William Russell

Global Life & Income Protection Plans

Application Form for Individuals

Please complete this form in **BLOCK CAPITALS** using black ink, and return it to us by email, or post. You can find our contact details at the end of this form.

Broker/intermediary details

If you were introduced to us through an intermediary or broker, please state their name and company:

TFG Global Insurance Solutions Ltd.

Your personal details

First name: ..... Surname: ..... Title: .....

Address: .....

.....

Mobile number: ..... Home number: .....

Email: .....

Date of birth: ..... Nationality: ..... ☐ Male ☐ Female

Country where you will be living/working: ..... How long have you lived here? ..... years

Start date required

When would you like your plan to start? ☐ On acceptance of your application ☐ Specific date: .....

Please note that your application is only valid for 90 days from the date you signed the form. Cover cannot be backdated.

Previous/current insurance

1. Have you ever applied for a plan or been insured with William Russell? ☐ Yes ☐ No

If YES, please state the plan number: ..... Date of expiry of plan: .....

2. Have you ever had an application for insurance declined or accepted with special terms, or had an insurance policy cancelled by any insurance provider? ☐ Yes ☐ No

If YES, please provide details: .....

.....

3. Do you currently have any other life, accident or income insurance? ☐ Yes ☐ No

If YES, please state the name of insurer: .....

Type of cover: ..... Amount of cover: .....

Policy Number: ..... Policy expiry date: .....

Your occupation

Occupation: ..... Industry: .....

Are you self-employed? ☐ Yes ☐ No

Please state your current annual earnings (including the currency): .....

Please state the name and registered address of your business/employer: .....

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Is your occupation 100% office-based? ☐ Yes ☐ No

If NO, please itemise your ordinary work duties, including the percentage of work time ordinarily spent on each duty:

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William Russell

Your occupation (continued)

Do you ever work offshore? (e.g. in the air, on water, underwater, on oil rigs) ☐ Yes ☐ No

If YES, please give full details: .....

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Does your work require a license which depends on your state of health? ☐ Yes ☐ No

If YES, please give full details: .....

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Do you ever participate in hazardous activities? ☐ Yes ☐ No

If YES, please give full details of any activities and how often you participate in them: .....

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The cover afforded by your plan may be affected if your occupation is not 100% office-based or if you participate in hazardous activities. Cover for higher risk occupations or hazardous activities may be subject to a premium loading and/or special terms. We reserve the right to decline cover depending on your occupation and activities.

Hazardous activities include (but are not limited to) off-piste skiing, scuba diving to a depth of more than 30 metres, unsupervised scuba diving of any kind, rock-climbing or mountaineering, pot-holing, hang-gliding, parachuting, bungee-jumping, hunting on horseback, driving or riding in any kind of race or competition, flying (other than as a passenger on a commercial aircraft), riding on motorcycles, mopeds or moto scooters (even as pillion), or any other activity which has a similar degree of danger as any of those mentioned here. If you are uncertain about whether an occupation is higher risk or whether an activity would be classed as hazardous, please provide the information as requested and we will confirm if we require anything further.

Please select the cover you require

If you have one, please state the quote illustration reference for the quote you wish to accept: .....

a) Life plan

The life plan lets you choose the cash lump-sum that your nominated beneficiary would receive if you were to die whilst your plan is in force.

Please state the life benefit you require: .....

Your total life benefit, including any other life insurance cover you have, must not exceed 20x your current annual earnings. The maximum benefit available under this life plan is US$2,000,000 or £1,500,000 or €1,700,000.

Please state your reason for cover: ☐ Family protection ☐ To cover a loan ☐ Other (please give details):

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b) Optional accident benefit

The optional accident benefit pays out an additional cash lump-sum in the event of your death or your permanent disability following an accident.

Please state the accident benefit you require: .....

The optional accident benefit is only available in conjunction with the life plan. The maximum accident benefit available is US$500,000 or £375,000 or €500,000. The accident benefit you have selected must not exceed the life benefit.

