

# Medical health and lifestyle questionnaire

Please return this form to Unum, Milton Court, Dorking, Surrey RH4 3LZ or by email to [muw@unum.co.uk](mailto:muw@unum.co.uk) (password protection or encryption is recommended).



Registered Office: Milton Court, Dorking, Surrey RH4 3LZ  
 This form should only be completed if underwriting is needed.

## Policy details

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

1. Policy name

2. Cover type

<input type="checkbox"/> Group Income Protection	Policy number(s) <input type="text"/>
<input type="checkbox"/> Group Life	Policy number(s) <input type="text"/>
<input type="checkbox"/> Group Dependants	Policy number(s) <input type="text"/>
<input type="checkbox"/> Group Critical Illness	Policy number(s) <input type="text"/>

3. Reason for completing this form

Application for new or increased benefit above non-medical limit for eligible member

Application for discretionary member (please specify):

Applicant does not meet scheme eligibility

Please state why

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 policy			
Policy-defined salary			
Membership category			

The following sections are to be completed by the applicant.

**Please complete this application carefully. We rely on the information you give us to make our decision about insuring you.**

• **We will not routinely ask for a report from your GP.** We only ask you to tell us what we think it's reasonable for you to know. As you go through this questionnaire, if you are in any doubt about the need to tell us something, please give us the information in full. It's better to tell us about a fact that turns out to be irrelevant than risk missing something that later causes a problem.

• **You are responsible for what you tell us.** If you don't complete the form yourself, we expect you to read all the statements and our guidance carefully 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, refuse a claim and may withdraw some or all cover.

Please answer all our questions in **BLACK INK** and in **BLOCK CAPITALS**, and then sign and date the declarations and consents on page 16.

**Member details**

1. Surname

2. Title (please tick one of these boxes or state another title)  
Mr  Mrs  Miss  Ms   
Other

3. Forename(s)

4. Date of birth

5. Gender Male  Female

6. Home address   
  
  
Postcode

We can often sort out any unclear details with a quick call or email. If you are happy for us to contact you between 9am and 5.30pm Monday to Friday, please give us details. We won't use this information for any other purpose.

7. What is a good time to contact you? Between  and  Don't contact me directly   
Telephone number and/or email address

8. Who is your GP?   
Surgery address   
  
  
Postcode

GP's telephone number and/or email address

## Member details (continued)

9. Have you registered with this surgery within the last 6 months?

Yes

No

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


If we require medical evidence in support of your application, we may be able to use a health screen report on you completed 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 job 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 below if all or part of your duties require you to work in other environments, such as 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 occupation?

Yes

No

You should say **yes** if you need to drive on business at least once a week, including visiting clients or making deliveries, and you cannot do this by taking alternative means of travel. You should say **no** if you only use your vehicle to get 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

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

**If yes, please list in the table on the next page all trips taken 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

**If yes, please list in the table on the next page 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>				

Please use the end of this form if you need more space.

2. Do you review and follow Foreign Office advice before travelling outside the EU or North America? Yes  No

## Fitness and lifestyle details

1. What is your height?  **feet**  **inches**  
or  **cm**
2. What is your weight today?  **stones**  **pounds**  
or  **kg**
3. Has your weight changed by more than 2 stones (or 13kg) in the last 2 years? Yes  No
4. What is your waist measurement today?  **inches** or  **cm**
5. Have you smoked tobacco in the last 12 months? Yes  No

If **yes**, how much do you smoke in a typical day?

If you stopped smoking in the last 12 months, please tell us how much you smoked in a typical day 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

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

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

Month/year (year only if more than 2 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 activities? Yes  No

You should say **yes** if your activity requires you to meet 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 qualifies, please 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? (How many annual dives, races, climbs or flying hours?)</b>			
<b>Where will you do it? (Which countries, mountains, waters or caves?)</b>			
<b>What is your experience? (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? (Maximum height or depth, type of race or competition, special or extreme activity)</b>			

Please use the end of this form if you need more space.

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

If yes, please tell us which activities

## Sickness absence details

Please answer the following questions on your work absence history to the best of your recollection. There is no need to check the details with your employer or your GP.

Please use the end of this form if you need more space.

1. Have you ever been absent from work for more than 2 consecutive months due to illness or injury? 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 illness or injury?  
 None  Up to 15 days  Up to 30 days  More than 30 days

Please add all short and long-term absence together. 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 illness or injury 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 usual occupation 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 carry out your occupation been affected?


What caused it?


