Health and Activities Form

Group Life and Group Income Protection

To be completed by the policyholder

Employer Name

Scheme Number

Member Name

Salary on which benefits are to be based

Category (please include any additional details such as percentages of pension scheme contributions, if applicable)

To be read and completed by the member.

Introduction

Most group insurance policies provide cover up to a set limit without the need for evidence of health where certain conditions are met. This limit is called the automatic acceptance limit. Because you do not qualify for this automatic cover or you are entitled to cover in excess of this limit, you need to provide Zurich with details of your health and activities by answering the questions in this form. Please send the completed form to The Chief Medical Officer, at the address shown in the section headed **How to contact us**, in a sealed envelope marked 'Confidential Application Questions'. Before completing the form, please read both the **Important notes** and the **Declaration and consent**.

Where we say "Zurich" we mean "Zurich Assurance Ltd" and where we say "Zurich Group" we mean that company's holding companies and any of their subsidiaries.

How to contact us

- You can call us on:
  0800 151 3003
  Monday to Friday 9.00am to 5.00pm.
  We may record or monitor calls to improve our service.
- You can email us at:
  medical.underwriting@uk.zurich.com

Telephone data collection

Zurich offers a telephone data collection service as an alternative to completing this form. A representative from our third party provider will call you to help you provide the answers via a telephone interview. This will help you to give us the level of information we need to assess your application and may reduce the need for additional information at a later date.

If you choose telephone data collection

Completing this form

- Please tick 'Yes' in the box below and then fully complete questions 1, 2, 3, and 4.
- Please don't complete the remaining questions at this stage.
- Please then read and sign the **Declaration and consent** at the end of the form before returning it to Zurich.

Arranging the telephone interview

- We'll ask a representative from our third party provider to contact you, to schedule the telephone interview at a time that is convenient to you. If you're not contacted, please call us on 0800 151 3003.
- The representative will call you back at the agreed time to undertake the interview. Please allow between 30 minutes and an hour for the call and ensure you can speak freely in a quiet and comfortable location. The interview won't be undertaken if you're driving.
- The call will be recorded and you'll be sent an email which will contain a copy of questions and answers you've given.

Preparing for the telephone interview

Please find out the following information and have this available:

- Any past or present medical condition suffered (other than very minor ailments such as the common cold).
- Any medication you're currently taking, including name and dosage.
- The results of any tests or investigations, for example, blood pressure or cholesterol tests.
- Details of any serious condition, for example, cancer, heart attack, stroke, suffered by any member of your immediate family before age 65 (mother, father, brothers or sisters).
- Your height and weight. Please weigh yourself prior to the interview.

What happens next?

- You must review your answers to ensure they're accurate. If you need to make any amendments or provide us with any additional information, please email the relevant details to us at medical.underwriting@uk.zurich.com. We'll then contact you and let you know if your amendment affects our underwriting decision.
- If you don't receive the confirmation letter within five working days following your interview, please contact Zurich on 0800 151 3003.

Please let us know if you want to provide us with the information we need in this way.

Do you wish to choose telephone data collection? ☐ Yes ☐ No

Any special instructions (e.g. away on business travel, PA contact details etc.) _____

If you would like to choose telephone data collection, please ensure that you:

- Provide your contact details on page 4 as we'll pass this to a third party so they can contact you to arrange a convenient appointment. They may do this by telephone, text message or email.
- Sign and date the **Declaration and consent** at the end of this form, you don't need to complete any further health questions.

If you don't choose telephone data collection, please make sure you fully complete all the questions in this form if they're relevant, before reading, signing, dating and returning the form to Zurich.

Important notes

If you've any questions regarding your rights or any questions relating to the process of obtaining, assessing or storing medical information, please contact us using the details shown on page 1.

Before answering the following questions, please read 'Answering the questions – your duty to take reasonable care' below.

Answering the questions – your duty to take reasonable care

You should take reasonable care to answer all the questions honestly and to the best of your knowledge. If you don't answer the questions correctly we could restrict the amount of cover we provide or any claim may be rejected or not fully paid.

