

# Scheme Member's Application

Application to Unum Limited ("Unum", "we", "us")  
 Registered Office: Milton Court, Dorking, Surrey RH4 3LZ  
 Registered number: 983768



## Scheme details

**This section is to be completed by the financial adviser, employer or trustee in BLACK INK and in BLOCK CAPITALS**

The completed original form should be sent to Unum at the above address or scanned and e-mailed to muw@unum.co.uk

**Note to financial adviser/employer/trustee: Please do not have this form completed in full unless you know that underwriting will be required.** To notify us of a new joiner to the scheme, you may choose to send us this page on its own, giving us the scheme name and numbers and the new joiner details. We shall then confirm our underwriting requirements to you.

1. Scheme name

2. Cover type

<input type="checkbox"/>	Group Income Protection	Scheme Number	<input style="width: 100%; height: 20px;" type="text"/>
<input type="checkbox"/>	Group Life	Scheme Number(s)	<input style="width: 100%; height: 20px;" type="text"/>
<input type="checkbox"/>	Group Dependants	Scheme Number(s)	<input style="width: 100%; height: 20px;" type="text"/>
<input type="checkbox"/>	Group Critical Illness	Scheme Number	<input style="width: 100%; height: 20px;" type="text"/>

3. Reason for completing this form

Application for new or increased benefit above free cover for eligible member

Application for discretionary member (please specify):

The applicant does not meet scheme eligibility

Please state why the applicant does not meet scheme eligibility

Early entry

Late entry

(Applying to join Group Income Protection or Life/Dependants scheme more than 12 months after first eligible)

If early or late entrant, please state date joined company

4. Member details

Member's full name

Date of birth

Marital status

	Group Income Protection	Group Life	Group Critical Illness
Date of joining scheme	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
Scheme-defined salary	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
Membership category	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>

## Important information for the applicant

- **We ask you to complete this application carefully.** It is the basis of our agreement to consider cover that is not automatically granted by your scheme membership. Please answer all our questions in **BLACK INK**, writing in **BLOCK CAPITALS**.
- **We rely on the information you give us to make our decision about insuring you.** We will not routinely obtain a report from your GP. We only ask you to tell us what we think it's reasonable for you to know. If you are in any doubt about the need to tell us something, please give us the information in full as it's better to tell us a fact that turns out not to be relevant to the risk than to miss out something that later causes a problem.
- **We regard you as entirely responsible for what is disclosed to us.** If you don't complete the form yourself, we expect you to read carefully all the statements and our guidance before you sign it. If at any time after you have submitted this application we find you have given us incomplete or false information, we may change our underwriting decision, we may refuse a claim and we may withdraw some or all cover.

### Member details

1. Surname	<input type="text"/>			
2. Title (please tick one of these boxes or state another title)	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Miss <input type="checkbox"/>	Ms <input type="checkbox"/>
	Other	<input type="text"/>		
3. Forename(s)	<input type="text"/>			
4. Date of birth	<input type="text"/>	5. Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>
6. Home address	<input type="text"/>			
	<input type="text"/>			
	<input type="text"/>			
	Postcode <input type="text"/>			

We can often sort out unclear application details with a quick call or e-mail. If you are happy for us to contact you between 9am and 6pm Monday to Friday, please give us details. We shall not use this information for any other purpose.

7. What is a good time to contact you?	Between	<input type="text"/>	and	<input type="text"/>	Don't contact me directly	<input type="checkbox"/>
Telephone number and/or e-mail address	<input type="text"/>					
	<input type="text"/>					
8. Who is your GP?	<input type="text"/>					
Surgery address	<input type="text"/>					
	<input type="text"/>					
	<input type="text"/>					
	Postcode <input type="text"/>					
GP's telephone number and/or e-mail address	<input type="text"/>					
	<input type="text"/>					

## Member details (continued)

9. Have you registered with this surgery within the last six months? Yes  No

If **Yes**, who were you registered with before?  
(Please tell us the doctor's name, surgery  
address and telephone number here.)


