Personal Declaration of Health

Important Notes:
Please answer all of the questions on this form honestly and in full. If you miss out or give us misleading information, **this may mean that a claim will not be paid and/or the benefit being underwritten will be cancelled.**

If you are uncertain about whether any particular fact should be disclosed to us, you should include it.

If you would prefer to complete the medical questions in private you may do so and return the form directly to the Chief Medical Officer, Generali Employee Benefits, 100 Leman Street, London, E1 8AJ.

If there is any change in your health or other circumstances between completion of the form and confirmation by us that you have been accepted for cover you must inform us as soon as possible.

If you have had a genetic test you do not need to disclose that information unless the level of benefit applied for is in excess of £500,000 for life assurance or £300,000 for income protection or critical illness and the test was for Huntington's disease. However, if you have had a genetic test which is in your favour, you can choose to disclose this. If you are actually having treatment for, or experiencing symptoms of, a genetic disease this should be disclosed in the normal way.

Policy Name/Employer:

Policy Number:

Personal Details:

Title: Mr/Mrs/Miss/Ms/Dr/other:

Date of Birth:

Surname:

Place of Birth:

Forenames:

Sex:

Address:

Postcode:

Home telephone number:

Mobile telephone number:

Daytime telephone number:

Email address:

Country of residence for taxation purposes:

Occupational & Lifestyle details:

Job title:

Environment (eg office, factory etc):

Precise duties:

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Occupational & Lifestyle details (cont.):

% of working day standing:

% of working day sitting:

% of working day carrying/lifting:

% of working day working at heights:

Annual business miles and method of transport:

Have you ever been resident or travelled outside the UK for a period ofgreater than 2 months in the last 5 years. If yes please give details below. ☐ Yes ☐ No

Details:

Do you participate, or do you have, any intention of participating in any hazardous activities such as hang-gliding, rock climbing, motor sports, diving, parachuting or flying other than as a fare-paying passenger? If yes please give details below. ☐ Yes ☐ No

Details:

Height, weight & habits:

Height: feet: inches:

or cm:

Weight: stones: lbs:

or kilos

When did you last weigh yourself and what is your waist measurement? Date: Waist:

Have you smoked or used any nicotine product in the last 12 months? ☐ Yes ☐ No

If yes, please confirm your average daily consumption of:

cigarettes

cigars

pipes

other tobacco products

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Occupational & Lifestyle details (cont.):

What is your average weekly alcohol consumption in units?

1 pint beer = 3 units
1 glass wine = 1.5 units
1 measure spirits = 1 unit

Has your regular alcohol consumption ever exceeded 40 units per week? ☐ Yes ☐ No

If yes, please give full details:

Have you ever been advised to reduce your alcohol consumption for medical reasons? ☐ Yes ☐ No

If yes, please give full details:

Have you ever used recreational drugs (eg cocaine, heroin)? ☐ Yes ☐ No

If yes, please give full details:

Family history:

Have your natural parents, brothers or sisters ever had any of the following medical conditions before they reached the age of 65? ☐ Yes ☐ No

Heart disease
Stroke
Diabetes
Cancer
Multiple Sclerosis
Huntington's disease
Polycystic kidney disease
Polyposis of the colon
Any other hereditary disorder

If yes, please give full details including relationship, nature of the medical condition and the age at which it occurred.

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Medical Questions:

1. Have you ever tested positive for HIV or are you awaiting the results of such a test? *Please note that if the result is negative, the fact that you have undergone a test will not, in itself, have any adverse effect on the provision of cover.*	☐ Yes	☐ No
2. Have you ever injected non-prescription drugs?	☐ Yes	☐ No
3. Within the last 5 years have you been exposed to the risk of HIV infection? *This can be contracted through unsafe sex, intravenous drug abuse or blood transfusions or surgery undertaken outside the EU.*	☐ Yes	☐ No

If you have answered yes to questions 1, 2 or 3, please provide full details:

Do you currently have or have you ever had any of the following:

4. Within the last 5 years have you tested positive or been treated for any sexually transmitted disease?	☐ Yes	☐ No
5. Cancer, leukaemia, Hodgkin's disease, lymphoma, brain or spinal cord tumour?	☐ Yes	☐ No
6. Heart disease or disorder (including heart attack, angina, acute coronary syndrome, cardiomyopathy, heart valve disorder?	☐ Yes	☐ No
7. Stroke, brain haemorrhage or permanent brain injury due to accident?	☐ Yes	☐ No
8. Multiple Sclerosis, Parkinson's Disease, paralysis, epilepsy, Alzheimer's disease, dementia or cerebral palsy?	☐ Yes	☐ No
9. Any disorder of the central nervous system (the brain, spinal cord and nerves) not already mentioned?	☐ Yes	☐ No
10. Any disease or disorder of the arteries or veins? (Including disease in the legs or of the aorta)	☐ Yes	☐ No
11. Diabetes or sugar in the urine?	☐ Yes	☐ No
12. Mental Illness that has required hospital treatment or referral to a specialist?	☐ Yes	☐ No

In the last 5 years have you had any of the following:

13. A lump, growth of any kind, or any mole or freckle that has bled, become painful, changed colour or increased in size?	☐ Yes	☐ No
14. Chest pain, irregular heart beat, raised blood pressure or raised cholesterol?	☐ Yes	☐ No

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Medical Questions (cont.):

15. Asthma, bronchitis or any other respiratory disorder?	Yes	No
16. Numbness, loss of feeling or tingling of the limbs or face, or temporary loss of muscle power or sight?	Yes	No
17. Seizure, fits, fainting, dizziness or blackouts?	Yes	No
18. Any disorder of the eyes including blurred or double vision or optic neuritis? (Please ignore sight problems corrected by glasses or contact lenses)	Yes	No
19. Any disorder of the ears including loss of hearing or tinnitus?	Yes	No
20. Arthritis, spine, neck or joint disorder including slipped disc, sciatica, back, neck or knee pain or gout?	Yes	No
21. Any disorder of the digestive system, liver, stomach, pancreas or bowel (including gastric or duodenal ulcer, hepatitis, colitis or Crohn's disease)?	Yes	No
22. Blood disorder or anaemia?	Yes	No
23. Thyroid disorder?	Yes	No
24. Kidney, bladder or any other disorder of the genito-urinary system (including blood or protein in the urine or urinary tract infections)?	Yes	No
25. Any kind of medical attention or time off work for depression, anxiety, stress, nervous breakdown, insomnia or tiredness?	Yes	No
26. Received or been advised to have any investigations, scans or blood tests in connection with any medical condition not already mentioned?	Yes	No
27. Received any form of medical attention at a hospital as an inpatient or outpatient?	Yes	No
28. Had any surgical operation?	Yes	No

Are you:

29. Due to have any check-up in the next 12 months in connection with any medical condition, or are you awaiting the results of any check-up or investigations?	Yes	No
30. Currently taking prescribed drugs, medicines, tablets or any other treatment?	Yes	No
31. Intending to seek medical advice or treatment in connection with any condition in the near future?	Yes	No

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Medical Questions (cont.):

Please confirm the name and address of your usual doctor.

Name:

Address:

Telephone Number:

If you have changed doctors in the last 12 months, please confirm your previous doctor's details.

Name:

Address:

Telephone Number:

If you are required to undergo a medical examination in connection with the provision of cover, please indicate the geographical location most convenient for you.

If you have had a company or private health medical in the last 12 months please attach a copy as this may help us to reduce the need for further examinations and tests.

Additional Information:

Has any application for life, health, accident or critical illness insurance on your life ever been declined, postponed, accepted only upon payment of an increased premium or been subjected to any other special terms or exclusions?

☐ Yes ☐ No

If yes, please give full details.

IMPORTANT NOTES:

1. IF YOU HAVE ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE PLEASE PROVIDE FULL DETAILS ON THE FOLLOWING PAGE/PAGES IN RESPECT OF EACH OF THESE ANSWERS. THE MORE INFORMATION YOU PROVIDE, THE MORE QUICKLY AND EFFICIENTLY WE WILL BE ABLE TO COMPLETE THE UNDERWRITING PROCESS.

2. FAILURE TO DISCLOSE RELEVANT INFORMATION MAY RESULT IN NON-PAYMENT OF A CLAIM AND THE CANCELLATION OF THE COVER BEING UNDERWRITTEN. IF YOU ARE IN ANY DOUBT AS TO WHETHER ANY INFORMATION IS RELEVANT PLEASE DISCLOSE IT.

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ADDITIONAL MEDICAL INFORMATION:

Please answer these questions for each “yes” box ticked above. If you run out of space please attach an additional sheet with full details and sign and date it.

Question number:

What is the exact diagnosis?

When did symptoms first occur?

Do you have recurrent symptoms? If so please give full details.

Please describe the nature and severity of your symptoms.

Do they restrict you in any way?

What treatment have you received and what treatment are you currently receiving?

Have you seen a specialist for the condition? If so please confirm their contact details.

What medical investigations have been performed and what were the results?

Have all investigations now been completed and are you waiting for any follow-ups or reviews?

When did you last see your GP in connection with the condition?

How many times have you been admitted to hospital in connection with this condition and when was the last time?

When was your last hospital outpatient check up for this condition?

How much time have you taken off work in relation to this condition?

Is any operation planned or being considered and if so when is the likely to be carried out?

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WARNINGS AND DECLARATIONS

PLEASE READ THE FOLLOWING SECTIONS AND DECLARATIONS CAREFULLY AS THEY CONTAIN IMPORTANT INFORMATION REGARDING THE PROVISION OF COVER AND YOUR RIGHTS.

DATA PROTECTION ACT 1998:

The information that we collect and hold about you (such as details of your job, age, salary, health and medical records) will be used in connection with the insurance arrangements that your employer has put in place with us.

This will include the processes of underwriting, administration, claims assessment, claims management, claims review, compliance, rehabilitation, customer concern handling and fraud prevention. As part of such processing information may be requested from, and shared with, your employer and your employer's advisers, other insurers, re-insurers, insurance intermediaries, professional advisers and other service providers.

