Private Medical Insurance Plan
Full Medical Underwriting Application Form
(For Individual, inSpire and SME plans)

1. Policy details

Plan name: Individual ☐ inSpire ☐ SME ☐

Name of company (only complete if covered under a Group Policy):

Calculated premium amount: | Annual ☐ Monthly ☐ | Commencement date:

Single ☐ Joint ☐ Family ☐ Single Parent ☐

Excess: _____

Additional Options (if applicable):

Out-patients Benefits: Full Cover ☐ or Limited Cover ☐

Complementary Medicine ☐

Health Cash Benefits ☐ Psychiatric Benefits ☐

Extended Hospital List ☐

2. Main applicant details

Title: | Surname: | Forename(s):

Address:

Postcode:

Male: ☐ Female: ☐ | Date of birth: | Occupation: | E-mail address:

Work tel no: | Home tel no: | Mobile tel no:

3. Other applicants to be covered - partner/children

If more space is required, please continue on a separate sheet of paper

Title	Surname	Forename(s)	Male / Female	Date of birth	Occupation (if over 16)

4. Previous insurance details

1. Do you currently hold Private Medical Insurance? Yes ☐ No ☐

If yes, please provide details of your current insurer and policy:

Name of insurer:	Policy type:	Policy number:

2. Have any of those named in the application been declined cover, had insurance cancelled, declared void or had special conditions or premium loading imposed upon them? Yes ☐ No ☐

If yes, please provide details:

5. Medical History Questionnaire

Guidelines for Completing the Medical History Questionnaire
This section must be completed for each person included in the application and asks for health and medical details, both past and present. The main applicant should answer on behalf of themselves and children under the age of 16. The spouse/partner and any children over the age of 16 should answer on their own behalf. Every question must be answered and if the answer is yes, please provide details. If you run out of space, please use extra sheets of paper, making it clear which question you are answering.

Help us to speed up the processing of your application form, for example:
- If the event was more than 6 months ago, give approximate dates, if more recent be specific.
- If there were consultations, state how many.
- Left or Right if referring to a limb, eye etc.
- Broken bones set by pin, plaster or plates?
- How long a condition lasted, describing severity.
- Routine tests should be mentioned including reason for test and result.
- Current tests where results are as yet unknown must be disclosed.
- All visits by children to either GP or dentist for illness or discomfort must be disclosed.

If you are unsure of the relevance of any information, please declare it.

QUESTION 1:

Has any person named in this application ever suffered from, or been diagnosed with:

	Applicant 1	Applicant 2	Applicant 3	Applicant 4	Applicant 5
NAME:					
a. Any form of cancer.	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
b. Any form of pre-cancerous or pre-malignant condition, benign condition (e.g. lumps or bumps) or any condition which leads to an increased risk of cancer.	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
c. Any form of heart disease, heart condition or cardiovascular condition (to include high or low blood pressure, high cholesterol, chest pain and heart murmurs).	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
d. Any form of stroke, transient ischaemic attack (TIA), or cerebrovascular disease.	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
e. Any form of psychiatric or psychological condition or disorder (to include depression, anxiety and stress) that required treatment by a GP, specialist or mental health practitioner.	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
f. Any form of arthritic or rheumatological condition or disorder.	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐

QUESTION 1 CONTINUED...

If you have answered Yes to any of the questions, please provide further information below:

Name of applicant	Illness or medical condition	When did symptoms start/finish?	Treatment, including medication, results of investigations, admission to hospital etc.	Ongoing treatment

Please continue on a separate piece of paper if you run out of space.

Additional information attached: Yes ☐ No ☐

QUESTION 2:

Within the last 5 years, has any person named in this application:

- Been admitted to a hospital, clinic or nursing home, or
- Seen a GP or other healthcare professional (e.g. specialist or physiotherapist), or
- Undergone investigation or received treatment, or
- Experienced symptoms, or
- Taken medication/special diet.

Due to any of the following medical conditions:

	Applicant 1	Applicant 2	Applicant 3	Applicant 4	Applicant 5
NAME:					
a. Cardiovascular conditions – e.g. Circulation problems, varicose veins or DVT/blood clots.	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
b. Neurological conditions (brain, central nervous system) - e.g. epilepsy, fits, migraines/repeated headaches, multiple sclerosis, paralysis.	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
c. Musculoskeletal conditions - e.g. back or neck problems, joint problems, cartilage, ligament or tendon problems, osteoporosis, gout.	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
d. Breathing or respiratory problems - e.g. asthma, chest infections, bronchitis, tuberculosis, chronic obstructive airways disease or other shortness of breath.	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
e. Digestive disorders (stomach, intestine, liver, gallbladder) - e.g. indigestion, ulcer, change of bowel habit, colitis, irritable bowel disease, rectal bleeding, haemorrhoids (piles), liver failure, hepatitis, cirrhosis, gall stones, pancreatitis.	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
f. Urinary disorders - e.g. prostate problems, bladder infections, kidney stones, incontinence.	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
g. Glandular disorders (metabolism, endocrine) - e.g. thyroid problems, diabetes, hormonal problems.	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
h. Women's Health problems - e.g. breast lump, abnormal smear, heavy or irregular periods, fibroids, ovarian cysts, endometriosis, infertility problems, menopause problems.	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
i. Eyes, ears, nose, throat, mouth and dental problems - e.g. cataracts, glaucoma, recurrent ear infections, loss of hearing, tonsillitis, sinus problems, wisdom teeth, dental disorders.	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
j. Dermatological (skin) problems - e.g. eczema, psoriasis, rashes, moles, lumps and bumps, acne.	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐

QUESTION 2 CONTINUED...

If you have answered Yes to any of the questions, please provide further information below:

Name of applicant	Illness or medical condition	When did symptoms start/finish?	Treatment, including medication, results of investigations, admission to hospital etc.	Ongoing treatment

Please continue on a separate piece of paper if you run out of space.

Additional information attached: Yes ☐ No ☐

QUESTION 3:

Please answer the following lifestyle questions:

	Applicant 1	Applicant 2	Applicant 3	Applicant 4	Applicant 5
NAME:					
a. Have any of the applicants smoked within the last 12 months? - If yes, please indicate daily consumption and type of tobacco (e.g. cigarettes, cigars etc).	YES ☐ NO ☐ Daily Consumption: Type of Tobacco:	YES ☐ NO ☐ Daily Consumption: Type of Tobacco:	YES ☐ NO ☐ Daily Consumption: Type of Tobacco:	YES ☐ NO ☐ Daily Consumption: Type of Tobacco:	YES ☐ NO ☐ Daily Consumption: Type of Tobacco:
b Alcohol intake - Please indicate weekly consumption in units. NB: 1 unit of alcohol = half pint of beer, a 25ml measure of spirits or a small glass of wine.	UNITS	UNITS	UNITS	UNITS	UNITS
c. Please indicate your height.	cm	cm	cm	cm	cm
d. Please indicate your weight.	Kg	Kg	Kg	Kg	Kg

QUESTION 4:

Are any of those mentioned in the application aware of any physical or mental condition, illness, long-term disease, sign, symptom or injury not yet mentioned, whether or not they have consulted a doctor, dentist or other healthcare professional?

Yes ☐ No ☐ If Yes, please provide further details below:

Name of applicant	Illness or medical condition	When did symptoms start/finish?	Treatment, including medication, results of investigations, admission to hospital etc.	Ongoing treatment

Please continue on a separate piece of paper if you run out of space.

Additional information attached: Yes ☐ No ☐

QUESTION 5:

Are any of those mentioned in the application waiting for any investigation or treatment not yet mentioned?

Yes ☐ No ☐ If Yes, please provide further details below:

Name of applicant	Illness or medical condition	When did symptoms start/finish?	Treatment, including medication, results of investigations, admission to hospital etc.	Ongoing treatment

Please continue on a separate piece of paper if you run out of space.

Additional information attached: Yes ☐ No ☐

QUESTION 6:

Are any of those mentioned in the application taking any medication, whether prescribed or not?

Yes ☐ No ☐ If Yes, please provide further details below:

Name of applicant	Details

QUESTION 7:

Have any of those mentioned in the application ever tested positive for HIV/AIDS, Hepatitis B or C, been treated for any sexually transmitted disease, or are awaiting any such test? Yes ☐ No ☐ If Yes, please provide further details below:

Name of applicant	Details

6. Main Applicant Declaration - please read carefully and complete

I understand this application is subject to written acceptance by us. Cover will commence once approved and accepted by us at which point any special terms relating to your cover will be highlighted. We reserve the right to decline any application.

Full Medical Underwriting Clause
This is based on your completing a health questionnaire (also called a Medical History Declaration).

If you choose this option, you will be asked a number of questions about your health. These will enable us to understand your medical history (and that of any member of your family whom you wish to insure). It is important that you consider the questions carefully for each person to be covered, and answer them fully. We will review your details and decide the basis on which we can accept you for cover. If necessary, we may need to ask your Doctor for any further information we need to help us to do this.

If you have a pre-existing condition that may need treatment in the future, we will usually exclude it from the cover along with any conditions related to it. We will show any exclusions on the certificate of registration you receive from us when we have processed your application. (The same process will also apply for any members of your family included in your application).

If we exclude treatment for a pre-existing condition at the time when your policy starts we will, in some cases, review the exclusion in the future should you wish us to do so.

Of course, any new conditions arising after the start of your policy will be covered immediately subject to the policy terms and conditions.

Note: You must ensure that you provide full and accurate information in answer to the questionnaire. Failure to do so may mean that we cannot cover a claim or even that your policy is void. If you are unsure whether we would want to know about a particular condition, you should tell us about it.

What is the advantage of Full Medical Underwriting?
Although this option involves more of your time when completing your application, it does mean that, when you receive your policy documentation, you will know what conditions are excluded from cover.

Full Medical Underwriting Declaration
I/We hereby apply for insurance with the Insurer for those shown on this form. I/We agree to be bound by their usual terms and conditions contained in the policy document.

I/We declare to the best of my knowledge and belief that the statements made in this application form, and any supplementary information provided as part of this application are accurate, true and complete. I/We shall read the terms and conditions of the policy when received and agree to be bound by them. I/We agree to advise the Insurer if there is any change in the information given on this application which occurs before I/We receive written confirmation as to whether or not a policy will be issued, or before the start date of the policy if later.

Data Protection Act 1998
I/We confirm and agree that information about me/us and this application form may be retained on paper and computer by APRIL UK and used:

a) By Arch Insurance Company (Europe) Limited and other businesses that provide insurance services relating to the policy as may be necessary for the administration of my/our policy and dealing with our claims under my/our policy. I/we agree that it may be necessary for Arch Insurance Company (Europe) Limited to obtain and use sensitive personal information about me/us.
b) To provide information about me/us (whether provided in the application form or any claim form) to other insurers for the prevention of fraud and to other third parties for the purpose of administration of their policy or any claim. Details of such third parties and other insurers will be made available on request.

The information may also be used to send you details about other services available from APRIL UK that might be of interest to you. If you wish to opt out of this service, please tick this box. ☐

Please sign and date here:

Main Applicant Signature:	Date
X	X

To be completed by the Business Consultant:

Name: Number: Date:

Cheque enclosed: Yes / No Direct Debit Form enclosed: Yes / No Signature:

Head Office use only:

Premium checked: Yes / No Actual premium: £

7. YOUR RIGHTS UNDER THE ACCESS TO MEDICAL REPORTS ACT (1988) AND THE ACCESS TO PERSONAL FILES AND MEDICAL REPORTS (NORTHERN IRELAND) ORDER 1991

Before giving your consent to our obtaining a Medical Report, you should read the following as it sets out your rights under the above Act and Order.

You do not have to give your consent, but if we do not receive it, we may not be able to proceed with your application. If you consent, we will inform you at the time we request the report. You then have the right to advise the Doctor, in writing, that you wish to see the report before it is sent to us. If you exercise that right, the Doctor cannot send the report to us until either you have seen it and consented, in writing, to us seeing it, or you have allowed 21 days to pass without the Doctor having received any further instructions. It is your responsibility to make any arrangements with your Doctor for the inspection of the report.

We will pay for the report, but if you ask for a copy the Doctor may charge a reasonable fee to cover the costs of supplying it. You will need to pay this cost. If you have not initially requested to see the report, you may change your mind; in which case you must inform both us and your Doctor and you will then have 21 days to arrange to see the report. You have the right to see the report that is sent to us by asking your Doctor to let you see a copy within 6 months.

If you see the report, in accordance with your rights, the Doctor will need your consent before sending it to us. You can ask the Doctor to amend any part of the report which you consider to be incorrect or misleading. If you and the Doctor cannot agree on the facts set out in the report, you have the right to ask that a statement of your views on any part of the report about which you are not in agreement is attached to the report.

The Doctor is not obliged to let you see any part of the report if, in their opinion, that would be likely to cause serious harm to your physical or mental health, or that of others, or it would indicate the Doctors' intentions in respect of you, or if disclosure would be likely to reveal information about, or the identity of another person who has supplied information about you, unless that person has consented or the information provided relates to, or has been supplied by, a health professional involved in caring for you. In such cases, the Doctor must notify you accordingly and you will be able to see only the remainder of the report. If it is the whole report which is affected, the Doctor must not send it to us unless you give your consent.

Access to Medical Reports Act Declaration
If deemed necessary by the Insurer or their Agents I/We consent to them obtaining a medical report from my/our specialist and/or General Practitioner. I/We have been informed of our rights under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (Northern Ireland) order 1991. I/We agree that a copy of this consent shall have the validity of the original. I/We understand that I/We will be informed if any report is requested and have indicated whether I/We do/do not wish to see any report before it is sent.

To be completed by main applicant

Signature of Main Applicant: X
Print Name:
Date:
Name of GP:
Surgery Name:
Address of GP:
Do you wish to see any report before it is sent? Yes ☐ No ☐

To be completed by partner/spouse

Signature of partner/spouse: X
Print Name:
Date:
Name of GP:
Surgery Name:
Address of GP:
Do you wish to see any report before it is sent? Yes ☐ No ☐

MEDICAL CONSENT CONTINUED...

To be completed by Child 1

Signature of Child 1 (If under 16, main applicant should sign on their behalf): X
Print Name:
Date:
Name of GP:
Surgery Name:
Address of GP:
Do you wish to see any report before it is sent? Yes ☐ No ☐

To be completed by Child 2

Signature of Child 2 (If under 16, main applicant should sign on their behalf): X
Print Name:
Date:
Name of GP:
Surgery Name:
Address of GP:
Do you wish to see any report before it is sent? Yes ☐ No ☐

To be completed by Child 3

Signature of Child 3 (If under 16, main applicant should sign on their behalf): X
Print Name:
Date:
Name of GP:
Surgery Name:
Address of GP:
Do you wish to see any report before it is sent? Yes ☐ No ☐

To be completed by Child 4

Signature of Child 4 (If under 16, main applicant should sign on their behalf): X
Print Name:
Date:
Name of GP:
Surgery Name:
Address of GP:
Do you wish to see any report before it is sent? Yes ☐ No ☐