Membership Application

dg mutual

Income Protection Insurance

IMPORTANT NOTES - PLEASE READ BEFORE COMPLETING THIS FORM

When you complete this application form you should be aware that you must disclose all material facts. A material fact is any information that is likely to affect our decision to accept your application or the amount of subscription you pay. **You are obliged to disclose this type of information to us, even if the application form has not asked specific questions about it.** So, if you are unsure whether a fact is material or not , you must include it on your application form. Failure to disclose all material facts could result in your application being rejected, or you could find that your policy is invalid when you make a claim and no benefit will be payable. **We will rely on what you tell us and you must not assume that we will clarify or confirm any information that you have provided with your medical attendants.** Any rates, subscriptions or benefits indicated by the Society in any literature are based on an application being accepted on normal terms. The Society reserves the right to decline membership or offer membership on different terms based on information shown on the application form or received from other sources.

SECTION 1
(i) Personal Details

Surname M ☐ F ☐

Title *(please tick)* Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms ☐

Forenames

Private Address

Postcode

Telephone

E-mail

Business Address

Postcode

Telephone

E-mail

Date of birth

Place of birth (Town) (Country)

If your place of birth is not in the UK how long have you resided here?

Have you ever resided or have any prospect or intention of residing outside the British Isles? (please tick) Yes ☐ No ☐

Do you intend to engage in flying other than as a fare paying passenger? (please tick) Yes ☐ No ☐

Please list any competitive sports, hobbies or activities likely to cause injury in which you currently or intend to participate.

Source of introduction

(ii) Employment Details

Profession or Occupation *(please be precise)*

For how long have you been so employed? years

Are you self-employed? *(please tick)* Yes ☐ No ☐

If yes, for how long? years

What is your average weekly gross income?
(Net pre-tax earnings if self-employed) £

In the event of incapacity for how long would you receive income or benefit from any source and at what rate £ per week

for weeks. If more than one source, give full details separately.

If employed are you on a fixed term contract? Yes ☐ No ☐

If so, please provide the date the contract ends

(iii) Other Insurances

Have you ever been refused or offered insurance on terms other than standard, for a life, accident or sickness policy? *(please tick)* Yes ☐ No ☐

If yes, please give details here or separately.

Do you have, or have you applied for, sickness or accident insurance here or elsewhere? *(please tick)* Yes ☐ No ☐

If yes, please give details here or separately.

Name of Company or Society

Weekly Benefit

Deferred Period

If you have this type of cover elsewhere will it continue? *(please tick* Yes ☐ No ☐

SECTION 2
Health Details
(please tick)

Please answer every question. If you answer YES to any question please use the space provided on page 3 to give full details, including dates, time off work and current prognosis.

a. Name and address of your Doctor

b. How long have you been registered with your Doctor?

(If less than 6 months please provide your previous Doctor's details below)

c. Please state your weight

d. Has there been any increase or loss in your weight in the last year? Yes ☐ No ☐

e. Please state your height

f. Have you ever smoked? Yes ☐ No ☐

If yes, how many per day?

g. What is your average weekly consumption of alcohol in units?

Units *(1 pint beer = 2 Units)*

1 glass wine/measure of spirits = 1 Unit

h. Have you been advised to reduce your alcohol intake? Yes ☐ No ☐

i. Are you currently undergoing any treatment or awaiting any referral, tests, results or surgery? Yes ☐ No ☐

j. Are you at present suffering from any disease, disorder or disability? Yes ☐ No ☐

k. Have you ever taken or are you currently taking any drug not prescribed by your Doctor? Yes ☐ No ☐

l. Have you consulted any other health professional such as a Chiropractor or Osteopath? Yes ☐ No ☐

m. Have you ever tested positive for HIV/Aids, Hepatitis B or C or any other sexually transmitted disease? Yes ☐ No ☐

Have you ever had:-

1. Anxiety, stress, depression, fatigue, breakdown or counselling? Yes ☐ No ☐
2. Back, neck or shoulder pain, disc problems? Yes ☐ No ☐
3. Arthritis, joint, bone, ligament or muscle problems Yes ☐ No ☐
4. Chest lung, breathing, problems including asthma and bronchitis? Yes ☐ No ☐
5. Heart disease, including heart attack, angina, chest pains or heart defects? Yes ☐ No ☐
6. Digestive system, stomach, bowel or liver problems? Yes ☐ No ☐
7. Any disorder or the genito-urinary system, kidneys, bladder or prostate? Yes ☐ No ☐
8. Blood pressure problems or blood disorders? Yes ☐ No ☐
9. Skin disorders or allergies? Yes ☐ No ☐
10. Eye or ear problems? (You can ignore sight problems corrected by glasses or contact lenses) Yes ☐ No ☐
11. Diabetes or impaired glucose intolerance? Yes ☐ No ☐
12. Debility, post viral/chronic fatigue syndrome or ME? Yes ☐ No ☐
13. Migraine attacks, fits, faints, blackouts or paralysis or any disorder of the central nervous system? Yes ☐ No ☐
14. Hernia, haemorrhoids or varicose veins? Yes ☐ No ☐
15. Tumours, cancers or growths (including leukaemia or Hodgkin's disease)? Yes ☐ No ☐
16. Any gynacological, menstrual, uterine or breast disease/disorder? Yes ☐ No ☐
17. Any other illness, disability, mental or physical impairment or previous consultation that might be relevant to this application Yes ☐ No ☐

If you have answered YES to any of the questions in Section 2 please give full details, continuing on a separate sheet if necessary. Please note that failure to disclose relevant information could mean that we will reject your claim and your policy will be cancelled.