- Is your ability to carry out your occupation 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? yes/no (if yes please give details and dates)	Number of days off work	Have you made a full recovery? yes/no

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 lasted 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

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

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

Yes

No

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

Month/year of onset	Condition and cause, if known (eg. divorce, bereavement, 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, even if you did not consult 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 tick 'don't know'. Don't know

Month/year	Month/year	Month/year
Level	Level	Level
On treatment? (yes/no)	On treatment? (yes/no)	On treatment? (yes/no)

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 tick 'don't know'. Don't know

Month/year	Month/year	Month/year
Reading	Reading	Reading
On treatment? (yes/no)	On treatment? (yes/no)	On treatment? (yes/no)

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 3 most recent glycosylated haemoglobin (HbA1C) levels or tick 'don't know'.

Don't know

Month/year	Month/year	Month/year
HbA1C Level	HbA1C Level	HbA1C Level

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 yes/no	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 have any relevant hospital letters that may help us, 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? (yes/no)	Has there been any recurrence or spread to another site? (yes/no)
<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 have any relevant hospital letters that may help us, 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. In the last 5 years, have you been exposed to the risk of HIV infection? HIV infection can be caught through unsafe sex, intravenous drug abuse or blood transfusion or surgery outside the European Union.

Yes

No

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 don't have to tell us about short or long-sight that's 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? yes/no	Have you ever had treatment in A&E or as an in-patient? If yes, please give details and dates

Please use the space at the end of the form if you need it.

## Medical details (continued)

13. How many times in the last 12 months have you consulted a healthcare practitioner about your health?

You should count as one consultation each time you saw a practitioner. If you are in any doubt about whether to count a particular consultation, please include 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 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? (yes/no)</b>			

Please use the space at the end of the form if you need it.

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

When answering this question:

- You do not need to tell us about a negative HIV test result.
- If you're applying to us for Income Protection or Critical Illness insurance, you do not need 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 need 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 policy's non-medical limit or if you already have more than £500,000 of Life cover with other insurers.

If you're unsure about your level of Life cover with us, your policy 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?

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 finished</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 12 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, please 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)

**Other insurance details**

1. In the last 3 years, has any Life, Critical Illness or Income Protection insurer accepted your application on special terms or refused to cover you? Yes  No

If **yes**, which cover did the decision relate to, what was each adverse decision, why and when was it made?

Cover type	Decision	Reason for adverse decision (if known)	Month/year

**Additional information**

Please use this page if you need more space to give a full answer to an earlier question. You should indicate the name of the section and the question number you are answering.


**Please check that you have answered every question.**  
**Please read the following notes, declarations and consents carefully and then sign and date the form on page 16.**

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

### **Requesting reports about your medical history**

We may need to get medical reports to support your application. Before we can ask any doctor that you have consulted to fill in a report, we need your permission under the Access to Medical Report Act 1998. Your rights under the act are as below.

You do not have to give your permission, but if you do not, we may not be able to go ahead with your application. This does not prevent you from applying to other companies for insurance.

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 contact us by email at [muw@unum.co.uk](mailto:muw@unum.co.uk)

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 start of 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 Notice for Employees

### **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 laws and the Access to Medical Reports Act 1988.

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 have legitimate business interests to share data with underwriters, medical agencies, other insurance companies and sub-contractors and agents for validation purposes and we have to comply with our legal and regulatory obligations. We will therefore additionally share information and conduct checks with third parties for purposes relating to the application. 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. Details of third parties that we share data with are available on our website at [www.unum.co.uk/third-party-datasharing](http://www.unum.co.uk/third-party-datasharing). By signing this application you acknowledge that we can share the information provided by you in making this application.

Except where you have given consent in this form, and for the purposes stated, we will not discuss medical information about you with anyone other than you. 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 and record keeping.

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

## Your declarations and consent

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 as described in the Data Protection Notice above concerning the processing and use of information relating to my application as set out in this form.

I consent to Unum seeking, in accordance with the Access to Medical Reports Act and data protection laws, for the purpose of underwriting or to review the accuracy and completeness of the statements made in this application,

- information from my medical records from any doctor I have consulted about my physical or mental health.

**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 other insurers about any other applications for life, critical illness, sickness, disability, accident or private medical insurance that I have applied for.
- 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 start of the policy to monitor the accuracy and completeness of any statement made in, or in connection with, this application.

I agree that this information can also be used to maintain management information for business analysis.

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 understand that this can include some medical information and non-medical information about me which is necessary to be able to enter into the insurance policy.

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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