

FLIGHTCREW RISK SOLUTIONS



UK INDIVIDUAL PROPOSAL FORM FOR MULTI CHOICE INDIVIDUAL LUMP SUM AND MONTHLY BENEFIT FLYING LICENCE PROTECTION INSURANCE

PART 1 - INSTRUCTIONS AND UNDERTAKINGS:

1. All sections of this proposal form **MUST** be completed in full in **ENGLISH**.
2. The Insurer relies on the proposal form containing all material information about you and that the information is true and complete. Material information is **anything** that may influence the Insurers decision to issue a policy or not or to decide on what terms a policy will be offered to you. If you are unsure if something is material, you **must** disclose it.
3. If there is any change in the information declared after the date you sign this proposal form and before any cover offered by the Insurer commences, you must advise the Insurer immediately. The Insurer may alter the terms quoted to you in such circumstances.
4. If you do not make a true and complete disclosure of material information, the Insurer may at their election cancel your policy or modify the terms on which it was issued. **It will also prejudice your ability to claim under the policy.**

The Data Protection (Bailiwick of Guernsey) Law 2001

Flightcrew Risk Solutions PCC Ltd ("the Insurer")

By taking out this insurance policy you consent to the Insurer using the information held by the Insurer such as medical and any other information obtained from you or from other parties about you in connection with this policy. This data will be used by the Insurer for determining your application, the operation of insurance (which includes the process of underwriting, administration, claims management, rehabilitation and customer concerns handling) and fraud protection and detection.

Information will be held outside the EEA for these purposes.

Information may be shared by the Insurer for these purposes with group companies and third party insurers, reinsurers, insurance intermediaries and service providers. Such parties may become data controllers in respect of your personal data. Specifically, your membership of BALPA or any other subsequent trade union granted a membership discount will also be divulged. All information will be held for a limited period after the policy has expired or been cancelled. From time to time we may communicate with you about other products and services.

Please tick this box if you do NOT wish to receive such communication.

Your personal data will be processed fairly and securely in accordance with the Data Protection (Bailiwick of Guernsey) Law 2001. Your personal data will only be available to those who need to see it. For example, sensitive data, such as medical records will be used for the purposes of underwriting or claim management and rehabilitation only.

You are entitled to a copy of all your personal data upon receipt of a written request (for which we may charge a small fee) to the following address:

Flightcrew Risk Solutions PCC Limited, Level 5, Mill Court, La Charroterie, St Peter Port, Guernsey, GY1 1EJ.

Flightcrew Risk Solutions PCC Limited is a Company incorporated as a Protected Cell Company in accordance with the provisions of the Protected Cell Companies Ordinance, 1997 (as amended). Its liability for transactions attributable to Cell BF4 is statutorily limited to the assets of that cell and its liabilities for any other transaction is limited to the extent of its non cellular assets only.

Failure to disclose relevant information may result in the non-payment of a claim and all cover under the policy being cancelled.

PART 2 - PERSONAL INFORMATION:

1. Surname:

2. First name(s):

3. Nationality:

4. Rank:

5. Address: (in full)
Post/Zip Code:

6. Is this your permanent residence? Yes No

7. Telephone:

8. Email:

(This will be the nominated contact method)

9. Date of birth: (dd/mm/yyyy)

10. Main employer:

Is this employment Permanent Yes No Temporary Yes No

Fixed term Contract Yes No Self-Employed Yes No

If Temporary or fixed-term contract, please confirm the length of the contract Years

Is your employment Full Time Part Time

If part time, please confirm the number of hours flown per annum or percentage of full time hours worked

11. Are you a member of BALPA (full or associate)? Yes No

Membership number, if known

12. Date cover to commence: (dd/mm/yyyy)

13. Annual taxable earned income (Main Employer): (ccy) Monthly net income (ccy)

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14. Any other earned income: (from flying)
If none, please state "none".