- When answering the questions we ask on this form, or if applicable during your telephone data collection interview, you must take reasonable care to ensure the information you provide is correct. So, you need to answer each question fully and truthfully.
- You must not assume that we'll contact your doctor to obtain medical information.
- You must inform us in writing about anything that happens during the period between the date of completion of this form, or the date of completion of the telephone data collection interview if later, and the date when we communicate our underwriting decision, that alters any answers you've given, whether or not you seek medical advice.
- If someone other than you records your answers on this paper form, you must ensure the recorded answers accurately reflect what you've said. Our decision to offer cover and on what terms will be based upon the recorded answers and won't include any verbal information not otherwise recorded.

Genetic tests

The only predictive genetic test you need to tell us about is the test for Huntington's Disease for Group Life Cover of £500,000 above any automatic acceptance limit. If you're unsure about the level of any automatic acceptance limit or whether you're eligible for this limit, please phone us on 0800 151 3003.

If you're unsure about what genetic information you need to tell us, please use the number above to contact the Company's Nominated Genetics Underwriter, or refer to the Association of British Insurer's website www.abi.org.uk/data-and-resources/tools-and-resources/genetics/code-on-genetic-testing-and-insurance.

If you wish to tell us about a negative genetic test result, which shows that you've not inherited a genetic disorder, we'll take this into account when assessing your application, provided your clinical geneticist confirms that the test result indicates a reduced risk of developing the inherited disease.

You must tell us if you've a family history of, are experiencing symptoms of, or are having treatment for, a medical condition including any genetically inherited condition (please refer to question 38).

Access to Medical Reports

If we apply to your doctor for a medical report we'll need your permission under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991.

Your legal rights are:

- You don't have to give your consent but if you don't we may not be able to provide the proposed level of cover.
- You can ask to see the report before your doctor returns it to us; if you do, we'll ask your doctor to retain it for 21 days so that you can arrange to see the report.
- You can ask your doctor for a copy of the report at any time during the six months after it has been sent to us.
- You can ask your doctor to amend the report if you consider any aspect of the report to be incorrect or misleading.
- If your doctor refuses to make the amendments, you may add your comments to the report.

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

Your medical report will ask about:

- Past and current health including relevant consultations, treatment, operations, investigations and test results that you may have undergone at any surgery, hospital or clinic or that are pending.
- Details of any family history of disease that you've told your doctor about.

Your consent will give us access to this information.

Your medical report will not ask about:

- Negative tests for HIV, Hepatitis B or C.
- Incidences of sexually transmitted diseases unless there are long-term health implications.
- Predictive genetic test results unless there is a favourable test which shows you haven't inherited a condition.

Personal contact details

1. Your details

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other *(please give details)*

First name(s)

Surname

Previous name (if applicable)

Gender ☐ Male ☐ Female

Date of birth

Address

Telephone number (Evening)

Telephone number (Daytime)

Mobile number

Email address

Should you require a Medical Examination or have opted to complete this form over the telephone, we may pass your contact details to a third party so they can gather any medical evidence that we need. They may contact you by telephone, text message or email.

By providing your contact details and signing the Declaration and consent below you accept that we may contact you by any of these means in order to clarify your responses or to collect further health information from you. Also that we may need to pass your contact details on to a third party so they can gather any medical evidence that we need.

General Practitioner (GP) details

2. Asking for this information does not necessarily mean we'll request a medical report.

a) Name, address and telephone number of your usual doctor.

b) Previous doctor's name, address and telephone number if registered with your current doctor for less than six months.

c) Please provide the name, address and telephone number of any medical professional you may have attended privately in the last five years where your usual NHS GP won't have the details.

d) Please confirm the dates and the reason for any consultation to the medical practitioner detailed in question 2c.

Occupation

3a) What is your occupation title?

3b) What are your daily occupational duties (e.g. managerial, admin, sales, manual – operating machinery, lifting)?

3c) Is the ability to travel essential to perform your occupational duties (e.g. car/train/aeroplane)? ☐ Yes ☐ No

If "Yes" please provide full details.

Medical examinations

4a) If we require you to have a medical examination in support of your application, please state where would be most convenient for you to attend (e.g. postcode area). Please note our independent doctor examinations can often be arranged more quickly than via an NHS GP.

