Voluntary Group Life Policy

Spouse or partner application form

Introduction

This form is to be completed when an eligible employee of an insured scheme is applying for, or increasing, cover in respect of their eligible spouse or partner.

The form needs to be completed by the spouse or partner and the employee.

Once completed please pass it to the employer's Human Resources Department who will retain the form and provide it to Zurich in the event of a claim.

Employee name	
Employee date of birth	D D M M Y Y Y Y
Employee staff number	
Employer name:	
Policy number	
Requested total amount of cover	£
Current total amount of cover	£

Important notes

Before completing and signing this form, please read the following information very carefully.

- When we refer to 'spouse' we mean spouse or civil partner.
- When we refer to 'partner' we mean someone (regardless of gender or marital status) who must reside with the employee in the UK and share a joint financial commitment with the employee. They cannot be a member of the employee's immediate family.
- The employer is the policyholder for this Group Life Assurance policy and they have details of the terms and conditions.

If you have any questions about this life assurance arrangement, please ask the employer before you fill in this form.

The employee who is applying for life assurance to cover their spouse or partner's life must also sign the declaration at the end of this form.

The spouse or partner who is to be covered must provide the answers personally. If the answers are filled in by anybody else they must be checked and amended or altered, if necessary, by the spouse or partner before they complete the declaration.

If you do not complete the form or you fail to send it to your employer's Human Resources Department, then the application for Life Assurance cover will be declined.

Your duty to take reasonable care

You should take reasonable care to answer each of the questions in this form honestly and to the best of your knowledge. If you don't answer each question correctly a claim may be rejected or not fully paid.

Genetic tests

You do not need to tell us about any genetic tests.

Details

To be completed by the spouse or partner.

1. Have you ever been treated or counselled or advised to seek treatment or counselling for the use of alcohol, drugs or other substance abuse or joined an organisation for alcohol or drug dependence or abuse? ☐ Yes ☐ No

2. Have you ever been tested positive for HIV/AIDS, or Hepatitis B or C, or are you awaiting the result of such a test? ☐ Yes ☐ No

3. During the last 12 months have you seen a doctor (or other medical practitioner) or been advised to attend a hospital or clinic for any form of advice, test, investigation or operation? ☐ Yes ☐ No

If you have answered 'No' to all of the above questions, please sign the declaration and once your spouse or partner (the employee) has also completed the form it should be returned to their Human Resources Department.

If you have answered 'Yes' to questions 1 or 2, we are unable to offer cover.

If you have answered Yes' to question 3, please answer all parts of Question 4.

4. Was your consultation with the doctor or other medical practitioner or the advice to attend a hospital or clinic for any form of advice, test, investigation or operation in the last 12 months in connection with any of the following:

   a) Cancer, leukaemia, Hodgkin's disease, brain or spinal cord tumour, including benign brain or spinal growths? ☐ Yes ☐ No

   b) Heart disease or disorder, including heart attack, angina, cardiomyopathy (a condition of the heart muscle) or heart valve disorder? ☐ Yes ☐ No

   c) Stroke, brain haemorrhage, transient ischaemic attack ('mini' stroke) or any permanent brain injury? ☐ Yes ☐ No

   d) Disease or disorder of the arteries (e.g. narrowing, hardening, inflammation of or fatty deposits) including disease in the legs or of the aorta? ☐ Yes ☐ No

   e) Multiple sclerosis, Parkinson's disease, paralysis, cerebral palsy, epilepsy, motor neurone disease, dementia, Huntington's disease or any other disorder of the central nervous system? ☐ Yes ☐ No

   f) Muscular dystrophy? ☐ Yes ☐ No

   g) Diabetes Mellitus (Type 1 or 2) that is controlled with insulin, or sugar in the urine, or any kidney disease or disorder, including blood or protein in the urine? ☐ Yes ☐ No

   h) Mental illness that has required psychiatric or hospital assessment or treatment, schizophrenia, bi-polar disorder, or any other depression that has required more than one month off work (or your usual activities), either continuously or in total? ☐ Yes ☐ No

   i) Lumps, growths or cysts; any moles or freckles that have bled, become painful, changed colour or increased in size? ☐ Yes ☐ No

