



**MERSEYSIDE POLICE TOP UP DECLARATION**  
**FOR A SERVING POLICE OFFICER**

**Name of Scheme:** .....

**Title:** ..... **Forename(s):** ..... **Surname:** .....  
(Mr/Mrs/Miss/Ms)

**Date of Birth:** ..... **Collar Number:** .....

**Address:** .....  
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**Statement of Health:**  
I confirm that I have been actively at work in my usual occupation for a period of 8 consecutive weeks prior to my intended commencement of cover date (normal annual holiday entitlement may be ignored).  
  
I confirm I am in good health and I am not currently awaiting referral to a medical practitioner or specialist/consultant and I am not awaiting the results of any tests or medical investigation.  
  
I confirm that I have not had more than 14 days absence through illness and/or injury during the last 12 months.  
  
I confirm I have not had any application for Life or Critical Illness Insurance declined, postponed or subject to an increased premium or other special terms.  
  
*(If you are unable to confirm any of the above a full Personal Declaration form will be required. If you are in any doubt please declare the details in the space provided).*  
  
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**Important Notes:**

- Please note that the information you provide on this form will be used to assess the risk involved in providing you with the proposed level of cover. All material facts must be disclosed since part or all of the benefit might be forfeited if relevant information were to be withheld. A material fact is one that is likely to influence the assessment and acceptance of your cover. If you are unsure whether a particular fact is material you should disclose it. You must not assume that we shall be asking your doctor for confirmation of what you have informed us.
- Cover will not start until we have assessed and accepted the information you have provided in this form.
- We may ask you to contact your doctor to speed up the completion of reports that we have requested.
- If we ask you to attend a medical examination, it will be necessary for us to share your application information with another company authorised by us. They will make the arrangements for the examination to take place.
- It may be necessary for us to send your form and relevant medical reports to the participating Lloyd's Underwriters or their Reassurers for their opinion or agreement of the terms offered.
- On occasion the faxing of medical reports may help to ensure a speedier assessment of your medical information. We only accept faxed information direct to a fax machine in a secure part of our building. This ensures that we maintain strict confidentiality. If you do not agree to allow the faxing of information please indicate by deleting the appropriate section in this form.
- Risk Assurance Management Limited has a confidentiality practice in place which means that your medical information is held securely and access is limited to authorized individuals who need to see it.
- You must inform us of any changes in your health or other circumstances during the period between this form being completed and in us notifying the terms on which cover will be offered.



### **Statement of Practice on Genetics**

In accordance with the Association of British Insurer's ('ABI') policy on genetics and insurance, you do not need to tell us about any genetic test you have had if the proposed level of cover, taken together with any other insurance cover you already have, total:

- £500,000 or less for life assurance
- £300,000 or less for critical illness or income protection

Above these limits you may need to tell us about certain genetic test results when applying for certain types of insurance. We will only be interested in genetic test results which have been approved by the Government's Genetic and Insurance Committee for insurers' use.

If you think this may apply to you please ask us for details of the current position. These details are also available from the ABI website at [www.abi.org.uk/consumer2/disclosure.htm](http://www.abi.org.uk/consumer2/disclosure.htm).

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

### **Data Protection Act 1998**

I understand and consent to the use of any information provided by me for the operation of this insurance. This includes the process of underwriting, administration, claims management, rehabilitation and handling customer concerns.

I understand that in order to do this the information may be shared with other insurers, reinsurers, insurance intermediaries and service providers who are involved in either the operation of insurance which covers employees or the employee benefit arrangements provided by the company.

I understand the data will be processed fairly and securely in accordance with the Data Protection Act 1998 and the details will be stored on computer but will not be kept for longer than necessary.

I confirm that the data in relation to this insurance has been obtained and passed to Risk Assurance Management Limited in accordance with the requirements of the Data Protection Act 1998 and confirm that I give my consent to forward such information to the insurer.

**Declaration:**

Please sign the Personal Declaration once you have read and completed all relevant sections contained in this form. If you are unsure as to whether any information should be given, you should provide it. If you are applying for insurance with other companies at the same time, by signing the form you are consenting to copies of medical reports being sent to these other companies at their request. However, if we are approached by another company to provide copies of highly sensitive information we shall ask for your specific written permission before doing so.

- I confirm I wish to effect insurance under the Scheme and understand that my cover will not commence until confirmation has been received from Risk Assurance Management Limited or its agents.
- I will inform you immediately of any changes that occur before Risk Assurance Management Limited notify the terms on which cover will be offered. I understand that failure to do so may result in the loss or cancellation of the cover being assessed.
- To the best of my knowledge and belief all the statements made, which includes anything I may have said, have been recorded accurately in this form or are attached in a sealed Private and Confidential envelope, and are true and complete.

Please tick if you have attached a Private and Confidential envelope.

- I agree to Risk Assurance Management Limited obtaining medical information from any doctor whom I have consulted about my physical or mental health, in order to assess my application. You may obtain relevant information from other insurers about previous or concurrent applications for life, critical illness, sickness, disability, accident or private medical insurance that I have applied for. I authorise those asked for such information to provide it on the production of a copy of this consent. This consent allows Risk Assurance Management Limited to obtain medical reports at any time during the period of the cover or after my death to support any claim made on the cover proceeds.
- This information can also be used to maintain management information for business analysis.
- I agree that a copy of the agreement given in this Declaration will have the validity of the original.
- I agree to Risk Assurance Management accepting medical reports faxed directly to the company from my doctor's surgery. I do not\* object to copies of the report being faxed to any other company that I have applied to at their request. (\*Delete the word "not" if you do not wish us to fax information.)

By signing this form I am allowing Risk Assurance Management Limited to carry out my risk assessment using the information that I have provided. This information can also be used to process any claim made in respect of me on this policy.

I have read and understood the Important Notes (including the Data Protection section information relating to my rights under the Access to Medical Reports and Statement of Practice section) information relating to my rights under the Access to Medical Reports Act and the Declaration and Consent.



**Personal Declaration:**

I hereby acknowledge and accept that if any of the statements made by me in this form are untrue or deliberately misleading any payment of benefit may be denied.

Copies of this declaration will be legally valid.

I understand that this form will be passed to or used by member companies of Risk Assurance Management Limited for the purpose of my insurance. This includes underwriting, processing, claims handling and fraud prevention, which could include passing details to agents of Risk Assurance Management Limited or other insurers. You may ask other insurers for information to check the information I have given.

**Signature:**

**Dated:**

**Print Name:**

**For Office Use Only:**

**Acceptance Date:**

**Accepted by:**

**Signature:**

**Dated:**

**Print Name:**

**Please ensure this form is forwarded to Risk Assurance Management Limited.**

**Please Return to:**

**Federation Office  
Malvern House  
13 Green Lane  
Tuebrook  
Liverpool  
L13 7DT**