William Russell

Please select the cover you require (continued)

c) Income protection plan

The income protection plan provides you with the replacement income you will need if an illness or injury prevents you from working, for longer than your deferment period.

Please state the income benefit you require: .....

Please state the deferment period you require (the period during which no benefit is paid): ☐ 3 months ☐ 6 months

The income benefit we pay will be restricted to 75% of your pre-disability earnings, less any other income you are entitled to receive whilst you are disabled. The maximum income benefit is US$144,000 or £108,000 or €144,000.

Paying for your plan

Please select the currency in which you would like to pay your premiums. The currency you select will also be the currency in which your plan benefits will be denominated.

☐ US Dollars ☐ GBP Sterling ☐ Euros

Please select your payment method and frequency:

Credit/debit card	☐ Annually	☐ Half-yearly[2]	☐ Quarterly[3]	☐ Monthly[3]
Direct debit[1]	☐ Annually	☐ Half-yearly[2]	☐ Quarterly[3]	☐ Monthly[3]
Bank transfer	☐ Annually			

[1] Direct debit payments are only available when you pay in Sterling from a UK bank account.

[2] Half-yearly premiums are subject to a 3% surcharge.

[3] Quarterly or monthly premiums are subject to a 5% surcharge.

Beneficiary nomination

You only need to complete this section if you are applying for a life plan.

I hereby nominate the following person(s) as beneficiary of my life benefit (and accident benefit, if applicable) in the event of my death:

no.	Full name	% of benefit to be paid	Address	Relationship to policyholder
1				
2				
3				
4				
5				
6				

Beneficiary nomination (continued)

If the death of one or more of the above named beneficiaries precedes your own, the proportion of that benefit that would have been paid will be shared between any surviving beneficiaries, in proportion with the percentages specified above. If this is not your wish, or if you would like to nominate any alternative beneficiary/beneficiaries,, please state your wishes here:

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If you are diagnosed with a terminal illness, then, subject to the terms of the plan agreement, your life benefit will be paid directly to you. If you would prefer otherwise, please state your wishes here:

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Health declaration

We rely on the information you provide on this form to decide whether or not we can accept your application, and if so, whether or not we need to apply any special terms to your cover. Please complete the following health declaration and provide us with full details of any medical conditions. Pre-existing medical conditions and related conditions will not be covered by your plan, unless you have told us about them and we have agreed to cover them.

Please answer the following questions fully, accurately, and to the best of your knowledge. If you answer YES to any question, please supply full details in the spaces provided. If there is insufficient space please continue on an additional sheet of paper. If, after you have submitted the application, we find that you have not answered the questions fully and accurately, your plan may be cancelled, claims may be rejected, or special terms may be applied retroactively.

If you are in any doubt as to whether you should tell us anything, please tell us anyway. It better to provide information that turns out not to be relevant to the risk than to miss out something that causes problems later. If something changes after you have sent us the form but before we have confirmed your cover has started, you must write in and update us.

What is your height? (cm)		
What is your weight today? (kg)		
Has your weight changed by more than 10 kg in the last 2 years? If YES, please provide details	☐ Yes ☐ No	
Have you smoked cigarettes/cigars in the last 12 months?	☐ Yes ☐ No	If YES, please give the average number a day: .....
What is your typical weekly alcohol consumption?	Beer, lager or cider up to alcohol 4.5% volume	..... pints
	Beer, lager or cider alcohol 4.6% volume or more	..... pints
	Wine	..... 175ml glasses
	Fortified wine	..... 50ml glasses
	Spirits	..... 35ml measures

(1) Have you consulted a healthcare practitioner in the last 3 years? ☐ Yes ☐ No

If YES, please give full details (please continue on an additional sheet of paper if required):

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Health declaration (continued)

② Please answer the following:

a) Have you ever tested positive for hepatitis B or hepatitis C, or are you awaiting the results of such a test?

☐ Yes ☐ No

b) Within the last five years have you been exposed to the risk of HIV infection? HIV can be contracted through unsafe sex, intravenous drug abuse, or blood transfusions, or surgery undertaken outside Europe)

☐ Yes ☐ No

If **Questions 2 a)** and/or **2 b)** were answered YES, please provide full details: .....

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③ Have you ever suffered from, or been diagnosed with, treated for or prescribed drugs for:

a) **Auto-immune disorders?** ☐ Yes ☐ No
For example: HIV/AIDS, rheumatoid arthritis, systemic lupus erythematosus, scleroderma.

b) **Cancer, growths or tumours?** ☐ Yes ☐ No
For example: any type of cancer, pre-cancerous conditions, benign growths.

c) **Back, joint, muscular or skeletal problems?** ☐ Yes ☐ No
For example: back or joint pain, whiplash, sciatica, degenerative changes, osteoarthritis, osteoporosis, gout, bunions, joint replacements, fractures, cartilage or ligament problems.

d) **Diabetes, thyroid or any other endocrine disorder?** ☐ Yes ☐ No
For example: diabetes type 1 or 2, overactive or underactive thyroid, pituitary or adrenal problems, obesity.

e) **High blood pressure, cardiac or circulatory conditions?** ☐ Yes ☐ No
For example: angina/chest pains, heart attacks, abnormal heartbeat, palpitations, varicose veins, strokes, deep vein thrombosis, high cholesterol.

f) **Breathing or respiratory conditions?** ☐ Yes ☐ No
For example: asthma, chronic obstructive pulmonary disease (COPD), emphysema.

g) **Stomach, liver/gall bladder, or digestive system conditions?** ☐ Yes ☐ No
For example: ulcers, irritable bowels, Crohn's disease, colitis, reflux/heartburn abdominal pain, liver inflammation, cirrhosis, gallstones, hernias, haemorrhoids/piles.

h) **Any depression, anxiety of other psychiatric or psychological conditions?** ☐ Yes ☐ No
For example: anxiety, bipolar disorder, schizophrenia, stress, low mood, depression, eating disorders.

i) **Any kidney or prostate conditions?** ☐ Yes ☐ No
For example: chronic kidney disease, raised PSA level.

j) **Any alcohol and/or drug dependency problems?** ☐ Yes ☐ No

k) **Any other medical condition not mentioned above**. ☐ Yes ☐ No

If you have answered YES to any of the questions **Above**, please give full details below

Please continue on a separate sheet if necessary.

Question number	Month/year of onset	Condition and cause if known	Frequency of symptoms	Treatment and medication (please state if ongoing)	Month/year of last symptoms
				Treating physician name and address:	

Health declaration (continued)

Question number	Month/year of onset	Condition and cause if known	Frequency of symptoms	Treatment and medication (please state if ongoing)	Month/year of last symptoms
				Treating physician name and address:	
				Treating physician name and address:	
				Treating physician name and address:	

④ Are you currently pregnant? ☐ Yes ☐ No

If YES, please confirm the due date, and details of any non-standard treatment and/or medication you have received, or are continuing to receive:

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⑤ In the last 3 years, have you been told the result of any medical test you have had was abnormal? ☐ Yes ☐ No

Month/year	What was the test?	What was the reason for it?	Have you had a subsequent test that you have been told was normal?

⑥ Do you have any other signs, symptoms, conditions, disabilities or impairment for which the following apply:

- You are waiting to see a GP or specialist
- You are due to have surgery
- You are waiting to have tests or investigations or to receive the results
- You are still under follow-up by a GP or specialist
- You are on medication prescribed or otherwise
- You routinely use any type of aid except spectacles and lenses

☐ Yes ☐ No If YES, please complete the table on the following page.

Health declaration (continued)

Month/year of onset	Condition and cause if known	Duration of symptoms	Treatment and medication (please state if ongoing)	Number of days off work	Month/ year of last symptoms

If you require more space, please continue on a separate sheet of paper.

You only need to complete Question 7 if you are applying for an income protection plan.

⑦ Have you been absent from work for more than 5 consecutive days in the last 5 years for reasons other than annual leave?

☐ Yes ☐ No

If YES, when was each absence period?

From: ..... To: ..... Reason: .....

.....

From: ..... To: ..... Reason: .....

.....

Are you fully recovered from the illness/injury that caused each absence?

☐ Yes ☐ No

If NO, please provide full details: .....

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If you require more space, please continue on a separate sheet of paper.

Marketing communication preferences

We would like to stay in touch with you in ways we think you might find helpful. Every now and then we would like to share information about the expat lifestyle plus other useful content we think could be of interest to you, like promotions for products and services. These could include being contacted by email or by phone. We won't spam you or share your details with anyone else and you can unsubscribe at any time.

Please tick the box to opt into our marketing communications:

☐ Email ☐ Phone ☐ No thank you (no direct marketing allowed)

☐ Newsletter ☐ Text/SMS

We value your privacy and will never sell your data on to third parties. You can read our full privacy policy here.

How we use your information

Please read this section carefully.

- We will use the information that you have given us on this application form for the purposes of administering your plan, processing your claims, identifying and preventing fraud, complying with our legal and regulatory obligations, and carrying out research and statistical analysis to help us improve our services. We will not retain your information for longer than is necessary.
- We may share your information with other organisations in relation to the above purposes, e.g. the insurer of your plan and payment service providers. This may involve transferring your information to countries outside the European Union.

How we use your information (continued)

- Telephone calls to and from William Russell Ltd. may be recorded for training and monitoring purposes.
- By submitting this application form, you consent to us processing your personal information, including sensitive information such as details about your health, in accordance with our privacy policy.
- Our privacy policy also contains information about who to contact if you have any questions about how we use your information, or if you would like to request a copy of the information we hold about you. For full details of our privacy policy, please visit william-russell.com/privacy or consult your plan agreement.

Declaration for your plan

Please read this section carefully and sign below.

- I understand that my application for a life or income protection plan is subject to written acceptance by William Russell Ltd.
- I declare that I have taken reasonable care to answer every question fully, accurately, and to the best of my knowledge and belief.
- I understand that misrepresentation could result in claims being rejected or not fully paid, and/or my plan being cancelled.
- I understand that the plan I am applying for does not cover medical conditions that existed before the proposed start date of the plan, unless I have provided full details of any such medical conditions to William Russell Ltd. and William Russell Ltd. has agreed to cover them. I also understand that my certificate of insurance will advise me of any medical conditions that are not covered by my plan, based on the information I have provided on this form.
- I understand that I must inform William Russell Ltd., in writing, of any changes in the facts provided in my application occurring before the start date of my plan.
- In order to process my claims, I understand that William Russell Ltd. may need to obtain details of my medical history.
- I authorise William Russell Ltd. to send all insurance documents as PDF files to the email address I have provided on this form. If I have applied through a broker or intermediary, I give consent for these documents to be sent via email to that broker or intermediary.
- I give my consent for William Russell Ltd. to use my personal information, including sensitive personal information, in accordance with the privacy policy of William Russell Ltd. I confirm that I have read and understood the privacy policy.
- I understand that, upon receipt of my insurance documents, if I am not entirely satisfied, I can cancel my application from inception and receive a full refund of the premium paid, provided I notify William Russell Ltd. within 30 days of the plan start date, and provided no claim has been made.

Some important notes

Your application is valid for 90 days from the date you signed this form. If cover has not commenced within 90 days, you may have to complete a new form. If your health changes after you submit this form but before your plan starts, you must let us know immediately.

Please provide, with your application, a certified copy of your passport and a utility bill less than four months old, which confirms your residential address.

If you have applied for a life policy please provide us with proof of salary (not compulsory).

Any copies of documents, including this form, must be clearly legible when received by us.

Please return this form to us using the contact details below by post or email. We can also accept signed and scanned copies of the form attached to an email as a PDF.

Declaration for your plan (continued)

We can also accept a digital version of this form, provided you have typed your name below, and your email contains the following copy: "I, [your name], have signed the form myself, and I am happy to be bound by the terms of the plan/ agreement attached to this email." This needs to be sent from the same email address as stated on your form.

Name of applicant: .....

Signature of applicant: ..... **Date:** .....

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