   j) Chest pains, irregular heart beat, heart murmur? ☐ Yes ☐ No

   k) Seizures, fits, fainting, blackouts, numbness, loss of feeling or tingling of the limbs or face, loss of balance or co-ordination or loss of muscle power? ☐ Yes ☐ No

   l) Blindness, blurred or double vision, retrobulbar or optic neuritis (inflammation of the optic nerve) or other problems in one or both eyes (sight problems corrected by glasses or contact lenses do not need to be disclosed)? ☐ Yes ☐ No

   m) Sarcoidosis or bronchitis? ☐ Yes ☐ No

   n) Disease or disorders of the liver or pancreas, including cirrhosis or pancreatitis? ☐ Yes ☐ No

   o) Rheumatoid arthritis treated with oral steroids, Methotrexate or anti-TNF (Tumour Necrosis Factor) agents? ☐ Yes ☐ No

   p) Any eating disorder, chronic fatigue or persistent tiredness? ☐ Yes ☐ No

If you have answered 'Yes' to any part of question 4, we are unable to offer cover.

If you have answered 'No' to all parts of question 4, please sign the declaration and once your spouse or partner (the employee) has also completed the form it should be returned to their Human Resources Department.

Declaration and consent

To be completed by the spouse or partner.

- I am the spouse or partner of the eligible employee detailed in this form and I understand that, where cover is provided it is subject to them continuing to be an employee.
- I agree to Zurich obtaining information from other insurers about previous applications I have made for any life, sickness, accident or private medical insurance.
- This consent form allows Zurich to obtain medical reports after a claim is made to verify the accuracy of the information provided.
- I authorise those asked by Zurich for the information outlined above to provide it on production of a copy of this consent.
- I declare that the information and statements made in this form and any additional forms completed or to be completed following my telephone data collection interview (if applicable) in connection with this application are or will be, to the best of my knowledge, true and complete.
- I confirm that I have read the data protection statement 'Your privacy is important to us' included at the back of this form, which explains how the personal data I have provided will be used.
- I consent to my medical data being used in the way described.
- I confirm that I have read this **Declaration and consent**, together with the Important notes at the front of this form.

Spouse or partner Full Name

Date of Birth D D M M Y Y Y Y

Sex ☐ Male ☐ Female

National Insurance Number

Marital status

Signature

Spouse or Partner Name:

Date D D M M Y Y Y Y

☐ By checking this box I (the spouse or partner named above) accept and agree to the statements above.

Employee declaration

To be completed by the employee.

- I wish to apply for life assurance cover under the group life arrangement payable in the event of the death of my spouse or partner named above.
- I declare that the information provided in this form and any additional forms completed or to be completed following my telephone data collection interview (if applicable) in connection with this application are or will be, to the best of my knowledge, true and complete.
- I confirm that I have read the data protection statement 'Your privacy is important to us' included at the back of this form, which explains how the personal data I have provided will be used.

Signature

Employee Name:

Date D D M M Y Y Y Y

☐ By checking this box I (the employee named above) accept and agree to the statements above.

Please pass all completed forms to your Human Resources team.

Data protection statement

Zurich takes the privacy and security of your personal information seriously. We collect, use and share your personal information so that we can provide policies and services that meet your insurance needs, in accordance with applicable data protection laws.

The type of personal information we will collect includes: basic personal information (i.e. name, address and date of birth), occupation and financial details, health and family information, claims and convictions information and where you have requested other individuals be included in the arrangement, personal information about those individuals.

We and our selected third parties will only collect and use personal information (i) where the processing is necessary in connection with providing a quotation and/or contract of insurance; (ii) to meet our legal or regulatory obligations; (iii) where you have provided the appropriate consent; (iv) for our 'legitimate interests'.

It is in our legitimate interests to collect personal information as it provides us with the information that we need to provide our services more effectively including providing information about our products and services. We will always ensure that we keep the amount of information collected and the extent of any processing to the absolute minimum to meet this legitimate interest.

A full copy of our data protection statement can be viewed **here.**

How you can contact us

If you have any questions or queries about how we use your data, or require a paper copy of the statement, you can contact us via gbz.general.data.protection@uk.zurich.com or alternatively contact our Data Protection Officer at Zurich Insurance, Unity Place, 1 Carfax Close, Swindon, SN1 1AP.

Please let Zurich know if you would like a copy of this in large print, braille or audio.

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