If we require medical evidence in support of your application, we may be able to use a health screen report on you dated within the last 12 months. You will need to supply a copy of the report, which you can attach to the form in a sealed envelope.

10. Have you supplied a medical report? Yes, attached  No

11. If a medical examination is required, in which town or postal district should this take place?

## Occupation details

1. What is your occupation title?

2. Do you regularly work more than 60 hours each week? Yes  No

3. Do you work entirely in an office environment? Yes  No

You should say **No** and give full details in the box below if all or part of your duties require you to work in other environments, such as in a shop, on the factory floor, on a building site, at heights over 50 feet or offshore.


4. Do you need to drive to perform your duties? Yes  No

You should say **Yes** if you need to drive on business at least once a week, for example to visit clients or make deliveries, and if you cannot perform those duties by taking alternative means of travel. You should say **No** if business use of your vehicle is only to get you to and from your normal place of work.

## Travel details

1. Will your occupation duties require you to travel outside the European Union and North America in the next 12 months?  
No, my occupation duties do not require me to travel outside the EU or N America

Yes, but I have nothing planned yet for the next 12 months

**(on the next page please give details of travel destinations in the last 12 months and/or where you anticipate visiting)**

Yes, and I know what trips I will be making in the next 12 months

**(on the next page please list all trips planned for the next 12 months, including the cities/areas of each country to be visited)**

## Travel details (continued)

If you answered **Yes** to the previous question, please give full details here.

	Country 1	Country 2	Country 3	Country 4
<b>Countries you visited or will visit</b>				
<b>Cities or areas</b>				
<b>Total number of days you will spend in each country in the next 12 months</b>				
<b>Total number of days spent in each country in the last 12 months</b>				
More space is available at the end of the form to continue your answers if you need to.				

2. Do you review and follow Foreign Office advice prior to travelling outside the EU or North America?

Yes

No

## Fitness and lifestyle details

1. What is your height?

<b>feet</b>	<b>inches</b>
or	<input type="text"/> <b>cm</b>

2. What is your weight today?

<b>stones</b>	<b>pounds</b>
or	<input type="text"/> <b>kg</b>

3. Has your weight changed by more than 2 stones (or 13kg) in the last two years?

Yes

No

4. What is your waist measurement today?

<b>inches</b>	<b>cm</b>
or	<input type="text"/>

5. Have you smoked tobacco in the last 12 months?

Yes

No

If **Yes**, what is your typical DAILY consumption?

(if you stopped smoking in the last 12 months, please tell us your typical daily consumption before you gave up.)

Cigarettes

Cigars

Pipe tobacco  **g/oz**

6. Have you used a nicotine containing product, such as e-cigarettes, patches or gum in the last 12 months?

Yes

No

7. Do you drink alcohol?

Yes

No

If **Yes**, what is your typical WEEKLY alcohol consumption?

Beer, lager or cider up to alc 4.5% vol  **pints**

Beer, lager or cider alc 4.6% vol or more  **pints**

Wine  **175ml glasses**

or  **75cl bottles**

Fortified wine  **50ml glasses**

Spirits  **35ml measures**

## Fitness and lifestyle details (continued)

8. Has a healthcare practitioner ever advised you to reduce your alcohol intake? Yes  No

If **Yes**, when was the advice given and what was your average weekly alcohol intake at that time?

Month/year (the year only is sufficient if more than two years ago).

Beer, lager or cider up to alc 4.5% vol

 **pints**

Beer, lager or cider alc 4.6% vol or more

 **pints**

Wine

 **175ml glasses**

or

 **75cl bottles**

Fortified wine

 **50ml glasses**

Spirits

 **35ml measures**

9. Do you take part in, or do you intend to take part in, any hazardous sports? Yes  No

You should say **Yes** if your sport requires you to adhere to formal safety standards or have your competence or fitness certified. Examples: all forms of aviation, caving, climbing, competitive horse riding, sports diving, martial arts, motor sport and competitive and/or offshore sailing. If your activity is not in this list and you are unsure if it is of interest to us, you should tell us about it.

