William Russell

Business protection plan

Application form for employees

Please complete this form in **BLOCK CAPITALS** using black ink, and return it to us by email or post. You can find our contact details at the end of this form.

Your employment details

Company that employs you: ..... Business plan number: .....

Date that you started working for your employer: .....

Your personal details

First name: ..... Surname: ..... Title: .....

Address: .....

.....

Mobile number: ..... Home number: .....

Email: ..... Occupation: .....

Nationality: ..... Date of birth: ..... ◯ Male ◯ Female

Country where you will be living/working: ..... How long have you lived there? ..... years

Previous/current insurance

1 Have you ever applied for a plan or been insured with William Russell? ◯ Yes ◯ No

If **YES**, please state the plan number: ..... Date of expiry of plan: .....

2 Have you ever had an application for insurance declined or accepted with special terms, or had an insurance policy cancelled by any insurance provider? ◯ Yes ◯ No

If **YES**, please provide details: .....

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3 Do you currently have any other life, accident or income protection insurance? ◯ Yes ◯ No

If **YES**, please state the name of insurer: .....

Type of insurance: ..... Amount of cover: .....

Policy number: ..... Policy expiry date: .....

Your occupation

Occupation: ..... Industry: .....

Please state your current annual earnings (including the currency): .....

Please state the name and registered address of your employer: .....

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Is your occupation 100% office-based? ◯ Yes ◯ No

If **NO**, please itemise your ordinary work duties, including the percentage of work time ordinarily spent on each duty: .....

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Do you ever work offshore? (e.g. in the air, on water, underwater, on oil rigs) ◯ Yes ◯ No

If **YES**, please give full details: .....

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Your occupation (continued)

Does your work require a license which depends on your state of health? ◯ Yes ◯ No

If **YES**, please give full details: .....

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Do you ever participate in hazardous activities? ◯ Yes ◯ No

If **YES**, please give full details of any activities and how often you participate in them: .....

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The cover afforded by your protection plan may be affected if your occupation is not 100% office-based or if you participate in hazardous activities. Cover for higher risk occupations or hazardous activities may be subject to a premium loading and/or special terms. We reserve the right to decline cover depending on your occupation and activities.

Hazardous activities include (but are not limited to) off-piste skiing, scuba diving to a depth of more than 30 metres, unsupervised scuba diving of any kind, rock-climbing or mountaineering, pot-holing, hang-gliding, parachuting, bungee-jumping, hunting on horseback, driving or riding in any kind of race o-r competition, flying (other than as a passenger on a commercial aircraft), riding on motorcycles, mopeds or moto scooters (even as pillion), or any other activity which has a similar degree of danger as any of those mentioned here. If you are uncertain about whether an occupation is higher risk or whether an activity would be classed as hazardous, please provide the information as requested and we will confirm if we require anything further.

Beneficiary nomination

You only need to complete this section if your employer has selected a life plan for you.

I hereby nominate the following person(s) as beneficiary of my life benefit (and accident benefit, if applicable) in the event of my death:

No.	Full name	% of benefit to be paid	Address	Relationship to you
1				
2				
3				
4				
5				

If the death of one or more of the above named beneficiaries precedes your own, the proportion of that benefit that otherwise would have been paid will be shared between any surviving beneficiaries, in proportion with the percentages specified above. If this is not your wish, or if you would like to nominate any alternative beneficiary/beneficiaries, please state your wishes here:

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If you are diagnosed with a terminal illness, then, subject to the terms of the plan agreement, your life benefit will be paid directly to you. If you would prefer otherwise, please state your wishes here:

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Health declaration

We rely on the information you give us in the form to decide whether or not we can accept your application, and if so, whether or not we need to apply any special terms to your cover. Please complete the following health declaration and provide us with full details of any medical conditions. Pre-existing medical conditions and related conditions will not be covered by your protection plan, unless you have told us about them and we have agreed to cover them.

Please answer the following questions fully, accurately, and to the best of your knowledge. If you answer **YES** to any question, please supply full details in the spaces provided. If there is insufficient space please continue on an additional sheet of paper. After you have submitted the application, if we find that you have not answered the questions fully and accurately your protection plan may be cancelled, claims may be rejected, or special terms may be applied retroactively.

If you are in any doubt as to whether you should tell us anything, please tell us anyway. It better to provide information that turns out not to be relevant than to miss out something that causes problems later. If something changes after you have sent us the form but before we have confirmed your cover has started, you must write in and update us.