Postcode of preferred location

4b) Alternatively, have you undergone a medical screening for your employer or private health plan within the last 12 months? ☐ Yes ☐ No

If "Yes" please provide a copy of the report using our contact details found on page 1 of this form. If you don't have a copy and want us to consider the results, please provide the details of where they can be obtained.

Contact details

Health and lifestyle details

Please complete the rest of the questions in this form **only** if you've chosen NOT to give your responses by telephone.

5. Build

a) What is your height? ☐ ft ☐ in ☐ cm

b) What is your weight? ☐ st ☐ lbs ☐ kgs

6. Tobacco and smoking

a) Have you smoked or used any form of tobacco or nicotine products in the last 12 months? ☐ Yes ☐ No

If "Yes" please state the amount smoked on average each day.

cigarettes cigars grams of tobacco

b) Do you, or have you used e-cigarettes containing nicotine or any other tobacco or nicotine product in the last 12 months? ☐ Yes ☐ No

If "Yes", please provide full details.

Health and lifestyle details (continued)

7. Alcohol consumption

a) Do you drink alcohol? ☐ Yes ☐ No

b) If "Yes" how often do you have a drink containing alcohol?

- ☐ Once a month or less
- ☐ 2-4 times a month
- ☐ 2 or 3 times a week
- ☐ 4 or more times a week

c) How many drinks containing alcohol do you have on a typical day when you're drinking? For example, a drink is a glass of wine, a glass or bottle of beer or a measure of spirits.

- ☐ 1 or 2 drinks
- ☐ 3 or 4 drinks
- ☐ 5 or 6 drinks
- ☐ 7, 8 or 9 drinks
- ☐ 10 or more drinks

d) Have you ever been advised or treated for alcohol consumption or abuse, or attended an alcohol support group, or been told you have liver damage? ☐ Yes ☐ No

If "Yes" please state when and why you were given this advice and, on average, how many units were you drinking each week?

_____

8. Drug use

In the last 10 years have you used recreational drugs such as cannabis, ecstasy, cocaine, heroin, amphetamines, or anabolic steroids? ☐ Yes ☐ No

If "Yes", please confirm for each drug:

Drug name	Frequency of use	Date last used	Was the drug injected?

Health and Medical history

9. Mental Health

Have you ever had schizophrenia, bi-polar disorder, manic depression, attempted suicide, episode of self-harm, an eating disorder, or any other mental health condition that has required a stay in hospital or referral to a psychiatrist? And/or in the last five years have you had any symptoms of anxiety, stress, depression, chronic fatigue, obsessive compulsive disorder or other form of mental health conditions? ☐ Yes ☐ No

If "Yes", please answer the below questions:

i) What was the diagnosis? _____

ii) When was your first episode or symptoms? Date _____

iii) When was your last episode or symptoms? Date _____

iv) What was the main cause of your symptoms (e.g. bereavement, work related etc.)? _____

v) How many episodes have you had in total? _____

vi) Are you currently taking any treatment, or have you done so in the last two years? ☐ Yes ☐ No

If "Yes", please confirm the name(s) of the treatment. _____

vii) Do any of your natural parents, brothers or sisters have a history of mental health conditions? ☐ Yes ☐ No

viii) Have you ever been referred to or treated by a counsellor, a psychiatrist, psychologist or psychotherapist for this? ☐ Yes ☐ No

ix) Have you ever planned or attempted suicide or harmed yourself in any way? ☐ Yes ☐ No

x) How many days, in total, have you had off work or from your normal activities due to this in the last two years? _____

10. Musculoskeletal

In the last five years have you had any symptoms of or been diagnosed with rheumatoid arthritis, osteoarthritis, whiplash, sciatica, slipped disc, back, neck, shoulder or knee pain, gout, or any other joint disorder? ☐ Yes ☐ No

If "Yes" please answer the below questions:

i) What was the diagnosis or name of the disorder? _____

ii) When were your first symptoms? Date _____

iii) When were your last symptoms? Date _____

iv) What area/joint(s) was affected (e.g. back, left knee, right shoulder)? _____

v) How many occurrences have you had? _____

vi) What investigations were carried out (if none please state 'none')? _____

vii) Please confirm the results of these investigations (if applicable). _____

viii) What treatment have you received? Please confirm the name(s) of any medication. _____

ix) What treatment is currently being given? (include any physio/chiropractor/surgery/medication). _____

x) What future treatment or investigations are planned? _____

xi) How many days, in total, have you had off work or from your normal activities due to this in the last two years?

xii) Does this condition restrict your usual daily activities in any way? ☐ Yes ☐ No

If "Yes" please describe how.