Question Ref	Details	Dates

Please give details below of the last time you sought medical advice if it was within the last three years (including the name and address of the medical practitioner if different to that given at 2a). Show dates, nature of incapacity and indicate any time away from work.

Please provide details if any of your immediate family have been diagnosed with or died from any of the following diseases before the age of 65. Heart disease, stroke, diabetes, kidney disease, cancer, multiple sclerosis, raised blood pressure. Alzheimer's disease, motor neurone disease, Parkinson's disease and any hereditary disorder including Huntington's disease.

	Conditions (if diagnosed with cancer please advise site)	Age at Diagnosis	Age at Death (if applicable)
Father			
Mother			
Brother(s)			
Sister(s)			

SECTION 3
Benefits Required

Please indicate the amount and type of cover you require. Under the limitation of Benefits Clause the maximum you may apply for is 66% of net pre-tax earnings, less any other continuing income or insurances. Each bond provides £20 per week benefit and cover is available from £60 to £1200 per week.

1. Weekly Benefit Required £ **or** Number of Bonds Required

   All applications for benefit above £800 must be supported by proof of earnings. For the employed - Original printed payslips or P60. For the self employed - Original most recent accounts or Inland Revenue Notice of Assessment.

2. Benefit from Day One ☐ 4 Wks ☐ 13 Wks ☐ 26 Wks ☐ 52 Wks ☐
   (please tick)

3. Constant ☐ Escalating ☐ Reducing *(N.B. Reducing benefit is available for Day One cover only)* ☐
   (please tick)

4. Retirement Age 55 ☐ 60 ☐
   (please tick)

5. Double Bond Option Yes ☐ No ☐
   (please tick)

I do/do not wish to receive a copy of this application form *(please delete).*

SECTION 4

Data Protection

- The information you provide will be held by the society in accordance with the Data Protection Act 1998 and it will be used in the administration of the policy.
- A copy of the application form and any supporting documents, including financial and medical reports may be given to a reassurance company where the risk is shared with such a company.
- We reserve the right to discuss any relevant aspects of your medical treatment or examination with the providers of those services.
- Medical information provided will be used for underwriting and claims purposes only and your consent is required for us to use, hold and retain it. It will not be supplied to any other third party without your consent, unless it is lawful to do so.
- Information may be released to your financial advisor to enable them to give you advice. This will not include medical information. If your financial advisor no longer represents you it is your responsibility to notify us.

Medical Reports Act 1988

Summary

Before we can apply for a medical report from your doctor we need your consent. Before signing in the space below you should know you have certain rights under the Access to Medical Reports Act 1988. The main points are as follows:

1. You can withold your consent
2. You can see the report before it is sent to us provided that you apply to the doctor within 21 days or during the six months after that. The doctor may charge you a fee for providing the report to you.
3. You can ask the doctor if he will amend any part of the report which you consider to be incorrect or misleading. If the doctor is not in agreement, you may append your comments.
4. The doctor can withhold from you the report, or part of it, if he thinks you would be harmed by seeing it.

Full details of your rights under the Act are available on request.

Declaration and Consent to Obtain a Medical Report

I hereby declare that I am the person referred to in this application form, that I have read over my answers to all the questions and to the best of my knowledge and belief that the information provided is true and complete. I am aware that subscriptions increase with age and have noted the information relating to the Limitation of Benefits.

I have been informed of my statutory rights under the Access to Medical Reports Act 1988, as explained above, and in connection with my application, hereby consent to The Dentists' and General Mutual Benefit Society Limited being provided with medical information, including copies of my medical records, from any doctor that has attended me regarding my physical and mental health and I agree that a copy of this consent shall have the validity of the original.

I undertake to inform the Society if I obtain additional similar insurance in the future or if any medical fact arises or changes before membership is in force.

(please tick one box only)

☐ I wish to see the report before it is sent to the Society

☐ I do not wish to see the report before it is sent to the Society

Name *(block capitals)*

Signature

Date

Have you enclosed?

1. Completed Direct Debit Form
2. Proof of age i.e. Passport, Driving Licence or Birth Certificate
3. Evidence of earnings (applications above £800 p.w. benefit)

To be completed by Intermediary Firm

Name of Intermediary Firm

Please tick this box if you gave advice to your client about this product. ☐

The Dentists' & General Mutual Benefit Society Limited

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