If **Yes**, what is each activity?

	Activity 1	Activity 2	Activity 3
<b>Activity name</b>			
<b>How often will you take part? eg how many annual dives, races, climbs or flying hours?</b>			
<b>Where will you do it? eg which countries, mountains, waters or caves?</b>			
<b>What is your experience? eg how many years and which qualifications or licence do you hold?</b>			
<b>If appropriate, what type of craft or vehicle and engine capacity?</b>			
<b>What will the extent of your activity be? eg maximum height or depth, type of race or competition, special or extreme activity</b>			

More space is available at the end of the form to continue your answers if you need to.

10. a) Do you participate in cardiovascular exercise or sport (such as at a gym, jogging, circuit training, swimming, football, tennis or squash) at least once each week? Yes  No

- b) Do you participate in road running, racquet sports, football or other high impact sports? Yes  No

## Sickness absence details

Please answer the following questions on your work absence history to the best of your recollection. We do not expect you to have to check the details with your employer or your GP. More space is available at the end of the form for you to continue your answers if you need to.

1. Have you ever been absent from work for more than 2 consecutive months due to sickness or accident? Yes  No

Reason for absence	Month/year first absent	Month/year returned to work	Do you have any ongoing restrictions? If yes, please give full details

2. In the last 3 years, for how many days **in total** have you been absent from work due to sickness or accident?  
 No absence  Up to 15 days  Up to 30 days  More than 30 days

Please add together all your short and long term work absence. If you are unsure of the exact number of days, please tick the box that gives the closest indication.

3. In the last 3 years, have you been absent from work due to sickness or accident for more than 1 week at a time? Yes  No

Reason for absence	Month/year first absent	Month/year returned to work	Do you have any ongoing restrictions? If yes, please give full details

4. In the last 3 months, has your ability to perform your occupation duties been affected in any way by your health? (You should say **Yes** if for example, you have reduced your hours, adjusted your duties or required adaptations or special equipment to assist you, even if only temporarily.) Yes  No

If **Yes**, how has your ability to perform your occupation duties been affected?


What caused it?


- Is your ability to perform your duties still limited? Yes  No

## Medical details

1. In the last 3 years, have you had pain, discomfort, numbness or weakness for more than 3 days at a time in any muscles, joints or bones? (You should tell us about back, neck, shoulder, hip or limb problems that did not resolve quickly, even if you did not seek medical attention.)

Yes

No

If **Yes**, please give full details of each occurrence.

Month/ year of onset	Condition, location and cause (if known)	Duration of episode	Treatment (please say if this is ongoing)	Have you had or do you expect to have surgery? Y/N (if Y please give details and dates)	Number of days off work	Have you made a full recovery? Y/N

During episodes, how have your activities been limited and what have you done to manage the pain or discomfort?


2. a) In the last 3 years, have you had stress, anxiety or low mood that has persisted for more than 3 weeks or for which you have sought medical advice or counselling?

Yes

No

- b) Have you ever had depression or another psychiatric illness, according to a healthcare practitioner's diagnosis, or any mental illness that has required hospital treatment or referral to a psychiatrist or other specialist?

Yes

No

- c) Have you ever had in-patient treatment for any mental illness?

Yes

No

A healthcare practitioner is anyone qualified to advise you about or treat you for an illness or injury

If **Yes**, please give full details of each occurrence.