15. During a period of disability, does your employer provide contractual sick pay?
If **YES**, how much and for how long: Yes No

16. During a period of disability are you entitled to benefit from any other loss of licence, disablement or accident insurance policy which pays a temporary benefit?
If **YES**, how much and for how long: Yes No

17. During a period of disability will you receive any other regular income?
If **YES**, how much and for how long: Yes No

18. Are you entitled to benefit from any other loss of licence, disablement or accident insurance policy which pays a lump sum benefit only?
If **YES**, please give name of insurer(s), policy number(s) and benefit payable Yes No

19. Type of aircraft flown: (please tick all which apply):

Fixed Wing	<input type="checkbox"/>
Rotor Wing (On Shore)	<input type="checkbox"/>
Rotor Wing (Off Shore)	<input type="checkbox"/>

20. All current licences held: (Please specify type, number, country of issue and whether any limitations)

Type	Number	Country of Issue	Limitations (yes or no)

Please give details of any licence limitations under the Supplementary Information page.

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PART 3 - BASIS OF COVER:

21. Is lump sum benefit required? Yes No If **YES**, Amount? (ccy)

22. Are monthly benefits required? Yes No Amount (ccy)

If **YES**, please tick which waiting period applies? 90 days 180 days 365 days 18 months

If **YES**, please tick which benefit period applies? 24 months 60 months

23. Please state if this Proposal is: (Please tick which applies)

- a) your first proposal to the Insurer
 - or
 - b) an additional amount to an existing insurance
- (if (b) state existing Policy No. and amount insured and insurer)

PART 4 - MEDICAL INFORMATION:

24. Do you hold a current medical certificate? Yes No

25. What is your height: (cm) What is your current weight: (kg)

26. Has there been any significant change in weight in the last year? (\pm 6.5kg) Yes No

If **YES**, please give details:

27. Date of last aircrew medical examination: (dd/mm/yyyy)

Were you advised of any abnormality, referred for additional tests, specialist examination or asked to follow any treatment or diet plan?

If **YES**, please give details:

Yes No

28. Date of last electrocardiograph taken as required by the Licensing Authority:(dd/mm/yyyy)

Were you advised of any abnormality, referred for additional tests, specialist examination

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or asked to follow any treatment plan?

If **YES**, please give details:

Yes No

29. Have you been investigated, diagnosed or treated for any of the following:

- a) Cancer, leukaemia, Hodgkin's disease, lymphoma, brain or spinal tumour? Yes No
- b) A mole or freckle that has bled, caused pain or changed in appearance or any lump or growth? Yes No
- c) Heart disease (including heart attack, angina, valve defect, heart defects from birth or heart surgery)? Yes No
- d) Chest pain, irregular heart beat, raised blood pressure or raised cholesterol? Yes No
- e) Any other lung or chest complaint? Yes No
- f) Disease or disorder of the arteries (including disease in the legs or of the aorta)? Yes No
- g) Stroke, brain haemorrhage or brain injury? Yes No
- h) Asthma, bronchitis or any other respiratory disorder? Yes No
- i) Multiple Sclerosis, optic or retrobulbar neuritis, Parkinson's disease, paralysis, epilepsy, Alzheimer's Disease, dementia, bell's palsy or cerebral palsy? Yes No
- j) Any other disorder of the central nervous system not already mentioned? Yes No
- k) Numbness, loss of feeling or tingling of the limbs or face, loss of balance or coordination? Yes No
- l) Seizures, fits, fainting or blackouts? Yes No
- m) Mental illness that has required any kind of medical attention, time off work, hospital treatment or referral to a psychiatrist? Yes No
- n) Depression, anxiety, stress, insomnia, fatigue (including chronic fatigue syndrome / myalgic encephalopathy) or nervous breakdown? Yes No
- o) Any disorder of the eyes or ears including blurred or double vision, or impaired hearing? Yes No
- p) Gout, arthritis, back pain, sciatica, neck, knee or wrist pain? Yes No
- q) Any other disorder of the joints, bones or muscles (including repetitive strain injury)? Yes No
- r) Diabetes, abnormal glucose tolerance or sugar in the urine? Yes No
- s) Disorder of the kidneys, bladder, or the genitourinary system (including blood or protein in the urine and urinary tract infections)? Yes No
- t) Any disorder of the digestive system, gall bladder, liver, stomach, spleen, pancreas, bowel (including ulcers, hepatitis, colitis or Crohn's disease or any other form of bowel disease)? Yes No

