Group Terminal Illness for Police Federations

Personal statement

Please complete in **BLOCK LETTERS** where possible.

The issue of this form is not an admission of liability.

This form must be completed by the person in respect of whom benefit is being claimed.

Please return the form in the pre-paid envelope provided as soon as possible. Failure to provide full information may delay the assessment of the claim.

Name of Federation

Group policy number

Claim number *(if known)*

Personal details

Full name

Title

Address

Postcode

Date of birth *(day, month, year)*

Telephone number

Claim and related details

1. Please describe fully the nature and extent of your illness.

2. On what date did you first consult a medical practitioner in connection with your illness? *(day, month, year)*

Was this your usual medical attendant? Yes ☐ No ☐

3. What symptoms preceded diagnosis of the terminal illness and when did they start?

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

Yes ☐ No ☐

5. Date of diagnosis of the terminal illness *(day, month, year)*.

6. What treatment have you received and are you currently receiving in connection with your illness?

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Medical consultants

1. Name, address and telephone number of your usual General Practitioner.

Postcode

Telephone number

2. Have you consulted any other doctor or specialist, or attended a hospital either as an in or out patient? If Yes, please give full details including names, addresses, telephone numbers and your hospital reference number, if known.

Yes ☐ No ☐

Name and speciality	Name and speciality	Name and speciality
Address	Address	Address
Postcode	Postcode	Postcode
Hospital reference number		
Telephone number	Telephone number	Telephone number
Date of consultation or admission *(day, month, year)*	Date of consultation or admission *(day, month, year)*	Date of consultation or admission *(day, month, year)*
Who did you see?	Who did you see?	Who did you see?
Date of discharge *(day, month, year)*	Date of discharge *(day, month, year)*	Date of discharge *(day, month, year)*

Data protection

Canada Life handles any personal information it receives in line with the requirements of the Data Protection Act 1998.

We will use this information to set up and administer the insurance cover we provide as well as carrying out any other activity related to this insurance cover that is necessary. As a result we may release this information to:

- other companies in the Canada Life organisation, including our parent companies in Canada.
- our service providers and our reinsurers.
- other insurers.
- the policyholder.
- The Association of British Insurers (ABI), who may share this information with other insurers.
- official bodies where we are legally obliged to do so.

We may use this information to advise you of other products and services offered by the third parties or companies within the Canada Life organisation. You must advise us in writing if you do not want the information to be used for direct marketing.

By completing and signing this form you are giving your explicit informed consent for the use of the information for the purposes stated. If you are unsure or concerned about how this information may be used, you may contact us directly or alternatively you may seek independent advice.

Identity search

To protect you and us from financial crime, we may need to confirm your identity from time to time. We may do this by using reference agencies to search sources of information about you (an identity search). This will not affect your credit rating. If this identity search fails, we may ask you for documents to confirm your identity.

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Important notes

1. In order that we can assess this claim in respect of you, this may involve us, or another company authorised by us, asking your doctor to provide us with a report, or contacting you to make arrangements for a medical examination, should we require this. We will need to share the information in this form with that authorised company for that purpose.
2. We may ask you to contact your doctor to speed up the completion of reports that we have requested.
3. We may need to send your details and relevant medical reports to our reassurers for their opinion or agreement of the terms offered.
4. You should provide the answers in this form personally. If the answers are filled in by anyone else then they must be read over and agreed by you before the declaration is signed. Any amendments or alterations should be completed and initialled by you.
5. The questions asked in this form cover the facts that we regard as being material to our assessment of this claim. If you are in any doubt about the information required, you should disclose full details. If you do not disclose all relevant facts this claim in respect of you may be rejected or reduced.
6. We have a confidentiality policy in place which means we hold your medical information securely and access is limited to authorised individuals who need to see it, for example for the purpose of administering the employee benefit arrangements of which you are a member and for the purpose of underwriting, claims management and rehabilitation under the insurance we provide.

Access to medical reports – your rights

We may need to get medical reports in order to assess this claim in respect of you. Before we can ask any doctor that you have consulted to fill in a report, we need your permission under the Access to Medical Reports Act 1988. Your rights under the act are as follows.

You do not need to give your permission, but if you do not, we may not be able to assess this claim in respect of you.

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. 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 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 about.

We have asked 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.

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 write to the Underwriting Manager at Canada Life.

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Your declaration and consent

To my best knowledge and belief the statements in this declaration are complete and true and contain all Material Facts. (A Material Fact is one that will influence how this claim in respect of you is assessed by the company. Failure to give complete and true answers and disclose all Material Facts could result in the payment of any benefit being refused. If there is any doubt whether a certain fact is material it should be disclosed.)

Please tick this box if you have attached any information in a Private & Confidential envelope. ☐

I agree to you asking any doctor I have consulted about my physical or mental health to provide medical information so you may carry out your assessment of this claim in respect of me. You may gather relevant information from other insurers about any other applications for life, critical illness, sickness, disability, accident or private medical insurance that I have applied for. I authorise those asked to provide medical information when they see a copy of this consent form.

I authorise you to pass results from any independent medical examination held or associated tests to my own doctor.

I agree to you obtaining medical information about me from my employer and/or any agent that my employer may have used to medically assess me at any time.

I agree to you using this information to maintain management information for business analysis and for the administration of employee benefit arrangements of which I am a member.

I agree that a copy of this declaration will have the validity of the original.

I authorise you to share medical evidence with any of the companies set out at the end of this application form or obtain any evidence held by any other company within the Group.

I authorise you to share any medical information with another insurer should information be requested.

By signing this declaration I am allowing you to carry out your assessment of this claim in respect of me using the information that I have given.

I do **not*** want to see the report before it is sent to the company.

*(*Delete as appropriate)*

Signature

Date

Please return the completed form to:

Claims Management Services,
Canada Life Limited,
3 Rivergate,
Temple Quay,
Bristol
BS1 6ER

Our forms are available to download from our website: www.canadalife.co.uk/group

GRP695 – 810R

Canada Life Limited
3 Rivergate, Temple Quay, Bristol BS1 6ER
Telephone 0845 223 8000

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This section to be detached and retained by the member

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- Your past health
  - Details 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.
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