Month/ year of onset	Condition and cause, if known (eg bereavement, divorce, work related)	Duration of episode	Treatment	Month/ year of last symptoms	Number of days off work	Details of ongoing symptoms and/or treatment

## Medical details (continued)

3. In the last 3 years, have you had irritable bowel syndrome or prolonged or unexplained abdominal pain? Yes  No
4. In the last 3 years, have you had prolonged or unexplained fatigue, breathlessness, numbness or dizziness? Yes  No

**If Yes to questions 3 or 4**, please give full details of each occurrence.

You should say **Yes** if you have had these symptoms, whether or not you consulted a healthcare practitioner. If symptoms are ongoing, please say this under "month/year of last symptoms".

Month/year of onset	Condition	Frequency of symptoms	Duration of episodes	Treatment and/or investigations	Number of days off work	Month/year of last symptoms

5. a) In the last 3 years, has a healthcare practitioner advised you that your cholesterol has been raised? Yes  No
- b) In the last 3 years, have you been treated for high cholesterol? Yes  No
- c) Have you been advised that your cholesterol is now normal? Yes  No
- d) Please tell us any cholesterol levels advised to you by a healthcare practitioner or say here if you don't know. Don't know

<b>Month/year:</b>	<b>Month/year:</b>	<b>Month/year:</b>
<b>Level:</b>	<b>Level:</b>	<b>Level:</b>
<b>On treatment? (Y/N)</b>	<b>On treatment? (Y/N)</b>	<b>On treatment? (Y/N)</b>

e) If treatment is ongoing, please tell us what you are taking.

6. a) In the last 3 years, has a healthcare practitioner advised you that your blood pressure has been persistently raised? Yes  No
- b) In the last 3 years, have you been treated for high blood pressure? Yes  No
- c) Have you been advised that your blood pressure is now normal? Yes  No
- d) Please tell us any blood pressure readings advised to you by a healthcare practitioner or say here if you don't know. Don't know

<b>Month/year:</b>	<b>Month/year:</b>	<b>Month/year:</b>
<b>Reading:</b>	<b>Reading:</b>	<b>Reading:</b>
<b>On treatment? (Y/N)</b>	<b>On treatment? (Y/N)</b>	<b>On treatment? (Y/N)</b>

e) If treatment is ongoing, please tell us what you are taking.



## Medical details (continued)

7. Has a healthcare practitioner ever suggested or confirmed a diagnosis of diabetes, based on symptoms, signs or test results you have had? Yes  No

If **Yes**, please confirm the following:

Month/year of diagnosis:

Your three most recent glycosylated haemoglobin (HbA1C) levels or say here if you don't know. Don't know

<b>Month/year:</b>	<b>Month/year:</b>	<b>Month/year:</b>
<b>HbA1C Level:</b>	<b>HbA1C Level:</b>	<b>HbA1C Level:</b>

- Have you had a severe hypoglycaemic attack (hypo) in the last 2 years? (A severe hypo is one that required the assistance of another person.) Yes  No

Please give the month/year of your last and next diabetic clinic appointment and the address of your clinic.

Last appointment	Next appointment	Diabetic clinic address
<input type="text"/>	<input type="text"/>	<input type="text"/>

8. Have you ever had a stroke or any form of heart disorder including murmur, chest pain, palpitations or any problem with your blood circulation including haemorrhage or clots? Yes  No

If **Yes**, please give full details here. If symptoms are ongoing, please say this under "month/year of last symptoms".

Month/year of onset	Condition	Frequency of symptoms	Duration of episodes	Have you consulted a healthcare practitioner Y/N	Treatment and/or investigations	Number of days off work	Month/year of last symptoms
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If you hold any relevant hospital letters that may help us assess the risk, please attach copies to this form.

9. Have you ever had any form of cancer including leukaemia or a tumour or growth (including moles) that a healthcare practitioner has advised may be cancerous? Yes  No

If **Yes**, please give full details here.

Month/year of onset	Type and site of cancer	Type and start date of treatment	Month/year treatment ended	Number of days off work	Month/year of last follow up	Are you still under follow up? (Y/N)	Has there been any recurrence or spread to another site? (Y/N)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If you hold any relevant hospital letters that may help us assess the risk, please attach copies to this form.

