Elixia 123 Personal Critical Illness Cover Application Form

Personal Details

Policy Number

Title (please tick the appropriate box) Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other eg. Dr

Surname

Forename(s)

Date of birth / /

Address

Postcode

Telephone Number

Email

- **If you are claiming for Waiver of premium please complete Section 1 & 2.**
- **If you are claiming for Critical Illness please complete Section 1 only.**
- **If you are claiming for Total & Permanent Disability ensure section 3 is completed.**
- **If you are claiming for Critical Illness and Waiver of premium please complete Section 1 and 2.**
- **Section 4 should be completed by your General Practitioner for all claims.**

This box should only be completed for Children's Critical Illness Cover

Child's Full Name

Child's date of birth / /

If both parents have a policy please provide both policy numbers above and we require both signatures.

Name Signature

Name Signature

1. Medical and Claim Related Details

1.1 Please place a tick next to the critical illness for which you wish to make a claim under the categories below:

Category 1 (please tick)

- Cancer – invasive and life threatening ☐
- Chronic Emphysema ☐
- CJD (Creutzfeldt-Jocob Disease) ☐
- Heart Attack – Major ☐
- Kidney Failure ☐
- Liver Failure ☐
- Major Organ Transplant ☐
- Stroke – Severe ☐

Category 2 (please tick)

- Alzheimer's Disease ☐
- Blindness ☐
- Deafness ☐
- HIV infection/ AIDS contracted in the course of duty ☐
- HIV infection/ AIDS contracted due to a blood transfusion ☐
- Loss of independent existence ☐
- Loss of Limbs ☐
- Loss of Speech ☐
- Motor Neurone disease ☐
- Multiple Sclerosis ☐
- Paralysis/ Paraplegia ☐
- Parkinson's Disease ☐
- Pre-senile dementia ☐
- Third Degree Burns ☐

Category 3 (please tick)

- Aorta graft surgery ☐
- Angioplasty ☐
- Balloon Valvuloplasty ☐
- Benign Brain Tumour ☐
- Cancer ☐
- Coma ☐
- Coronary Artery Bypass ☐
- Heart Attack ☐

1. Medical and Claim Related Details (continued)

Category 3 (continued) (please tick)

- Heart valve replacement or repair ☐
- Open Heart Surgery ☐
- Severe Head Injury ☐
- Mastectomy ☐
- Stroke ☐

Total and permanent disability before age 60 ☐

Please answer the following questions regarding the Critical Illness for which you are claiming:

1.2 Please describe the nature and extent of your illness.

1.3 When did you first consult any doctor regarding your illness? / /

1.4 Please provide a name and address if this was not your usual Medical Attendant.

1.5 On what date was the Critical Illness diagnosed? / /

1.6 What symptoms did you notice before you first saw your doctor (regardless of their severity) and when did they first begin?

1.7 Have you previously suffered from or received treatment for the same or any related condition? If yes please provide full details.

1.8 Have you undergone any tests or investigations to confirm the diagnosis? If yes, please provide dates and details.

1.9 What treatment have you have received to date?, Are there any plans for future management? (please include the relevant dates where possible).

1. Medical and Claim Related Details (continued)

1.10 Please confirm whether a surgical operation will be or has been carried out and when?

1.11 Have any of your blood relatives (parents, brothers or sisters) suffered from a similar or related illness? If yes, please state relationship, nature of illness and the age of your relative when the illness was first diagnosed.

Relationship

Nature of Illness

Age when diagnosed

1.12 Do you smoke cigarettes? Yes ☐ No ☐

If yes what is your daily consumption? per day

1.13 Have you previously been a smoker? Yes ☐ No ☐

If yes what was your daily consumption and what date did you give up? per day

I gave up smoking on the / /

1.14 Do you hold a similar policy(s) with another company? Yes ☐ No ☐

If yes please provide the name of insurer, amount of benefit and policy number

Name

Policy Number Benefit

Name

Policy Number Benefit

1.15 Please provide the name and address of your General Practitioner (GP).

Name

Address

Postcode

Telephone Number

Dates of Consultations

1.16 If you have changed your GP in the past 12 months please provide the name and address of your previous GP.

Name

Address

Postcode

Telephone Number

Dates of Consultations

1. Medical and Claim Related Details (continued)

1.17 Please give details of any specialists or other doctors who have been consulted in connection with your illness.

Name	
Speciality	
Address	
	Postcode
Telephone Number	
Dates of Consultations	
Name	
Speciality	
Address	
	Postcode
Telephone Number	
Dates of Consultations	

