Application Form:

First Name:	
Last Name:	
Date of Birth (DD/MM/YYYY)	
Employer:	
Occupation and Rank:	
Home Address:	
Postcode:	
Home Phone Number:	
Mobile Phone Number:	
Email Address:	
Monthly Benefit Required **(between £ 1,000 and £ 5,000)**	**£** **(please remember to take into account any employer paid sickness or illness benefit)**
(subject to the total benefit including any employer paid benefit not exceeding 85% of your net monthly income)	
Waiting Period Required **(the period immediately after commencement of the disability in which no benefit will be paid)**	**180 days / 90 days / 60 days SELECT ONE** **(please remember to adjust this period to take into account any employer paid sickness or illness benefit)**
Personal Accident Lump sum benefit required (maximum £ 250,000)	**£**

Medical Declaration:

To join this group insurance we do not require any applicants to undergo any form of medical screening. We merely need each individual to complete our simple medical declaration:

Short Declaration:

I declare that:

- I am actively at work and/or fully fit for duty and have been for a continuous period of 30 days.
- I am the holder of a valid medical certificate which does not have any medical restrictions of any kind placed upon it (other than a standard visual/use of glasses if applicable)
- I am not on the advice of any Health Practitioner taking any form of medication or following any special diet or treatment plan.
- I have not taken any form of medication for a continuous period of more than 28 days.
- I have not been on sick leave for more than 14 consecutive days as a result of accident or sickness during the past 3 years.
- All of my routine ECG examinations have been accepted without the need for further referral or specialist examination.
- I have never been assessed as long term unfit nor had my license permanently revoked.

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

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

Signed: **Dated:**

Name (in capitals) **Employer:**

Date of Birth:

Any applicant who can not sign the declaration will only be considered for cover upon receipt of a fully completed proposal form by the insurers.