## Medical details (continued)

10. Have you ever tested positive or been treated for HIV, hepatitis B, hepatitis C or any other sexually transmitted infection or are you waiting for test results relating to one or more of these diseases?

Yes

No

If the result is negative, the fact of having an HIV test will not, of itself, have any effect on your acceptance terms for insurance.

If **Yes**, please give full details here.


11. Within the last 5 years, have you been exposed to the risk of HIV infection?

Yes

No

HIV infection can be caught through unsafe sex, intravenous drug abuse or blood transfusion or surgery outside the European Union.

If **Yes**, please give full details here.


12. Have you ever had any of the following illnesses or impairments?

a) Digestive problems such as ulcer or colitis, or any disease or disorder of the liver, pancreas or bowel?

Yes

No

b) Fits, blackouts or migraines?

Yes

No

c) Multiple sclerosis, Huntington's disease, motor neurone disease or any disease of the nervous system?

Yes

No

d) Any disorder of the kidneys or any recurrent urinary problem?

Yes

No

e) Asthma, bronchitis or any disorder of the lungs or airways?

Yes

No

f) Any defect or disease of the eyes or ears?

Yes

No

(You do not have to tell us about long or short sightedness that is corrected by lenses)

If you have answered **Yes to any part of question 12**, please give full details here.

Condition	Month/year of onset	Month/year of last symptoms	Frequency of symptoms	Number of days off work	What treatment have you had?	Is treatment ongoing? Y/N	Have you ever had treatment in A&E or as an in-patient? If Yes, please give details and dates

More space is available at the end of the form to continue your answers if you need to.

## Medical details (continued)

13. How many times in the last twelve months have you consulted a healthcare practitioner about your health?

A healthcare practitioner is anyone qualified to advise you about or treat you for an illness or injury. You should count as one consultation every time you saw a practitioner. If you are in any doubt about whether to count a particular consultation, you should count it.

No consultations at all in the last 12 months  1 to 5  6 to 10  11 or more

If you have consulted a healthcare practitioner in the last 12 months, please give details in the table below.

	Condition 1	Condition 2	Condition 3
<b>Reason for consultation</b>			
<b>Month/year first consulted</b>			
<b>Month/year last consulted</b>			
<b>Number of days off work</b>			
<b>Have further tests, investigations or surgery been suggested or recommended? If Yes, please give full details.</b>			
<b>Have you made a full recovery? (Y/N)</b>			

More space is available at the end of the form to continue your answers if you need to.

14. In the last 3 years, have you been x-rayed, had your blood or urine tested, had an ECG or any other specialist test or been advised to have such a test? Yes  No

In answering this question, you should keep in mind that:

- We don't expect you to tell us about a negative HIV test result.
- If you're applying to us for income protection or critical illness insurance, we don't expect you to tell us about any genetic test results. However if you wish to tell us about a negative genetic test result which shows that you have not inherited a genetic disorder, we will take this into account.
- For life insurance, we only require you to tell us the result of a genetic test you've had for Huntington's disease if your benefit is to be more than £500,000 above the scheme's free cover level or if you already have more than £500,000 of life cover with other insurers. If you're unsure about your cover level with us, your scheme trustees will be able to help you.

If **Yes**, please give details.

Month/year	What was the test?	What was the reason for it?	What was the result?

If any abnormal test results were from a routine health screen, please submit a copy of the screen with this form.

## Medical details (continued)

15. Are you receiving or waiting for treatment as directed by a healthcare practitioner (eg prescription or over the counter medication, physiotherapy, counselling, following a special diet) or have you done so in the last 12 months?  
(You do not need to tell us about prescriptions for the oral contraceptive pill.)

Yes

No

If **Yes**, please give details.