Your data will be processed fairly and securely in accordance with the Data Protection Act 1998. Details of your rights under that Act, the data which we hold, the data which might be passed to organisations outside Generali and the organisations which might be involved, can be obtained by writing to our Data Protection Officer at 100 Leman Street, London, E1 8AJ.

Your personal data will be available only to those who need to see it and will only be kept for as long as necessary.

ACCESS TO MEDICAL REPORTS

We may need to get medical reports to support your proposed level of cover. Before we can ask any doctor that you have consulted to fill in a report, we need your permission under the Access to Medical Reports Act 1988 and associated legislation. Your rights under the act are as follows:

You do not need to give your permission, but if you do not, we may not be able to provide you with cover.

You can ask to see the report before the doctor returns it to us. If this is the case, the doctor will hold the report for 21 days before returning it so you can arrange to see it. If you have not made arrangements within the 21 day period, your doctor will return it 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. Your doctor is obliged to retain a copy for this period. If you need to see the report after this time, we can send a copy to your doctor if he no longer holds one.

If you think that any part of the report is incorrect or is misleading, you may ask the doctor to amend it. If your doctor refuses to do so, you may ask him to attach a statement outlining your views which will be sent to us along with the report.

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

The medical report that we may request will ask about your current state of health, any care or medication being received, any referrals or tests you are waiting for, any time off work in the last three years and your past health including details of any relevant illness, trauma or other advice or referrals received from any other GP, medical adviser, therapist, counsellor or specialist. We will also ask about your habits (drug, alcohol, tobacco use etc.) as well as your height and weight, and any history of disease among your natural parents, brothers or sisters you have told your doctor about.

We will not ask your doctor to reveal details of:

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

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IMPORTANT NOTES

You will not be fully covered under your employer's group insurance policy until we have formally confirmed to your employer that cover is in place, and the terms have been agreed. Whilst medical underwriting is being carried out you may be covered for claims arising solely from an accidental cause, or for a lower level of benefit, but you should refer to your employer/employer's adviser for full details.

If we apply for information from your doctor we may ask you to contact him in connection with the process.

Failure to provide complete and accurate information may lead to the non-payment of any claim and/or the cancellation of the benefit being underwritten. Inaccuracies and incomplete information will also delay the provision of cover.

DECLARATION

I declare to the best of my knowledge and belief that the statements made in or in connection with this form in relation to the provision of insurance cover are true and complete and I have not withheld any material facts. Material facts are those which an insurer would regard as likely to influence the assessment or acceptance of the level of cover being proposed. I understand that if there is any doubt about whether a fact is material I should disclose it and that failure to provide full and accurate information may jeopardize the payment of any claim made and/or lead to the cancellation of the benefit being underwritten.

I confirm that I have checked and found correct any statements in this form that are not in my handwriting.

I undertake to advise you of any change in my circumstances that occurs between the completion of this form and confirmation by you of the terms upon which you are prepared to offer cover.

I consent to you, or any third party authorised by you, obtaining information about my past and present mental and physical health from any Medical Practitioner who I have ever consulted, or who has ever treated me.

I consent to you, or any third party authorised by you, seeking information from any insurance office to which an application has been made for insurance on my life (including life, critical illness, income protection, personal accident, waiver of premium/contribution and private medical insurance) and I consent to the provision of such information.

I understand my statutory rights under the Data Protection Act 1998 and the Access to Medical Reports Act 1988. I understand that my personal data will be used by you in connection with the insurance arrangements that have been entered into by my employer and I consent to such use.

I expressly consent to you processing my personal data and sensitive personal data (including medical information and reports) for the purpose of underwriting, administration, claims assessment, claims management, claims review, compliance, rehabilitation and customer concern handling. I also consent to you sharing such data with my employer and my employer's advisers, other insurers, re-insurers, insurance intermediaries, professional advisers and other service providers.

I agree that a copy of this consent shall have the validity of the original and I consent to undergoing any further medical examination or investigation necessary to assess the provision of cover.

I WISH TO SEE THE REPORT BEFORE IT IS RETURNED TO ASSICURAZIONI GENERALI S.p.A*

*(indicate if you wish to see the report before it is returned to us)

☐ Yes ☐ No

When you are ready to submit this document please print it, sign it and return it to Generali.
You can email this form to groupclaims@generali.co.uk - send by fax to +44 (0) 207 265 6102
- or send by post to: Claims Dept, Generali Employee Benefits, 100 Leman Street, London E1 8AJ

SIGNATURE DATE

Assicurazioni Generali S.p.A. UK Branch 100 Leman Street London E1 8AJ

Company incorporated in Trieste in 1831 - Share capital €1,556,873,283 fully paid-up - Registered office at Piazza Duca degli Abruzzi 2, Trieste, Italy
Italian tax identification and companies registry number 00079760328 - Authorised by Istituto per la Vigilanza sulle Assicurazioni (IVASS)
Registered in the IVASS register of insurance and reinsurance companies under no. 1.00003
Parent company of Generali Group and entered in the IVASS Register of insurance groups under no. 026
UK company registration no. BR1185