# Declaration of Health

## Important information

We need you to complete this form because you (or the plan holder if you are not the plan holder) would like to resume paying premiums to the plan. To help us consider this request we need some details about your health. Please note that under the terms of the plan we do not have to agree to the request to restart premium payments.

Please contact us if you would like a copy of the terms and conditions that apply to the plan. Our contact details are below. Before you fill out this form, please read the below information carefully. This form is for one life, a separate form must be completed by each life assured on the plan.

Please complete this form in **BLOCK CAPITALS** and return it to the address below.

## Personal information

| | |
|---|---|
| Life Assured's Name | |
| Plan number(s) | |

## How to contact us

You can write to us or phone us at:

Our office address:
Zurich Assurance Ltd
Unity Place
1 Carfax Close
Swindon
SN1 1AP

Call on: 0370 241695

We are open from Monday to Friday 8.30am to 6pm.
We may record or monitor calls to improve our service.

Where we refer to Zurich in this form we mean Zurich Assurance Ltd and where we refer to the Zurich Group we mean Zurich Insurance Group Limited and its subsidiaries.

## Data protection – Your information

Zurich is committed to ensuring the way we collect, hold, use and share information about you complies fully with data protection legislation.

Before completing this form, you should read the Data Protection information that we provided when you applied for the plan as this explains, in conjunction with the information contained in this form, how your data will be used. If you require a copy, please contact us at the address above.

## Your duty to take reasonable care

You should take reasonable care to answer all the questions honestly and to the best of your knowledge. If you don't answer the questions correctly the plan may be cancelled, or its terms may be changed, or a claim may be rejected or not fully paid. Cancelling a plan means that no cover or other benefits will be provided.

When answering the questions, please take reasonable care to ensure the information you provide is, to the best of your knowledge, complete and correct and answer each question in this form honestly and accurately.

If you haven't heard from us about our decision on restarting your premiums and there is a change to your personal health, alcohol consumption, smoking habits, or recreational drug use after you have submitted this form, please let us know immediately as any changes to your answers can affect our decision.

We will rely on the information you give us. Although we may ask for a report from any doctor that you have consulted about your physical or mental health, please don't assume that we will do so.

## Important information on genetic testing

You don't need to tell us about a genetic test result unless you have more than £500,000 of life cover with Zurich.

Above this limit, we will only be interested in genetic test results approved by the Government for insurers to use. If you are not sure what you need to tell us, please contact the Company's Nominated Genetics Underwriter at the address on page 1, or refer to the Consumer section of the Association of British Insurer's website (www.abi.org.uk/consumer2/disclosure.htm).

You must tell us if you are experiencing symptoms of, or are having treatment for, a medical condition including any genetically inherited condition.

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 when assessing your request provided that your clinical geneticist confirms that the test result indicates you have a reduced risk of developing the inherited disease.

In accordance with the Association of British Insurers' Code of Practice, Zurich has a documented set of practices in place to ensure confidential customer information (including access to medical and lifestyle information) is kept securely. A copy is available on request.

A copy of the Association of British Insurers' Code of Practice on Genetic Testing is also available on request.

## Access to medical reports

We may need to apply to your doctor (General Practitioner) for a medical report and, if we do, we'll need your permission under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. Your legal rights are:

- you don't have to give your consent but if you don't we may not be able to proceed. However, this doesn't stop you applying elsewhere
- you can ask to see the report before your doctor returns it to us. If you do, we'll ask your doctor to retain it for 21 days so that you can arrange to see the report. However, this may cause a delay in processing your request
- you can ask your doctor for a copy of the report at any time during the 6 months after it has been sent to us
- you can ask your doctor to amend the report if you consider any aspect of the report to be incorrect or misleading. If your doctor refuses to make the amendments, you may add your comments to the report
- your doctor can refuse you access to the report if he feels this would cause physical or mental harm to you or others
- your medical report will contain details of relevant illness, trauma, referrals for specialist advice or treatment, hospital admissions, operations, consultations, investigations and test results that you have undergone at any surgery, hospital, or clinic. It will also include details of any family history of disease that you have told your doctor about
- your consent will enable us to obtain information about your physical or mental health from any doctor and will give us access to copies of any letters, reports, and test results
- your medical report won't ask for details of any negative tests for HIV, hepatitis B or C. It won't ask about any isolated or multiple incidences of sexually transmitted diseases unless there are long term health implications.