	Treatment 1	Treatment 2	Treatment 3
<b>What is the treatment?</b>			
<b>What is the reason for treatment?</b>			
<b>When did treatment start?</b>			
<b>Please state if treatment is ongoing or the date it ceased</b>			

16. Do you have an appointment to see a healthcare practitioner, are you waiting for an appointment, do you expect to arrange one or do you have symptoms or signs of illness for which you have considered making one in the next twelve months?

Yes

No

You should say **Yes** if you are expecting to make an appointment in the next 12 months or if you are waiting to see a GP, specialist or other healthcare practitioner. You should also say **Yes** if you expect to attend a follow up appointment or renew a repeat prescription for an existing condition.

If **Yes**, what is the reason for the consultation and the date, if known?


17. Have any of your parents, brothers or sisters had any of the following medical conditions before they reached age 65: heart disease, a stroke, persistently high or treated blood pressure, diabetes, kidney disease, breast or ovarian cancer, bowel cancer, multiple sclerosis, Huntington's disease or any hereditary disease of the nervous system?

Yes

No

If your living or deceased parent, brother or sister was diagnosed before the age of 65 as having a serious illness or disease that may run in families, including any genetically inherited condition, we expect you to tell us as much as you know about that person's condition.

If you've told us about your family's medical history, you may decide to tell us of a genetic test result that shows you're not predisposed to a genetically inherited condition and we will take this into account.

If **Yes**, please give details.

Relationship to you	Condition	Age at onset	Cause of death (if deceased)



Please read these notes carefully - they outline your statutory rights concerning the processing and use of information relating to your application.

### **How we shall request reports about your medical history**

We may require a report about your medical history to support, or to review the completeness and accuracy of, your application. We would request this from the doctor who holds your medical records, a doctor you have consulted or one who has treated you. In requesting this evidence, we shall always comply with the law.

The Acts relevant to obtaining this type of medical report in the UK (except the Channel Islands) are the Access to Medical Reports Act 1988, the Access to Personal File and Medical Reports (Northern Ireland) Order 1991 and the Access to Health Records and Reports Act 1993 (Isle of Man). The Data Protection Act 1998 also governs the handling of medical reports.

We must have your written consent to obtain a report. We ask for this in the declarations and consents section at the end of this form.

You do not have to give your consent, but if you do not, we may not be able to go ahead with your application.

You can ask to see the report before the doctor returns it to us. If this is the case, we will tell the doctor to keep 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 six months of it being sent to us. There may be a charge for this to cover the doctor's costs. We can send a copy of the report to your doctor if you ask to see it at a later date.

If you think that any part of the report is not correct or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him or her to attach a statement outlining your views, which will then accompany the report.

Your doctor can withhold access to the report if he or she feels that it would cause physical or mental harm to you or others.

The medical report your doctor fills in asks about the following:

- Your current health.
  - Any care, medication or treatment you are currently receiving.
  - The results of referrals or tests you are waiting for.
- Any time off work in the last three years.
- Your past health.
  - Details (excluding minor self limiting ailments/conditions) of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your GP or any other medical adviser, therapist or counsellor, in particular whether you have a history of:
    - malignancy (cancer), cardiovascular (heart) disease, diabetes, and degenerative (gradually worsening) diseases;
    - musculoskeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles;
    - anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue;
    - suicidal thoughts or attempts at suicide; or
    - conditions related to drug or alcohol misuse or smoking or chewing tobacco.
- Details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations.
- Any blood pressure readings in the last three years.
- Any history of disease among your parents or brothers or sisters that you have told your doctor or another healthcare professional about.

We ask your doctor not to reveal information about:

- negative tests for HIV, hepatitis B or C;
- any sexually-transmitted diseases unless there could be long-term effects on your health; or
- predictive genetic test results unless there is a favourable test result which shows that you have not inherited a condition your family suffers from.

The information you and your doctor provide about your health may result in us:

- providing cover on standard rates;
- increasing premiums above standard rates;
- setting exclusions or postponing cover;
- refusing to provide insurance; or
- withdrawing cover.