2. Waiver of Premium Benefit

If you have chosen the Waiver of Premium option in your policy and suffer a disability as defined in your policy for a continuous period of six months or more we will waiver the premium due until the earliest of the following are satisfied

- The date you no longer satisfy the relevant tests described below
- The expiry date
- On death or payment of the main Critical Illness benefit

Please place a tick next to the boxes, which apply to your current physical or mental impairment:

2.1	Can you sit comfortably in a chair for 30 minutes?	Yes	☐	No	☐
2.2	Can you get up from a chair without using it's arms (means without using arms of chair and without assistance of any other person)?	Yes	☐	No	☐
2.3	Can you stand for a period of 10 minutes (the ability to stand and perform light tasks, using one hand for support)?	Yes	☐	No	☐
2.4	Can you walk a distance of 200m on flat ground without stopping (without sticks or crutches)?	Yes	☐	No	☐
2.5	Can you lift a 2 kg weight from counter height using either hand (both arms need to be disabled to satisfy this test)?	Yes	☐	No	☐
2.6	Can you walk up and down a flight of 12 stairs without holding on or taking a rest?	Yes	☐	No	☐
2.7	Can you either bend or kneel to pick up something light from the floor and straighten up again unaided?	Yes	☐	No	☐
2.8	Do you have the manual dexterity necessary to write a standard sized letter using a pen or pencil with either hand (using the dominant hand to write)?	Yes	☐	No	☐

2. Waiver of Premium Benefit (continued)

2.9 Do you have the manual dexterity to use a keyboard to input data under normal conditions for a period of 20 minutes (with this test we are not concerned with the speed or proficiency of the input but the dexterity)? Yes ☐ No ☐

2.10 Can you answer a telephone and relay a message ? Yes ☐ No ☐

2.11 Can you put on and take off items of clothing that are normally worn? Yes ☐ No ☐

2.12 Can you use normal cutlery to eat a meal that has already been prepared? Yes ☐ No ☐

2.13 Do you suffer blackouts that requires revocation of your UK driving licence (or such circumstances that would preclude you from obtaining a UK driving licence)? Yes ☐ No ☐

2.14 Are you registered either blind or partially sighted by a registered Consultant Ophthalmologist? Yes ☐ No ☐

2.15 Do you suffer from a mental illness and are under the care of a Consultant Psychiatrist? Yes ☐ No ☐

Is driving a substantial requirement of your occupation? Yes ☐ No ☐

Have you had your licence revoked as a result of a medical condition? Yes ☐ No ☐

3. Total & Permanent Disability (TPD) Benefit

The questions in this section are to be completed only for claims for Total & Permanent Disability.

3.1 Please confirm the nature of your occupation and describe your normal duties in detail.

3.2 Please provide the name and address of your employer

Name

Address

Postcode

Telephone Number

3.3 On what date did you become absent from work? / /

3.4 Please give details of the symptoms and what activities at work these prevent you from carrying out?

3.5 Do you envisage a return to work in the future? Yes ☐ No ☐

If 'yes' when would you expect to be able to return to work?

3.6 Have you intentions of seeking alternative employment? Yes ☐ No ☐

3. Total & Permanent Disability (TPD) Benefit (continued)

3.7 Are you trained or qualified for any other occupation? Yes ☐ No ☐

If 'yes' please give details of qualifications and experience

Application for Benefit Medical Access Declaration

ACCESS TO MEDICAL REPORTS ACT 1988/ACCESS TO PERSONAL FILES AND MEDICAL REPORTS (NORTHERN IRELAND) ORDER 1991/ ACCESS TO HEALTH RECORDS AND REPORTS ACT 1993 (ISLE OF MAN) ("the Acts")

To enable us to assess your claim, it will be necessary to obtain medical evidence. Any reports which are requested from your doctors are subject to the Acts. (Please note that Reports requested from Doctors appointed by UnumProvident are not subject to the Acts). In summary your statutory rights are as follows:

1. A Medical Report cannot be requested from any doctor who has attended you, without your written authority.
2. You do not have to give your consent. If you do consent, you can say whether you wish to see the report before it is sent to the Company's Chief Medical Officer. If you do not give consent we may be unable to proceed with your application for benefit.
3. If you say you wish to see the report, we will write to your doctor and tell them, and advise you that we have done so. You will then have 21 days to contact the doctor to make arrangements to see the report. Of course, the quicker you act the quicker your application for benefit can be considered.
4. If you say you do not wish to see the report, we do not have to notify you if we apply for one. However, if you may write to your doctor and request to see such a report before it is sent to us. You will then have 21 days to contact the doctor to make arrangements to see the report.
5. Whether or not you say you wish to see the report before it is sent to us, you may ask your doctor to show you a copy of the report for up to 6 months after it is supplied.
6. If you ask the doctor for a copy of the report, the doctor can charge you a reasonable fee to cover costs.
7. If you see a report before it is sent to us, the doctor cannot submit it until you give your consent. You can write to the doctor, asking that any part of the report which you consider to be incorrect or misleading be amended, and to have attached to the report a statement of your views on any part where you and the doctor are not in agreement.
8. The doctor is not obliged to let you see any part of a report if,
   - in his/her opinion it would be likely to cause serious harm to your physical or mental health, or that of others,
   - it would indicate the doctors intentions towards you,
   - disclosure would be likely to reveal information relating to, or the identity of, someone else who has supplied information about you, unless that person has consented
   - the information relates to, or has been supplied by, a health professional involved in caring for you.

In such cases, the doctor must notify you and you will be limited to seeing any remaining part of the report. If it is the whole report which is affected, the doctor must not send it to us unless you give your consent.

Data Protection Act 1998

Information about you will be put on our database and used by Unum Limited (trading as UnumProvident) who are the data controller, in assessing your claim and servicing your relationship with us and for the purposes of identity verification, fraud prevention, audit and debt collection and claim verification.

We may conduct, or have conducted on our behalf, checks with external agents in connection with this claim for validation purposes. We or our agent may ask you for more information, or carry out further checks and searches when assessing your claim, or at any time during the claim for the purposed of fraud prevention and claim verification.

We may share information about you, including but not limited to Medical Reports, Private Investigators Reports and Disability Counsellors Reports, with:

- Your nominated G.P.
- Third parties – including but not limited to the Association of British Insurers, Trustees in Bankruptcy, reinsurers, underwriters and medical agencies (in the UK and abroad) and sub-contractors and agents in order to provide you with the service applied for, fraud prevention or so that services may be processed on our behalf.
- Insurance reference agencies – this information will be used by other agency users in assessing insurance risk and for fraud prevention.
- Government regulators and the Ombudsman – to help resolve a complaint or for audit purposes.
- Other insurance companies who require the information for lawful purposes.

To help improve our service and in the interests of security we may monitor and/or record calls with us.

NOTICE – Insurers pass information on claims concerning income protection insurance, critical illness insurance and waiver of premium benefits to the income protection claims register, run by the Association of British Insurers. The aim is to prevent duplicate fraudulent claims. When you make a claim, we will notify the register of that event.

Declarations and Consents

1. I declare that all statements I have made are true and complete, that I have been unable to follow my occupation and have not followed any other occupation since the date shown as first absent from work, that the sole reason for this absence has been the symptoms as specified and I have disclosed all information material to my claim. I consent to UnumProvident undertaking any other enquiries they consider necessary concerning the admission and continuation of the claim.
2. I have read and I understand my statutory rights under the **Access to Medical Reports Act 1988/Access to Personal Files and Medical Reports (Northern Ireland) Order 1991/Access to Health Records and Reports Act 1993 (Isle of Man)** as outlined above and I consent to UnumProvident seeking medical information, including copies of my medical records, from any doctor who at any time has attended me, concerning anything which affects my physical or mental health.

   Do you wish to see the report before it is sent to UnumProvident? Yes ☐ No ☐
3. I have read and understood the section on the **Data Protection Act 1998** and

   - I consent to UnumProvident being provided with confidential information, concerning the application for this insurance, including but not limited to information concerning my physical and or mental health or condition from any third party.
   - I authorise the release of confidential information, including but not limited to information concerning my physical and/or mental health or condition obtained by UnumProvident, to my doctors or any doctors or specialists appointed by UnumProvident in relation to the claim and to any third party, who requires such information for lawful purposes.

Full Name:

Date: / / Signature:

4. Confidential Medical Report

(To be completed by your General Practitioner)

Your patient has submitted a claim for Critical Illness/ Waiver of Premium, under a policy that they hold with us. We shall be pleased if you would complete the following report. Your patient has given us written permission to obtain this information.

No Medical Examination is Required

Patients Details

Full Name of Patient

Date of birth / /

General

4.1 Do you wish to see the report before it is sent to Unum? Yes ☐ No ☐

If 'yes' over what period do your records extend? To / /

From / /

4.2 Please provide the precise diagnosis?

4.3 When was your patient first diagnosed?

4.4 Please provide a full account of your patient's initial presentation. What was the history as described to you: for example what symptoms did they notice, when did they start and how long did they persist until you were first seen.

4.5 What is your patient's current prognosis?

4.6 a. Has your patient ever suffered from this illness previously? Yes ☐ No ☐

b. Has your patient ever suffered from a related illness? Yes ☐ No ☐

If 'yes' please give any relevant details including dates and consultations

4. Confidential Medical Report (continued)

4.7 Please provide full and exact details of the underlying condition or injury that has caused the disability, including the nature and extent of symptoms.

4.8 Is the patient's condition permanent and irreversible? Yes ☐ No ☐

If 'yes' please clarify why they are not expected to make a recovery

4.9 Please provide dates and results of any investigations that have been carried out. (if a diagnosis for cancer has been made, please provide confirmatory histology tests, if heart attack a copy of ECG and CKMB levels would be appreciated).

4.10 Please provide details of treatment given to date and any planned treatment.

4.11 Please give details of your patient's habits in relation to cigarette smoking, including, to your knowledge, how many cigarettes the patient has smoked in the past and currently smokes.

4.11 Please provide the name and address of all Consultants or Specialists that your patient has seen with regard to their condition.

Name

Speciality

Address

Postcode

Telephone Number

Dates of Consultations

4. Confidential Medical Report (continued)

Name

Speciality

Address

Telephone Number

Dates of Consultations

Name

Speciality

Address

Telephone Number

Dates of Consultations

Name

Speciality

Address

Telephone Number

Dates of Consultations

Please provide all copies of any test results, medical notes or copy correspondence for patients claim

To / /

From / /

(Block Capitals Please)

Signature

Name

Qualifications

Date / /

STAMP

Has your patient requested any amendments to this document? Yes ☐ No ☐

Information for Physicians

Access to Medical Reports Act 1988/ Access to personal File and Medical Reports (Northern Ireland) order 1991 (only applicable to claimants resident in the united Kingdom excluding The Channel Islands and Isle of Man).

Under the Access to Medical Act 1988, certain legal requirements have to be complied with by both the insurers and any doctors who have responsibility for the health care of the claimant.

In short, the Claimant must have given consent for us to approach you and this is enclosed. The consent indicates whether or not the claimant wishes to see the report before it is sent to us. If the claimant has elected to view the report before it is sent to us, you may not release the Report until you have their consent or 21 days have passed without you making arrangement to see the you.

You should note that the claimant has the right during the next six months to see the report and to have a copy of it for which you may charge reasonable costs. You are advised to keep a copy of the original report.

You have the right to withhold the report, or part of it from the Claimant if you consider it might be harmful and, if in any doubt, you may wish to take advise from your Medical Protection Society or Defence Union on this matter.

Important

If there is any other relevant information which is confidential under the Access to Medical Reports Act 1988, and will not have been included in this report, please send a separate report to our Chief Medical Officer at our Registered Office, for which an appropriate fee will be paid.

Registered office:
Milton Court, Dorking,
Surrey RH4 3LZ.
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