We may need to send this form and any medical report to our reassurers or underwriting company for their opinion or to obtain their agreement to the terms offered. We may also need to send them at a later date in connection with the management of the plan. You can request details of general reassurance principles, and details of any company we use to assess your request, from us at the address on page 1.

A doctor may choose to fax a medical report to us. The report may also be faxed to our reassurers. If a medical report indicates abnormal findings or test results, we'll inform your doctor. If you have any questions about your rights or any questions about the process of obtaining, assessing, or storing medical information, please contact us using the details on page 1.

Please read the section headed "Your duty to take reasonable care" on page 1 carefully. If you do not understand any of the information in that section, please ask for more information before completing this form.

## Medical History

**Since the last regular premium was paid to the plan, have you suffered from any medical symptoms* (whether a medical practitioner has been consulted or not) or been asked to, or advised to have, any test or investigation or any medical consultation, hospital investigation, treatment, operation, blood test or psychiatric advice for any of the following:**

Please tick Yes or No to each question

| | |
|---|---|
| diabetes, raised blood glucose, or sugar in the urine? | ☐ Yes ☐ No |
| heart disease or disorder such as heart attack, angina, heart related chest pain, heart enlargement, heart failure, irregular or rapid heartbeat, heart valve defect, or any other heart condition? | ☐ Yes ☐ No |
| a disorder or abnormality of the blood vessels or arteries such as narrowing, blockages, blood clots, or deep vein thrombosis (DVT)? | ☐ Yes ☐ No |
| a stroke, transient ischaemic attack (TIA), mini stroke, brain haemorrhage, brain aneurysm, or any damage or surgery to the brain? | ☐ Yes ☐ No |
| cancer, leukaemia, Hodgkin's disease, melanoma, lymphoma, brain or spinal tumours or tumours? | ☐ Yes ☐ No |
| schizophrenia, bipolar disorder, manic depression, attempted suicide, episode of self-harm, an eating disorder, or any other mental health that required a stay in hospital or referral to a psychiatrist? | ☐ Yes ☐ No |
| any disorder of the nervous system such as multiple sclerosis, optic neuritis, Parkinson's disease, paralysis, cerebral palsy, motor neurone disease, dementia, or memory loss? | ☐ Yes ☐ No |
| any disease or disorder of the pancreas such as any form of hepatitis, abnormal liver function test, fatty liver, cirrhosis, or pancreatitis? | ☐ Yes ☐ No |
| raised blood pressure or raised cholesterol? | ☐ Yes ☐ No |
| anxiety, stress, depression, chronic fatigue, obsessive compulsive disorder, or other mental health? | ☐ Yes ☐ No |
| any respiratory or lung disease or disorder such as asthma, bronchitis, or COPD? | ☐ Yes ☐ No |
| any kidney disease or disorder such as any form of nephritis, cysts, or recurrent kidney stones? | ☐ Yes ☐ No |
| any disease or disorder of the bladder or urinary tracts such as recurrent infections, or protein or blood in the urine? | ☐ Yes ☐ No |
| any thyroid disorder? | ☐ Yes ☐ No |
| any disease or disorder of the stomach, bowel or digestive system such as ulcers, ulcerative colitis, or Crohn's disease? | ☐ Yes ☐ No |
| any tremor, numbness, loss of feeling or tingling in the limbs or face, blurred or double vision, loss of balance or co-ordination, epilepsy, seizures, or loss of muscle power? | ☐ Yes ☐ No |
| any lump, cyst, growth or polyp, or a mole or freckle that has bled or changed in appearance? | ☐ Yes ☐ No |
| anaemia or other blood disorder such as haemochromatosis or haemophilia? | ☐ Yes ☐ No |
| any disease or disorder of the back, bones or joints, such as arthritis, whiplash, sciatica, slipped disc, psoriasis, or gout? | ☐ Yes ☐ No |
| any disease or disorder of the eyes or ears such as visual impairment in one or both eyes, ringing in one or both ears, tinnitus, labyrinthitis, or Meniere's disease? | ☐ Yes ☐ No |
| a positive antigen test for Coronavirus (COVID-19), had a fever or high temperature, a new continuous cough, breathing difficulties or any other symptom of Coronavirus (COVID-19), or been advised to self-isolate for any reason? *(An "antigen" test is a test that confirms if you had the virus at the time of test)* | ☐ Yes ☐ No |
| any disease or disorder of the prostate or testicle, such as raised Prostatic Specific Antigen (PSA) or undescended testicle (males only)? | ☐ Yes ☐ No |
| any biopsy or ultrasound of the breast, cervix, ovary or uterus, an abnormal mammogram, an abnormal cervical smear and/or a positive test for the Human Papillomavirus (HPV) (females only)? | ☐ Yes ☐ No |

*Medical symptoms include weight loss or gain of more than 5kg (11lbs).

**If you have answered "Yes" to any of the above questions, please give further details:**

| Type of disorder | Date of diagnosis | Test(s) carried out / results / treatments | Is condition ongoing? |
|---|---|---|---|
| | D D M M Y Y Y Y | | ☐ Yes ☐ No |
| | D D M M Y Y Y Y | | ☐ Yes ☐ No |
| | D D M M Y Y Y Y | | ☐ Yes ☐ No |
| | D D M M Y Y Y Y | | ☐ Yes ☐ No |

## Treatments and medical advice

| **Since the last regular premium was paid to the plan:** | Please tick Yes or No to each question |
|---|---|
| have you taken any prescribed drugs, medicines, tablets, or any other treatment (please give the name of the condition for which you are taking this treatment)? | ☐ Yes ☐ No |
| have you sought or been given medical advice to reduce your alcohol consumption (other than during pregnancy)? | ☐ Yes ☐ No |
| do you intend to seek, or are you considering seeking, medical advice, or treatment? | ☐ Yes ☐ No |

**If you have answered "Yes" to any of the above questions, please give further details:**

| Condition | Date of diagnosis | Treatments/ prescribed drugs | Is condition ongoing? |
|---|---|---|---|
| | D D M M Y Y Y Y | | ☐ Yes ☐ No |
| | D D M M Y Y Y Y | | ☐ Yes ☐ No |
| | D D M M Y Y Y Y | | ☐ Yes ☐ No |
| | D D M M Y Y Y Y | | ☐ Yes ☐ No |

## HIV, Hepatitis B or C

| **Since the last regular premium was paid to the plan, have you tested positive for HIV, hepatitis B or C, or are you awaiting the result of such a test? (Note: If the result is negative, having an HIV test will not on its own, have any effect on your acceptance terms for insurance).** | Please tick Yes or No |
|---|---|
| | ☐ Yes ☐ No |

**If you have answered "Yes" to the above question, please give further details:**

| Type of test | Date of result | Awaiting test result? | Expected date of result |
|---|---|---|---|
| | D D M M Y Y Y Y | ☐ Yes ☐ No | D D M M Y Y Y Y |
| | D D M M Y Y Y Y | ☐ Yes ☐ No | D D M M Y Y Y Y |
| | D D M M Y Y Y Y | ☐ Yes ☐ No | D D M M Y Y Y Y |
| | D D M M Y Y Y Y | ☐ Yes ☐ No | D D M M Y Y Y Y |

## Drugs

| Since the last regular premium was paid to the plan, have you used or injected drugs that were not prescribed for you? Please include recreational drugs (e.g. cocaine, heroin, cannabis, ecstasy). | Please tick Yes or No<br>☐ Yes ☐ No |
|---|---|

If you have answered "Yes" to the above question, please give further details:

| Type of Drug | Date of first use | Date of last use |
|---|---|---|
| | D D M M Y Y Y Y | D D M M Y Y Y Y |
| | D D M M Y Y Y Y | D D M M Y Y Y Y |
| | D D M M Y Y Y Y | D D M M Y Y Y Y |
| | D D M M Y Y Y Y | D D M M Y Y Y Y |
| | D D M M Y Y Y Y | D D M M Y Y Y Y |

## Smoking

| Since the last regular premium was paid to the plan, have you smoked any cigarettes, cigars or pipe tobacco or used any nicotine or replacement products? | Please tick Yes or No<br>☐ Yes ☐ No |
|---|---|

If you have answered "Yes" to the above question, please give further details:

| | Amount per day | Date of last use |
|---|---|---|
| Cigarettes | | D D M M Y Y Y Y |
| Cigars | | D D M M Y Y Y Y |
| Tobacco | | D D M M Y Y Y Y |
| Nicotine or replacement product | | D D M M Y Y Y Y |

## Please provide your usual doctor's details

Asking for this does not mean we will automatically request a medical report.

| | |
|---|---|
| Doctors name | |
| Surgery name | |
| Address | *Address line 1* |
| | *Address line 2* |
| | *Address line 3* |
| Postcode | |
| Doctors telephone no. | |

## Previous Doctor

If you have been registered with your current doctor for less than six months, please give the details of your previous doctor.

| | |
|---|---|
| Doctors name | |
| Surgery name | |
| Address | *Address line 1* |
| | *Address line 2* |
| | *Address line 3* |
| Postcode | |
| Doctors telephone no. | |

## Declaration and consent

- I have read the data protection statement which explains how my personal information will be used.
- I consent to my medical and health related data being used in the ways described.
- I consent to my medical and health data being passed to Zurich's Chief Medical Officer, to third party life reassurers and to third party administrators arranging medical examinations.
- I consent to Zurich obtaining medical information from any doctor about anything affecting my physical or mental health in order to assess this application and to Zurich obtaining information from other insurers about other applications I have made for any life, sickness, accident or private medical insurance. I authorise those asked by Zurich for such information to provide it on the production of a copy of this consent.

I do/do not* want access to any medical report prepared as a result. (*Delete as appropriate)

I declare that:

- I have read the sections headed 'Access to medical reports' and 'Your duty to take reasonable care'.
- I have answered the questions in this form honestly and accurately and the information I have provided in response to the questions is, to the best of my knowledge, complete and correct.
- I am aware that the answers I have given to the questions in this form will be used to assess whether to offer cover/increased cover (as appropriate).
- I will tell Zurich about any change to my personal health, family history of disease, occupation, travel or place of residence, hazardous activities, alcohol consumption, smoking habits or use of recreational drugs that happens between completing this form and the start date of the plan (or, in the case of an increase, between completing this form and Zurich's written confirmation that the application for the increase has been accepted) if that change makes any of the answers to the questions Zurich asked wrong or incomplete. I am aware that if I haven't answered the questions correctly the plan, (or the increased cover, where applicable) may be cancelled, or the plan's terms may be changed, or a claim may be rejected or not fully paid. Cancelling a plan means that no cover or other benefits will be provided.

**Important**

Before signing this declaration please answer all questions in this form and read the notes on pages 1 and 2 which include an explanation of your rights regarding Access to Medical Reports.

Signature

Print name

D D M M Y Y Y Y

# Please let us know if you would like a copy of this in large print, braille or audio.

Zurich Assurance Ltd.
Registered in England and Wales under company number 02456671.
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