If you have any questions about your rights under the Act or questions relating to the process of getting, assessing or storing medical information, please write to: Head of Medical Underwriting, Unum, Milton Court, Dorking, Surrey, RH4 3LZ.

As part of our ongoing quality control process and to review the accuracy and completeness of the information given we may request a medical report within six months of the acceptance of any cover provided to you under the policy. If your application is selected we will use your signed Declaration to authorise us to contact your general practitioner (GP) and we will inform you that a medical report has been requested.

## Data Protection

### **How we shall process information relating to you**

We shall hold all information relating to you, including medical reports, electronically and/or in a manual system. We shall process all information fairly and lawfully in accordance with the principles of the Data Protection Act 1998.

Access to information concerning you will be limited to employees and contractors of Unum, for example independent health professionals, who need access in order to process and/or assess the application.

We may additionally share information and conduct checks with third parties for purposes relating to the application, for validation purposes and for other lawful purposes. Third parties (who may be situated either within or outside the European Economic Area) may include, but are not limited to, reinsurers, underwriters, the Financial Conduct Authority, the Prudential Regulation Authority, the Financial Ombudsman Service, medical agencies, other insurance companies and sub-contractors and agents. By signing this application you agree that we may share information concerning you.

We will not discuss medical information about you with anyone other than you without your written consent. This includes your financial and legal advisers, the policyholder, your employer, your spouse and other relatives and friends. To help us assess the risk or administer the policy, we may discuss non-medical information about you with the policyholder's financial advisers or with the policyholder.

Telephone conversations and e-mail communications may be monitored and/or recorded from time to time for the purpose of training in the interests of continually improving the quality of service we provide.

If you wish to access information that we hold about you, you should submit a request in writing to the Data Protection Officer at Unum: The Data Protection Officer, Unum, Milton Court, Dorking, Surrey, RH4 3LZ.

Further details regarding how we process information about you can be found on our website, [www.unum.co.uk/legal-privacy-notice](http://www.unum.co.uk/legal-privacy-notice).

## Your declarations and consents

I understand and I agree that I am entirely responsible for the statements I have made or that have been made on my behalf in this application and I declare that to the best of my knowledge and belief those statements are true and complete. I have taken the guidance provided in the application into account in making or in verifying my statements.

I agree to inform Unum immediately in writing of any change to my statements in this application before Unum's acceptance of the risk.

**I understand that if at any time after I have submitted this application Unum finds I have given incomplete or false information, Unum may change the underwriting terms, refuse my claim or withdraw my cover.**

I have read and I understand my statutory rights concerning the processing and use of information relating to my application as set out in this form.

I consent to Unum seeking, for the purpose of underwriting or to review the accuracy and completeness of the statements made in this application,

- information from my medical records or a medical report from any doctor who at any time has attended me and I authorise the giving of this information.

**Please read and tick one of these boxes only.**

I DO NOT WISH to see medical reports before they are sent to Unum.

I WISH to see medical reports from my GP and/or Consultant before they are sent to Unum.

If you do not make an appointment with your GP the report will be sent to us after 21 days.

(You can speed up the process by arranging to visit your GP's surgery to see the report as soon as possible once you have been notified that a medical report has been requested.)

- information from any insurance office to which an application has been made on my life and I authorise the giving of this information.
- information concerning this application, including but not limited to information concerning my physical and mental health, from any third party and I authorise the giving of this information.

I understand that Unum may request a medical report within six months of the acceptance of any cover provided to me to monitor the accuracy and completeness of any statement made in, or in connection with, this application.

I consent to Unum confirming the underwriting decision, including any exclusion wordings or other special terms, to the policyholder and to the policyholder's financial advisers.

I authorise Unum to release information, including but not limited to information concerning my physical and mental health, to my doctors, to doctors or specialists appointed by Unum in relation to my application and to any third party who requires this information for lawful purposes.

Your signature

Date

Your full name

[unum.co.uk](http://unum.co.uk)

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