	Details
What is your height? (cm)	
What is your weight today? (kg)	
Has your weight changed by more than 10 kg in the last 2 years? If YES, please provide details	◯ Yes ◯ No .....
Have you smoked cigarettes/cigars in the last 12 months? If YES, please give the average number a day:	◯ Yes ◯ No .....
If you consume alcohol, how many of the following do you consume each week?	
• Pints of regular-strength beer/cider	.....
• Pints of strong beer or cider	.....
• 175ml glasses of wine	.....
• 250ml glasses of wine	.....
• 35ml measures of spirits	.....

1 Have you consulted a healthcare practitioner in the last 3 years? ◯ Yes ◯ No

If YES, please give full details (please continue on an additional sheet of paper if required): .....

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2 Please answer the following:

a) Have you ever tested positive for hepatitis B or hepatitis C, or are you awaiting the results of such a test? ◯ Yes ◯ No

b) Within the last five years have you been exposed to the risk of HIV infection? (HIV can be contracted through unsafe sex, intravenous drug abuse, or blood transfusions, or surgery undertaken outside Europe) ◯ Yes ◯ No

If **Questions 2 a)** and/or **2 b)** were answered **YES**, please provide full details: .....

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3 Have you ever suffered from, or been diagnosed with, treated for or prescribed drugs for:

a) **Auto-immune disorders?** ◯ Yes ◯ No
For example: HIV/AIDS, rheumatoid arthritis, systemic lupus erythematosus, scleroderma.

b) **Cancer, growths or tumours?** ◯ Yes ◯ No
For example: any type of cancer, pre-cancerous conditions, benign growths.

Health declaration (continued)

c) **Back, joint, muscular or skeletal problems?** ◯ Yes ◯ No
For example: back or joint pain, whiplash, sciatica, degenerative changes, osteoarthritis, osteoporosis, gout, bunions, joint replacements, fractures, cartilage or ligament problems.

d) **Diabetes, thyroid or any other endocrine disorder?** ◯ Yes ◯ No
For example: diabetes type 1 or 2, overactive or underactive thyroid, pituitary or adrenal problems, obesity.

e) **High blood pressure, cardiac or circulatory conditions?** ◯ Yes ◯ No
For example: angina/chest pains, heart attacks, abnormal heartbeat, palpitations, varicose veins, strokes, deep vein thrombosis, high cholesterol.

f) **Breathing or respiratory conditions?** ◯ Yes ◯ No
For example: asthma, chronic obstructive pulmonary disease (COPD), emphysema.

g) **Stomach, liver/gall bladder, or digestive system conditions?** ◯ Yes ◯ No
For example: ulcers, irritable bowels, Crohn's disease, colitis, reflux/heartburn abdominal pain, liver inflammation, cirrhosis, gallstones, hernias, haemorrhoids/piles.

h) **Any depression, anxiety of other psychiatric or psychological conditions?** ◯ Yes ◯ No
For example: anxiety, bipolar disorder, schizophrenia, stress, low mood, depression, eating disorders.

i) **Any kidney or prostate conditions?** ◯ Yes ◯ No
For example: chronic kidney disease, raised PSA level.

j) **Any alcohol and/or drug dependency problems?** ◯ Yes ◯ No

k) **Any other medical condition not mentioned above?** ◯ Yes ◯ No

If you have answered YES to any of the above questions, please give full details

Question no: ..... Month/year of onset: ..... Month/year of last symptoms: .....

Frequency of symptoms: .....

Condition and cause if known: .....

.....

.....

Treatment and medication (please state if ongoing): .....

.....

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Treating physician name and address: .....

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Question no: ..... Month/year of onset: ..... Month/year of last symptoms: .....

Frequency of symptoms: .....

Condition and cause if known: .....

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Treatment and medication (please state if ongoing): .....

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Treating physician name and address: .....

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If you require more space, please continue on a separate sheet of paper. If you are attaching any supporting medical documents, please note that we can only accept them in English.

Health declaration (continued)

4 Are you currently pregnant? ◯ Yes ◯ No

If YES, please confirm the due date, and details of any non-standard treatment and/or medication you have received, or are continuing to receive:

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5 In the last 3 years, have you been told the result of any medical test you have had was abnormal? ◯ Yes ◯ No

If YES, please confirm the due date, and details of any non-standard treatment and/or medication you have received, or are continuing to receive:

Month/year	What was the test?	What was the reason for it?	Have you had a subsequent test that you have been told was normal?

6 Do you have any other signs, symptoms, conditions, disabilities or impairment for which the following apply: ◯ Yes ◯ No

- You are waiting to see/ still under follow-up by a GP or specialist
- You are waiting to have tests or investigations or to receive the results
- You are due to have surgery
- You are on medication prescribed or otherwise
- You routinely use any type of aid except spectacles and lenses

If **YES**, please give full details (If you require more space, please continue on a separate sheet of paper):

Month/year of onset: .... Month/year of last symptoms: .... Duration of symptoms ....

