supplied, the doctor must keep a copy of it for six (6) months and you are entitled to inspect it or receive a copy of it during that time.

Procedures

(i) If you indicate in the Declaration that you do not wish to see any report, the doctor can send it to the Insurer immediately.

(ii) If at any time within the six months time limit you change your mind, you should notify the doctor that you wish to see the report and arrange with him to do so or to supply you with a copy. If you indicate in the Declaration that you do not wish to see any report the Insurer will notify you if they apply for one and you will then have twenty one (21) days to arrange with the doctor to see the report before he sends it to them. This could, of course, delay the processing of medical information. The doctor is entitled to charge you a fee for any copy report supplied to you.

Declaration

I have been informed of my rights under the Access to Medical Reports Act 1988 and hereby consent to the Insurer obtaining medical reports in connection with this application.

If you do **not** wish to see the report before it is sent to the Insurer, please tick this box. ☐

If you **do** wish to see the report before it is sent to the Insurer, please tick this box. ☐

Signed:		Dated: (dd/mm/yyyy):	

Part 6 –Supplementary Information:

Which question does this information relate to?

Date of occurrence (if more than one episode, please give all dates):

Diagnosis (suspected or confirmed):

Details of any treatment/medication received:

Periods off work (if no time off work, the duration of the problem):

If you had time off work, were the Licencing Authorities advised of your condition?

☐ Yes ☐ No (please delete as applicable).

If **Yes**, please give details of all formal groundings and any licence limitations imposed:

Is any further problem or treatment anticipated?

☐ Yes ☐ No (please delete as applicable).

If **Yes** please give further details:

If no further problem or treatment anticipated, has a full recovery been made?

☐ Yes ☐ No (please delete as applicable).

If **No** please give further details:

Which question does this information relate to?

Date of occurrence (if more than one episode, please give all dates):

Diagnosis (suspected or confirmed):

Details of any treatment/medication received:

Periods off work (if no time off work, the duration of the problem):

If you had time off work, were the Licencing Authorities advised of your condition?

☐ Yes ☐ No (please delete as applicable).

If **Yes**, please give details of all formal groundings and any licence limitations imposed:

Is any further problem or treatment anticipated?

☐ Yes ☐ No (please delete as applicable).

If **Yes** please give further details:

If no further problem or treatment anticipated, has a full recovery been made?

☐ Yes ☐ No (please delete as applicable).

If **No** please give further details:

Which question does this information relate to?

Date of occurrence (if more than one episode, please give all dates):

Diagnosis (suspected or confirmed):

Details of any treatment/medication received:

Periods off work (if no time off work, the duration of the problem):

If you had time off work, were the Licencing Authorities advised of your condition?

☐ Yes ☐ No (please delete as applicable).

If **Yes**, please give details of all formal groundings and any licence limitations imposed:

Is any further problem or treatment anticipated?

☐ Yes ☐ No (please delete as applicable).

If **Yes** please give further details:

If no further problem or treatment anticipated, has a full recovery been made?

☐ Yes ☐ No (please delete as applicable).

If **No** please give further details:

Free Text Area Below For Any Additional Information To Be Declared: