Lutine Assurance Services Limited,
PO Box 1189
Doncaster
DN1 9RP

T: 0344 854 2074
E: enquiries@lutine.com
www.lutine.com

Lutine
Assurance Services Limited
'our life is our business.

# Group Life Assurance Member's Declaration

**This page -** for completion by financial advisor/scheme administrator only
**Note:** Missing information **will** delay the underwriting process.

## Member Details

| | | | |
|---|---|---|---|
| Member Name | | Scheme Salary | |
| Category and benefit basis | | | |
| Post code of normal place of work | | | |

## Scheme Details

| | |
|---|---|
| Scheme Name | |

## Reasons for underwriting

Please confirm date (day/month/year) of member joining the company

/ /

Please confirm date (day/month/year) of members joining the scheme

/ /

Please tick relevant box

| | |
|---|---|
| Member over Free Cover Limit and/or previously accepted | ☐ |
| Member does not meet scheme eligibility<br>(Member does not meet the normal eligibility criteria e.g. category) | ☐ |
| Late entrant | ☐ |
| Early entrant | ☐ |
| Please confirm date (day/month/year) member would normally be eligible for inclusion<br>If not underwritten as an early entrant | / / |

Other Reasons and/or comments

Send this completed form attached to the fully completed Member Declaration in a sealed envelope to:

Chief Medical Officer
Lutine Assurance Services Limited,
PO Box 1189
Doncaster
DN1 9RP

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# Group Life Assurance Member's Declaration

**Pages 1-5 to be completed by the member**

## Important information

**You must answer all questions fully, accurately and truthfully to the best of your knowledge. Failure to do so may result in the payment of any benefit being rejected or reduced.**

● This Member's Declaration, along with any other information provided forms the basis of our agreement to consider providing cover that is not automatically granted by your scheme membership. We rely on the information you give us to make our decision about insuring you. If you are in any doubt about whether to provide information when filling in this form, please provide the information. If you do not disclose full details, the cover provided in the event of a claim could be rejected or reduced.

● In addition to the information you provide on this form, we may need to obtain further information about your health. This may involve us asking your doctor to provide us with a report, or contacting you to make arrangements for a medical examination should we require this.

● You should provide the answers on this form personally. If the answers are filled in by anyone else then they must be read over and agreed by you before the declaration is signed. Any alterations made should be completed and initialled by you.

● You need to tell us about any changes in health or circumstances during the period between completion of this form and Lutine Assurance notifying the terms on which cover will be offered. We are particularly interested in the following areas:

- Personal health;
- Family history;
- Occupation;
- Travel or residence;
- Hazardous pastimes;
- Alcohol consumption;
- Smoking habit
- Use of recreational drugs

## Section A: Personal Data

Scheme name

Title | Surname

Forename | Gender: Male ☐ Female ☐

Home Address

Post code | Telephone

Date of birth (Day/Month/Year) / / | Occupation

Nationality

If we require further information from you can we contact you directly? Yes ☐ No ☐

Please confirm agreeable method of contact. Please tick all acceptable options.

Correspondence to your home address ☐

Messages to an email address. If selected, please provide email address ☐

(We will only use this to contact you directly and will not pass your email address on to any parties not connected with this cover)

If you do not wish requests for medical information to go via the Sales Intermediary please tick this box ☐

Full name, address (including post code) and telephone number of your usual doctor/GP.

Post code | Telephone

Please note that we will not automatically contact your GP or Doctor. It is your responsibility to ensure the completed member's declaration is true, accurate and complete.

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# Group Life Assurance Member's Declaration

## Section B: Health Details

**IMPORTANT NOTES REGARDING COMPLETION OF THE MEMBER'S DECLARATION. READ CAREFULLY.**
**You must answer the questions fully and truthfully to the best of your knowledge. If you are in any doubt about whether to provide information when filling in the Member's Declaration, please provide the information. If you are unsure about any medical information, you may wish to consult your doctor before completing the form.**

**1.** What is your exact height? Ft ins or m cms

What is your exact weight? St lbs or Kilos

What is your waist measurement? ins or cms

**2. Smoking**

**a)** Have you consumed any cigarettes, cigars, pipe tobacco product or used any nicotine replacement product (eg patches, chewing gum, electronic cigarettes) within the last 12 months? Yes ☐ No ☐

If yes, please confirm weekly amount.

| Product | Weekly Amount |
|---|---|
| | |

**3..** Please confirm your average weekly consumption of alcohol in units
1 unit – 1 single pub measure of spirits; small (125) glass of wine;
½ pint of standard strength beer, lager or cider.

| Units per week | |
|---|---|

**4.** Have you ever been advised to reduced the amount you drink for medical reasons or have you ever received alcohol related counselling? Yes ☐ No ☐

**5. Have you ever had or been diagnosed with any of the following?**

a) Any cancer, leukaemia, Hodgkin's disease, lymphoma, brain or other tumour? Yes ☐ No ☐

b) Any disorder of the heart or circulatory disorders such as heart attack, angina, heart murmur, heart defects from birth, heart surgery, heart valve defect or cardiomyopathy? Yes ☐ No ☐

c) Any disorder of the brain such as stroke, brain haemorrhage, transient ischaemic attacks or permanent brain injury? Yes ☐ No ☐

d) Any neurological disorder such as paralysis, multiple sclerosis, numbness, tingling of the limbs or face, optic neuritis or visual disturbance? Yes ☐ No ☐

e) Any neurological disorder such as Parkinson's disease, epilepsy, Alzheimer's disease, dementia, cerebral palsy or muscular dystrophy? Yes ☐ No ☐

f) Any mental illness that has required hospital treatment or referral to a psychiatrist or other specialist? Yes ☐ No ☐

g) Any disorder of the digestive system, liver, hepatitis, pancreas or stomach including gastric or duodenal ulcer? Yes ☐ No ☐

h) Any bowel disorder such as colitis or Crohn's disease? Yes ☐ No ☐

i) Any form of diabetes or sugar in the urine? Yes ☐ No ☐

**6. In the past 5 years have you had:**

a) Raised blood pressure? Yes ☐ No ☐

b) Raised cholesterol? Yes ☐ No ☐

c) Chest pain or irregular heart beat? Yes ☐ No ☐

d) Any nervous disorders including depression, anxiety, stress, nervous breakdown or any eating disorder? Yes ☐ No ☐

e) Any musculoskeletal disorders such as gout, rheumatism, any form of arthritis or back and neck problems? Yes ☐ No ☐

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# Group Life Assurance Member's Declaration

## Section B: Continued

**IMPORTANT NOTES REGARDING COMPLETION OF THE MEMBER'S DECLARATION. READ CAREFULLY.**
**You must answer the questions fully and truthfully to the best of your knowledge. If you are in any doubt about whether to provide information when filling in the Member's Declaration, please provide the information. If you are unsure about any medical information, you may wish to consult your doctor before completing the form.**

f) Respiratory conditions such as asthma, bronchitis, shortness of breath or any other disorder of the lungs or respiratory system? Yes ☐ No ☐

g) Any blood disorder or anaemia? Yes ☐ No ☐

h) Any prostate, kidney or bladder disorder, including blood and/or protein in the urine? Yes ☐ No ☐

i) Any disorder of the adrenal, pituitary or thyroid glands? Yes ☐ No ☐

j) Any gynaecological disorder including abnormal smears? Yes ☐ No ☐

k) Any lump or growth or a mole / freckle that has bled, become painful, increased in size or changed colour? Yes ☐ No ☐

**7.** In the past 5 years have you attended or been asked to attend, any hospital or clinic for medical investigation, x ray, scan, check up or operation for any medical condition **not** already disclosed? Yes ☐ No ☐

**8.** **Are you presently:**

a) Suffering from any symptoms / conditions for which you have yet to seek medical advice for? Yes ☐ No ☐

b) Waiting for any consultation, investigation, test, follow-up or treatment for any medical condition not already disclosed? Yes ☐ No ☐

b) Taking any prescribed drugs, medicines, tablets or any other treatment / therapy? Yes ☐ No ☐

**9.** a) Have you ever tested positive for HIV/Aids or Hepatitis B or C, or are you awaiting the result of any such test? Yes ☐ No ☐

b) Within the last 5 years have you been exposed to the risk of HIV infection? (This can be caught through unsafe sex, intravenous drug abuse or blood transfusions or surgery undertaken outside the EU). Yes ☐ No ☐

c) Within the last 5 years have you tested positive or been treated for any disease, which is sexually transmitted? Yes ☐ No ☐

d) Have you ever used recreational drugs (e.g. cocaine, heroin, cannabis or ecstasy)? Yes ☐ No ☐

If you have answered 'yes' to any of the questions 4 – 9 please provide full details in the space provided below. For reasons of confidentiality, you may prefer to send information in respect of question 9 directly to the Chief Medical Officer, Lutine Assurance Services Limited, PO Box 1189, Doncaster, DN1 9RP, ensuring the name of the scheme is given.

- **You can also complete a Medical Conditions Questionnaire in respect of many of the conditions above. Completion of this form (where relevant) will speed up the underwriting process. Please ask for a copy where relevant.**

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# Group Life Assurance Member's Declaration

## Section B: Continued

**IMPORTANT NOTES REGARDING COMPLETION OF THE MEMBER'S DECLARATION. READ CAREFULLY.**
**You must answer the questions fully and truthfully to the best of your knowledge. If you are in any doubt about whether to provide information when filling in the Member's Declaration, please provide the information. If you are unsure about any medical information, you may wish to consult your doctor before completing the form.**

**10. Have any of your natural parents, brothers, or sisters, before the age of 65, suffered**

| | | |
|---|---|---|
| a) Hearth disease including angina, heart attack, cardiomyopathy? | Yes ☐ | No ☐ |
| b) Stroke? | Yes ☐ | No ☐ |
| c) Raised blood pressure? | Yes ☐ | No ☐ |
| d) Cancer? (Please confirm the type below) | Yes ☐ | No ☐ |
| e) Diabetes? | Yes ☐ | No ☐ |
| f) Polycystic kidney disease? | Yes ☐ | No ☐ |
| g) Multiple sclerosis, Parkinson's disease or motor neurone disease? | Yes ☐ | No ☐ |
| h) Haemochromotosis? | Yes ☐ | No ☐ |
| i) Huntington's disease? | Yes ☐ | No ☐ |
| j) Familial adenomatous polyposis? | Yes ☐ | No ☐ |
| k) Any other hereditary disorder? | Yes ☐ | No ☐ |

If you have answered yes, please confirm their relationship to you and the age when they were first diagnosed.

## Section C: Existing cover details

**1.** Do you have any existing insurance policies with Lutine Assurance (other than this group policy)? Yes ☐ No ☐

* If Yes please confirm the policy number

**2.** Has any application for life, health, critical illness or medical insurance ever been:

| | | |
|---|---|---|
| a) Declined? | Yes ☐ | No ☐ |
| b) Postponed? | Yes ☐ | No ☐ |
| c) Withdrawn? | Yes ☐ | No ☐ |
| d) Accepted on special terms? | Yes ☐ | No ☐ |

If yes, please confirm name of company, type of policy, dates and decision.

## Section D: Travel and Hazardous pursuits.

**1.** Do you have any intention to travel (other than holiday) outside of the following countries – UK, Isle of Man, Channel Islands, all other EU countries, Andorra, Australia, Canada, Gibraltar, Hong Kong, Iceland, Liechtenstein, Monaco, New Zealand, Norway, San Marino, Switzerland, USA and the Vatican City? Yes ☐ No ☐

*If Yes please confirm exact destination, durations and frequencies of trips.

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## Section D: Travel and Hazardous pursuits continued

**2.** ` Do you engage in, or have any intention of engaging in any hazardous sport? (e.g.. Aviation, motorsport, diving or mountaineering). Yes ☐ No ☐

* If yes please ask the financial adviser for the relevant questionnaire.

If your hazardous sport is not covered by one of our questionnaires, please confirm full details.

| |
|---|
| |
| |
| |

## Section E: Genetic Information Disclosure

In accordance with the Association of British Insurers' policy on genetics and insurance, you do not need to tell us about any genetic test result you have had if this application for insurance, taken together with any other insurance policies you already have for this type of insurance, totals £500,000 or less for life insurance. Above this limit, you may need to tell us about certain genetic test results when applying for insurance. We will only be interested in genetic test results where the Government's Genetics and Insurance Committee (GAIC) has approved them for insurers to 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 under 'information/for consumers/health and protection insurance/genetics'. However, you must tell us if you either have a family history of, or are experiencing symptoms of, or are having treatment for, a medical condition including any genetically inherited condition.

## Section F: Data Protection

The 1998 Data Protection Act places responsibilities on people and organizations who use personal information. The Act has particular regard to the right of the individual. It includes the right for individuals to have their information protected and imposes special conditions and rights if this information is classified as 'sensitive'.

'Sensitive personal information' is defined by the Act as comprising information about racial or ethnic origin, health, religious beliefs, sexual life, convictions or sentences and trade union membership. Our interest is restricted to the categories of health and sexual life for underwriting purposes. Any information collected from you by our underwriters will be carefully protected and any details which could be defined as 'sensitive' as above will receive extra protection.
We may, however, pass on information to our reassures and other individuals or groups for example, medical practitioners, who may be involved in the processing of this application for assurance.

'Sensitive' information relating to your application for assurance may not be processed without your explicit consent. Should your consent of the processing of 'sensitive' information not be given, it may not be possible to underwrite your application. Therefore would you please indicate your consent by signing below. All information provided may be retained for up to seven years from the date of your application or when you cease to be insured with us, whichever is the latter.

## Section G: Access to Medical Reports Act 1988

We may need to apply for a medical report from your doctor but before doing so we need your consent. You should know you have certain rights under the above Act. They are:

- You can withhold your consent BUT we may be unable to proceed without it.
- You have the right to see the report before it is returned by the doctor. Please indicate if you wish to do so.
- If you indicate that you wish to see the Medical report and we decide that one is required we will inform you of our intention to obtain a report. We will also notify the doctor that you wish to see the report. You will then have 21 days to make arrangements with the doctor to see the report. The doctor can charge a reasonable fee for this service.

If you indicate that you do not wish to see the report, you can change your mind but you must inform the doctor immediately. You will then have 21 days to make arrangements to see it before the report is returned to Lutine Assurance.

- You can also see the report up to six months after it has been provided to Lutine Assurance, even if you elected not to see it initially.
- If you consider the report (or any part of it) to be misleading you can add a statement of your own.
- The doctor can withhold the report (or part of it) from you if he feels it is in your interests to do so.

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## Section H: Your declaration and consent

I have been informed of my statutory rights under the Access to Medical Reports Act 1988, as explained on the previous page.

I consent to Lutine Assurance seeking medical information from any doctor who at any time has attended me concerning anything which affects my physical or mental health or seeking information, including the result of any HIV test, from any insurance office to which a proposal has been made on my life and I authorise the giving of such information, even after my death. I agree that a copy of this consent shall have the validity of the original.

I do **not** want to see the report before it is sent to Lutine Assurance ☐

I **do** want to see the report before it is sent to Lutine Assurance ☐

**Please ensure one box is ticked**

I declare that the answers given in this form are honest and to the best of my knowledge true and that I have not withheld any information which may influence the acceptance of my cover. I agree that this Member's Declaration will form part of my application for cover and understand that the terms of the cover to be issued shall be dependent upon the answers given and statements made in this form and made by me to any medical examiner appointed by Lutine Assurance.
I undertake to inform Lutine Assurance of changes to these statements which occur after the Member's Declaration has been completed and signed by me, up to the date Lutine Assurance notifies the terms on which cover will be offered.

If Lutine Assurance requires any further information from me, I undertake to inform Lutine Assurance of changes to these statements which occur until that additional information is received from me and accepted by Lutine Assurance. I understand that failure to do so may result in the loss or cancellation of the cover being assessed.

Signature: _____ Date ☐☐/☐☐/☐☐