Number of days off work: .... Condition and cause if known: ....

Condition and cause if known: ....

Treatment and medication (please state if ongoing) ....

....

Month/year of onset: .... Month/year of last symptoms: .... Duration of symptoms ....

Number of days off work: .... Condition and cause if known: ....

Condition and cause if known: ....

Treatment and medication (please state if ongoing) ....

....

Month/year of onset: .... Month/year of last symptoms: .... Duration of symptoms ....

Number of days off work: .... Condition and cause if known: ....

Condition and cause if known: ....

Treatment and medication (please state if ongoing) ....

....

Month/year of onset: .... Month/year of last symptoms: .... Duration of symptoms ....

Number of days off work: .... Condition and cause if known: ....

Condition and cause if known: ....

Treatment and medication (please state if ongoing) ....

....

Health declaration (continued)

You only need to complete Question 7 if you are applying for an income protection plan.

7 Have you been absent from work for more than 5 consecutive days in the last 5 years for reasons other than annual leave? ◯ Yes ◯ No

If YES, when was each absence period?

From: ..... To: ..... Reason: .....

.....

From: ..... To: ..... Reason: .....

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Are you fully recovered from the illness/injury that caused each absence? ◯ Yes ◯ No

If NO, please provide full details: .....

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If you require more space, please continue on a separate sheet of paper.

How we use your information

Please read this section carefully.

- We will use the information that you have given us on this application form for the purposes of administering your protection plan, processing your claims, identifying and preventing fraud, complying with our legal and regulatory obligations, and carrying out research and statistical analysis to help us improve our services. We will not retain your information for longer than is necessary.
- We may share your information with other organisations in relation to the above purposes, e.g. the insurer of your protection plan and payment service providers. This may involve transferring your information to countries outside the European Union.
- Telephone calls to and from William Russell Ltd.may be recorded for training and monitoring purposes.
- We will process the personal information of each person named on this form, including sensitive information such as details about your health, in accordance with our privacy policy.
- Our privacy policy also contains information about who to contact if you have any questions about how we use your information, or if you would like to request a copy of the information we hold about you. For full details of our privacy policy, please visit william-russell.com/privacy or consult your plan agreement.

Marketing communication preferences

We'd like to stay in touch with you in ways we think you might find helpful. Every now and then, we share information about international healthcare and expat life, plus other useful content we think could be of interest to you. We also send occasional emails that promote our products and services.

We won't spam you or share your details with third parties, and you can unsubscribe at any time. You can read our privacy policy at william-russell.com/privacy.

Please tick the box to opt into our marketing communications:

◯ Email

◯ Newsletter

◯ Telephone

◯ Text message/SMS

Declaration for your plan

Please read this section carefully and sign below.

- I understand that my application for a protection plan is subject to written acceptance by William Russell Ltd.
- I declare that I have taken reasonable care to answer every question fully, accurately, and to the best of my knowledge and belief.
- I understand that misrepresentation could result in claims being rejected or not fully paid, and/or my protection plan being cancelled.
- I understand that the protection plan I am applying for does not cover medical conditions that existed before the proposed start date of the plan, unless I have provided full details of any such medical conditions to William Russell Ltd. and William Russell Ltd. has agreed to cover them. I also understand that I will be advised in writing of any medical conditions that are not covered by the plan, based on the information I have provided on this form.
- I understand that I must inform William Russell Ltd., in writing, of any changes in the facts provided in my application occurring before the start date of my plan.
- In order to process my claims, I understand that William Russell Ltd. may need to obtain details of my medical history.
- If I leave my current employment, I understand that I will no longer be valid for cover under this business life and/or income protection plan and that my cover will cease with immediate effect. I also understand that, if I wish to take out an individual plan with William Russell Ltd., I may need to re-apply and that new insurance terms may be issued.
- I authorise William Russell Ltd. to send all insurance documents as PDF files to the email address I have provided on this form. If my employer has applied through a broker or intermediary, I understand these documents may be sent via email to that broker or intermediary.

Some important notes

Please make sure that this form and all supplementary documents are legible. Your completed application form is valid for 90 days from the date you sign it. If your protection plan has not commenced within 90 days, you may have to complete a new form. If your health changes after you submit this form but before yout plan starts, you must let us know immediately.

Please return this form to us by post or email, using the contact details below. We can accept signed and scanned copied of this form, attached to an email as a PDF.

Name of applicant: .....

Signature of applicant: ..... **Date:** .....

William Russell Ltd.
William Russell House
The Square, Lightwater
Surrey, GU18 5SS, UK

T +44 1276 486477
E sales@william-russell.com
william-russell.com

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