11. Have you ever had raised blood pressure? ☐ Yes ☐ No

If "Yes", please answer the below questions:

i How long ago was your blood pressure first found to be raised?

ii Are you currently receiving any treatment or medication for your blood pressure? ☐ Yes ☐ No

iii How long ago was your blood pressure last checked by a doctor or nurse?

iv Have you been told by a doctor that your blood pressure is normal? ☐ Yes ☐ No ☐ Don't know
Please confirm your last blood pressure reading (if known).

v Have you had or are you waiting for any hospital tests or investigations related to your raised blood pressure such as heart investigations (ECG), kidney tests or eye screening? ☐ Yes ☐ No
If "Yes", please provide full details.

12. Have you ever had raised cholesterol? ☐ Yes ☐ No

If "Yes", please answer the below questions:

i) Have you ever been told that your raised cholesterol is linked to a family history of raised cholesterol? ☐ Yes ☐ No

ii) How long ago was your cholesterol first found to be raised?

iii) Are you currently receiving any treatment or medication for your cholesterol? ☐ Yes ☐ No

iv) How long ago was your cholesterol last checked by a doctor or nurse?

v) Have you been told by a doctor that your cholesterol is normal? ☐ Yes ☐ No ☐ Don't know
Please confirm your last cholesterol reading (if known).

vi) Have you had or are you waiting for any hospital tests or investigations related to your raised cholesterol such as heart investigations (ECG), kidney tests or eye screening? ☐ Yes ☐ No
If "Yes" please provide full details

Health and Medical history (continued)

13. Do you currently, or have you ever had type 1 or type 2 diabetes, gestational diabetes, impaired fasting glucose or sugar in the urine? ☐ Yes ☐ No

If "Yes" please answer the below questions:

i) Please confirm the diagnosis. _____

ii) When was the diagnosis first made? _____

iii) Please provide the name(s) of any treatment you have been prescribed for this. _____

iv) Have you ever been admitted to hospital due to this? (Please confirm the date of your admission(s)). _____

v) Please confirm your latest HbA1c or blood sugar reading and the date taken. _____

vi) Have you ever had, been advised to have or are you waiting to have any tests for diabetic eye disease, tingling, numbness or loss of sensation on your fingers, toes or feet or protein in your urine due to your condition? ☐ Yes ☐ No

14. Do you currently, or have you ever had any respiratory or lung disorder such as asthma, bronchitis, chronic obstructive lung disease? ☐ Yes ☐ No

If "Yes" please answer the below questions:

i) Please confirm the diagnosis. _____

ii) When was the diagnosis first made? _____

iii) On average how many attacks have you had each year within the last three years? _____

iv) Have you been admitted to hospital with respiratory symptoms within the last three years? _____

v) Please provide the name(s) of any treatment you have been prescribed for this. _____

vi) Have you been treated with steroid tablets (e.g. prednisolone) within the last three years? _____

vii) When did you last have symptoms or need treatment for respiratory symptoms? Please provide full details. _____

Medical History

Do you currently have, or have you ever had:

15. Any heart related disease or disorder, such as heart attack, angina, cardiomyopathy, heart enlargement, heart failure, irregular or rapid heartbeat, heart valve defect or any other heart condition? ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Name of disorder _____

ii) Date of diagnosis _____

iii) Details of past and present treatment _____

iv) Details of any symptoms _____

v) Results of tests/investigations _____

vi) Full recovery made or detail any ongoing problems _____

16. Any disorder or abnormality of the blood vessels or arteries such as narrowing, blockages, blood clots or deep vein thrombosis (DVT)? ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Name of disorder _____

ii) Date of diagnosis _____

iii) Details of past and present treatment _____

iv) Details of any symptoms _____

v) Results of tests/investigations _____

vi) Full recovery made or detail ongoing problems _____

17. A stroke, transient ischaemic attack (TIA), mini stroke, brain haemorrhage, brain aneurysm or any damage or surgery to the brain? ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Name of disorder _____

ii) Date of diagnosis _____

iii) Details of past and present treatment _____

iv) Details of any symptoms _____

v) Results of tests/investigations _____

vi) Full recovery made or detail ongoing problems _____

18. Cancer, leukaemia, Hodgkin's disease, melanoma, lymphoma, brain or spinal tumours or growths? ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Name of disorder _____

ii) Date of diagnosis _____

iii) Details of past and present treatment _____

iv) Details of any symptoms _____

v) Results of tests/investigations _____

vi) Full recovery made or detail ongoing problems _____

Medical History (continued)

19. Any disorder of the nervous system such as multiple sclerosis, optic neuritis, Parkinson's disease, paralysis, cerebral palsy, motor neurone disease, dementia or memory loss? ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Name of disorder _____

ii) Date of diagnosis _____

iii) Details of past and present treatment _____

iv) Details of any symptoms _____

v) Results of tests/investigations _____

vi) Full recovery made or detail ongoing problems _____

20. Any disease or disorder of the liver or pancreas such as any form of hepatitis, abnormal liver function test, fatty liver, cirrhosis or pancreatitis? ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Name of disorder _____

ii) Date of diagnosis _____

iii) Details of past and present treatment _____

iv) Details of any symptoms _____

v) Results of tests/investigations _____

vi) Full recovery made or detail ongoing problems _____

21. A positive test for HIV or are you awaiting the results of an HIV test? (If the result is negative, having an HIV test will not have any effect on your acceptance terms for insurance). ☐ Yes ☐ No

If "Yes", please give details of when you were diagnosed and what treatment you received or are receiving. _____

If awaiting an HIV test, when do you expect the test results to be available? _____

Recent Health

In the last 5 years, unless you've already told us earlier in this application, have you had any of the following, or have you consulted a doctor, nurse or other health professional for:

22. Any thyroid disorder? ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Name of disorder _____

ii) Date of diagnosis _____

iii) Details of past and present treatment _____

iv) Details of any symptoms _____

v) Results of tests/investigations _____

vi) Full recovery made or detail ongoing problems _____

23. Any kidney disease or disorder such as any form of nephritis, cysts or recurrent kidney stones? ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Name of disorder _____

ii) Date of diagnosis _____

iii) Details of past and present treatment _____

iv) Details of any symptoms _____

v) Results of tests/investigations _____

vi) Full recovery made or detail ongoing problems _____

24. Any disease or disorder of the bladder or urinary tract such as recurrent infections or protein or blood in the urine? ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Name of disorder _____

ii) Date of diagnosis _____

iii) Details of past and present treatment _____

iv) Details of any symptoms _____

v) Results of tests/investigations _____

vi) Full recovery made or detail ongoing problems _____

25. Any disease or disorder of the stomach, bowel or digestive system such as ulcers, ulcerative colitis, or Crohn's disease? ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Name of disorder _____

ii) Date of diagnosis _____

iii) Details of past and present treatment _____

iv) Details of any symptoms _____

v) Results of tests/investigations _____

vi) Full recovery made or detail ongoing problems _____

Recent Health (continued)

26. Any tremor, numbness, loss of feeling or tingling in the limbs or face, blurred vision, loss of balance or co-ordination, epilepsy or loss of muscle power? ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Please describe the nature of your symptoms _____

ii) Please confirm the date when your symptoms first presented _____

iii) Details of past and present treatment _____

iv) Results of any tests or investigations and/or the date(s) of any that have been planned _____

v) Full recovery made or detail ongoing problems _____

27. Any lump, cyst, growth or polyp, or a mole or freckle that has bled or changed in appearance? ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Name of disorder _____

ii) Date of diagnosis _____

iii) Details of past and present treatment _____

iv) Details of any symptoms _____

v) Results of tests/investigations _____

vi) Full recovery made or detail ongoing problems _____

vii) Has the lump, cyst, growth been confirmed as benign? _____

28. Anaemia or other blood disorders such as haemochromatosis or haemophilia? ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Name of disorder _____

ii) Date of diagnosis _____

iii) Details of past and present treatment _____

iv) Details of any symptoms _____

v) Results of tests/investigations _____

vi) Full recovery made or detail ongoing problems _____

29. Any disease or disorder of the eyes such as double vision or visual impairment in one or both eyes? ☐ Yes ☐ No
(You don't need to tell us about sight problems corrected by glasses or contact lenses).
If "Yes" please confirm the following:

i) Name of disorder _____

ii) Date of diagnosis _____

iii) Details of past and present treatment _____

iv) Details of any symptoms _____

v) Results of tests/investigations _____

vi) Full recovery made or detail ongoing problems _____

Recent Health (continued)

30. Any disease or disorder of the ears such as hearing loss, ringing in one or both ears, tinnitus, labyrinthitis or Meniere's disease? ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Name of disorder _____

ii) Date of diagnosis _____

iii) Details of past and present treatment _____

iv) Details of any symptoms _____

v) Results of tests/investigations _____

vi) Full recovery made or detail ongoing problems _____

31. Any weight loss treatment such as medication, gastric banding or bypass? ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Name of disorder _____

ii) Date of diagnosis _____

iii) Details of past and present treatment _____

iv) Details of any symptoms _____

v) Results of tests/investigations _____

vi) Full recovery made or detail ongoing problems _____

32. **For females only** – any gynaecological disease or disorder, or any conditions of the breast, ovary or uterus, which have required medical advice, including abnormal mammogram or abnormal cervical smear or a positive test for the Human Papillomavirus (HPV)? (You don't need to tell us about any tests in connection with routine pregnancy). ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Name of disorder _____

ii) Date of diagnosis _____

iii) Details of past and present treatment _____

iv) Details of any symptoms _____

v) Results of tests/investigations _____

vi) Full recovery made or detail ongoing problems _____

33. **For males only** – any disease or disorder of the prostate or testicle(s), such as raised Prostate Specific Antigen (PSA) or undescended testicle(s)? ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Name of disorder _____

ii) Date of diagnosis _____

iii) Details of past and present treatment _____

iv) Details of any symptoms _____

v) Results of tests/investigations _____

vi) Full recovery made or detail ongoing problems _____

Current Health

Other than for the conditions you've already told us about earlier in this application:

34. In the last 3 months, have you had any symptoms of ill health, such as unexplained bleeding, weight loss, change of bowel habit, any lump or growth changes affecting either breast or testicle, breathing problems or shortness or breath or a cough that's lasted for 4 weeks or more? ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Nature of symptoms _____

ii) When did this start? _____

iii) Have you seen a doctor? _____

iv) Date and results of investigations (if applicable) _____

v) Full recovery made or detail ongoing probems _____

35. In the last month have you had a positive test for Coronavirus (COVID-19), had a fever or high temperature, a new continuous cough, breathing difficulties, any other symptoms of Coronavirus (COVID-19), Long COVID or Post-COVIDsyndrome? ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Nature of symptoms _____

ii) When did this start? _____

iii) Have you seen a doctor? _____

iv) Date and results of investigations (if applicabble) _____

v) Full recovery made or detail ongoing problems _____

36. Are you aware of any symptoms that you intend to seek medical advice or treatment for, or are you waiting for any test results, appointments or investigations with your doctor or other medical professional? ☐ Yes ☐ No

If "Yes" please confirm the following:

i) Nature of symptoms _____

ii) When did this start? _____

iii) Have you seen a doctor? _____

iv) Date and results of investigations (if applicable) _____

v) Full recovery made or detail ongoing problems _____

37. In the last 2 years have you had any medication or treatment that lasted more than four weeks? ☐ Yes ☐ No
(You don't need to tell us about oral contraceptive pill, iron supplements during pregnancy, hormone replacement therapy (HRT) or treatment for minor accidents).

If "Yes" please give details of the type and reason for the medication or treatment.

_____

Family Health

38. Have any of your natural parents, brothers or sisters, before their 65th birthday, been diagnosed with Alzheimer's disease, cancer*, stroke, heart attack, heart disease, heart disorder, cardiomyopathy*, diabetes, Huntington's disease, motor neurone disease, multiple sclerosis, myotonic (muscular) dystrophy, Parkinson's disease, polycystic kidney disease*, polyposis coli or other hereditary disorder? ☐ Yes ☐ No

*If you have a family history of one of these conditions, please also include the type and primary site (if cancer) and full details of any investigations that you've had as a result of this family history.

If "Yes" please provide details of the relative, the condition and their age at onset.

Relationship	Condition	Relative's age at onset	Type or Primary site (if appropriate)

Have you had any tests or investigations due to your family history? ☐ Yes ☐ No

If answered "Yes" please confirm the type of investigation, date and result.

Absence from work

39. Are you currently off work, working reduced hours or in the last 2 years had more than 10 consecutive days off work or altered your duties due to sickness or injury? ☐ Yes ☐ No

If "Yes" please give full details including the reason, dates and the length of time off work.

Travel

40a) In the last 5 years, have you spent more than 30 days in Africa, Thailand, The Caribbean, Russia, Ukraine, Afghanistan, Iraq, Syria or area of civil unrest? ☐ Yes ☐ No

If 'Yes', please provide details of all the countries visited, including the cities/areas of each country visited and the duration of stay in each place.

City/Area and Country	Duration of Stay

40b) In the next 2 years, do you expect to travel, live or work outside the United Kingdom, European Union (EU), North America, Australia or New Zealand or to travel to a country where the Foreign and Commonwealth Office guidance is not to travel to at all, or to only travel to for essential purposes? ☐ Yes ☐ No

You don't need to tell us about a total of 30 days' holiday each year to countries or regions where the Foreign and Commonwealth Office guidance says it is okay to travel to without restriction. If you're unsure, you can check the latest advice on their website: www.gov.uk/foreign-travel-advice.

If "Yes" please provide the details of all trips planned, including the cities/areas of each country you'll be visiting and the duration you plan to stay in each country.

City/Area and Country	Duration of Stay

Hazardous Pursuits

41a) Do you take part, or intend to take part in Underwater diving? ☐ Yes ☐ No

i) Are you a qualified diver, e.g. BSAC, PADI, NAUI? ☐ Yes ☐ No

If 'Yes' please provide details

ii) How many dives do you do a year?

iii) What is the maximum depth you dive to (in metres)?

iv) Do you dive in diving bells, in caves or potholes or internally in wrecks? ☐ Yes ☐ No

If 'Yes' please provide details

v) Do you take part in depth record attempts, free diving, special expeditions or do you dive unaccompanied? ☐ Yes ☐ No

If 'Yes' please provide details

41b) Do you take part, or intend to take part in Motor car/cycle sport? ☐ Yes ☐ No

i) What type of motor sport are you involved in?

ii) Please specify the make of the vehicle, engine size (cc) and whether it is standard or modified. Include RAC classification, if appropriate.

iii) At what level are you involved:

1) Club, national or international?

2) Are you sponsored? ☐ Yes ☐ No

iv) Where do you race?

v) How many races have you participated in during the last 12 months?

vi) How many races do you intend entering in the next 12 months?

vii) Have you ever taken part in, or do you intend to take part in Isle of Man TT racing? (only relevant for motor cycle sport) ☐ Yes ☐ No

If 'Yes' please provide details

viii) Do you take part in any record attempts or stunts? ☐ Yes ☐ No

If 'Yes' please provide details

Hazardous Pursuits (continued)

41c) Do you take part, or intend to take part in Mountaineering/ climbing? ☐ Yes ☐ No

i) What activities do you take part in, e.g. technical, mountain scrambling, trekking, mountaineering, etc.? Please provide full details.

ii) Are you a member of the British Mountaineering Council or other recognised organisation? ☐ Yes ☐ No

iii) Where do you climb? Please specify the mountain ranges and countries:

iv) What heights do you climb up to (in metres)?

v) What difficulty level do you climb up to?

vi) Do you ever climb alone, as a professional, or take part in ice climbing or expeditions? ☐ Yes ☐ No

If 'Yes' please provide details

41d) Do you take part, or intend to take part in flying or other aviation based activity (other than as aircrew or as a fare paying passenger)? (You don't need to tell us about gift experiences, charity parachute jumps or sky dives). ☐ Yes ☐ No

If 'Yes', we'll need some additional information and will send you an Aviation Questionnaire shortly to complete.

41e) Do you take part, or intend to take part in sailing or yachting? ☐ Yes ☐ No

If 'Yes', we'll need some additional information and will send you a Sailing Questionnaire shortly to complete.

41f) Do you take part, or intend to take part in other hazardous recreational activities such as boxing, martial arts, equestrianism, winter sports, extreme sports (you do not need to tell us about leisure activities such as gym, running or cycling)? ☐ Yes ☐ No

i) Describe your sporting activity (or activities)

ii) At what standard/level would you classify your involvement in your sport (e.g. hobby, amateur, professional)? If appropriate, state the recognised level.

iii) How frequently do you take part in your sporting activity?

iv) Where do you take part in your sporting activity?

v) Please summarise your involvement in your sporting activity over the last 12 months.

vi) Please summarise your intended involvement in this activity over the next 12 months.

Please read this Declaration and consent carefully before signing.

Please note: your application is subject to acceptance by us and completion of this form does not guarantee that your application will be accepted.

Declaration and consent

- I consent to Zurich obtaining medical information from any doctor I've consulted about my physical or mental health so that Zurich may assess my state of health as part of their underwriting process.
- I agree to Zurich obtaining information from other insurers about previous applications I've made for any life, sickness, accident or private medical insurance.
- I agree that this consent form allows Zurich to obtain medical reports prior to the date the underwriting decision is communicated, or after a claim is made to verify the accuracy of the information provided.
- I authorise those asked by Zurich to give the information outlined in the three bullet points above on production of a copy of this consent.
- I consent to Zurich passing any abnormal findings or test results arising from any independent medical evidence obtained to assess my application to my General Practitioner.
- I agree that the terms for providing cover, including any exclusion from cover, or any refusal or postponement of cover, resulting from a specific medical condition of which I'm aware, may be communicated to my employer as the policyholder.
- I agree that Zurich may share medical and other underwriting evidence with the policyholder, trustees, my employer, re-insurers and service providers, as appropriate, for the purposes of administering the employee benefit arrangements of which I'm a member.
- I agree that Zurich may disclose limited medical or other reasons for non standard underwriting decisions to insurance intermediaries or other insurers, where asked to do so, but that this does not include any medical reports or other underwriting evidence.
- I understand that Zurich may be asked to provide copies of medical reports or other underwriting evidence beyond the reasons, mentioned in the bullet point immediately above, to other insurers or insurance intermediaries and that Zurich will contact me for my consent at that time.
- I consent to my information being passed to Zurich's Chief Medical Officer, to third party life reassurers and to third party administrators arranging medical examinations.
- 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 will tell Zurich about any change to my personal health, family history, travel or residence, hazardous activities, alcohol consumption, smoking habits or use of recreational drugs which happens before the date Zurich communicates the underwriting decision, if that change makes any of my answers wrong or incomplete. I understand that if the information or statements I've given are not true, or changes in such facts are not notified to Zurich, the cover may be cancelled, or its terms changed or a claim rejected or not fully paid.
- I confirm that I've read this **Declaration and consent**, together with the **Important notes** at the front of this form including: Answering the questions – your duty to take reasonable care, Telephone data collection, Genetic Tests and the information relating to my rights under the Access to Medical Reports legislation.
- I confirm that I've read the 'Data Protection Statement', which explains how the personal data I've provided will be used.
- I consent to my medical data being used in the way described.

Please take reasonable care to answer all the questions honestly and to the best of your knowledge. If you don't answer the questions correctly, your cover may be restricted or a claim may be rejected or not fully paid.

By signing this **Declaration and consent** I agree to all of its contents.

Signature

☐ **I do NOT want to see the medical report before it is returned to Zurich.**

☐ **I do want to see the medical report before it is returned to Zurich.**

Print name

Date

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.

Zurich Assurance Ltd
Registered in England and Wales under company number 02456671.
Registered Office: Unity Place, 1 Carfax Close, Swindon, SN1 1AP.

PDF1525002 (128037) (05/23)