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- u) Any blood disorder or anaemia? Yes No
- v) Thyroid disorder? Yes No
- w) Any gynaecological, menstrual or breast problems (eg breast lumps)? (female applicants only) Yes No
- x) Any prostate problems or problems relating to the breast tissue? (male applicants only) Yes No
- y) Have you ever tested positive for HIV, Hepatitis B or C or are you awaiting the results of such a test? Yes No
- z) Any disease which was transmitted sexually? Yes No

- aa) Are you currently taking any form of medication, prescribed or otherwise or following any special diet or treatment or have you taken any form of medication for longer than 21 days? Yes No
- bb) Do you have any further disclosures to make with regard to any medical investigation, test or consultation, advice, counselling, operation, medication or treatment that you have had or been advised to have or are currently having, but have not already mentioned? Yes No

If you have answered **YES** to any of the above, please provide further information regarding the condition, including treatment (whether proposed or received), medication (whether proposed or received) and prognosis in PART 6 – SUPPLEMENTARY INFORMATION

- 30. During the last 5 years have you been off work, unable to carry out your normal duties due to sickness or injury for more than 21 days at any one time, other than previously stated?
If **YES**, please give details: Yes No

- 31. Are you aware of any symptoms or complaints for which you have not consulted a doctor or received treatment?
If **YES**, please give details: Yes No

- 32. Have you ever been advised by your doctor or another medical practitioner to drink less alcohol?
If **YES**, please give details: Yes No

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33. Have you used any form of tobacco or nicotine products in the last 12 months?

If **YES**, please give details of quantity per week:

Yes No

34. Have your parents, brothers or sisters, before the age of 65, died or suffered from, or had any investigations for heart disease, stroke, polycystic kidney disease, cancer or tumour or diabetes, Multiple Sclerosis or Polyposis of the colon?

If **YES**, please give details, including age when diagnosed:

Yes No

35. Have you ever had an application for loss of licence, life, critical illness or income protection insurance postponed, declined, accepted with an increased premium or on special terms?

If **YES**, please give details:

Yes No

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Access to Medical Reports Act 1998 (please see over for further details):

The Insurer may require additional medical information. If you have completed any section declaring medical history, please complete the following:

Usual Doctor or General Practitioner's name and contact address:

Consultant's name and contact address:

PART 5 - DECLARATION:

I hereby declare:

- that I have read the answers to the questions in this application form and, to the best of my knowledge and belief, the answers, whether in my own handwriting or not, are true and complete.
- that I have not withheld any material information which might influence the decision of the Insurer with regard to this proposal.

I agree that this proposal and declaration shall be the basis of the Contract between me and the Insurer if a policy is issued. I also consent to any information the Insurer may have about me being processed by them for the purposes of providing insurance and claims handling which may necessitate them providing such information to third parties.

Signed

Dated
(dd/mm/yyyy)

The Insurer reserves the right to impose special conditions or refuse to accept a proposal for insurance.

I confirm that I have read the Flightcrew Key Features document dated 08-08-11, and the BFS Client Agreement document dated 22-12-11.

Signed

Dated

Please return the completed proposal form to: -

**BALPA Financial Solutions Ltd
BALPA House
5 Heathrow Boulevard
278 Bath Road
West Drayton
UB7 0DQ**

Failure to disclose relevant information may result in the non-payment of a claim and all cover under the policy being cancelled.

NOTICE OF STATUTORY RIGHTS UNDER THE ACCESS TO MEDICAL REPORTS ACT 1988

Your Rights

- You can withhold your consent to the application of a medical report but without it, your cover may be restricted or your proposal for cover refused.
- If you do give your consent you can indicate in the Declaration whether or not you wish to see the report before the doctor sends it to the Insurer.
- If you wish to see any report the Insurer must tell you if they apply for one and notify the doctor of your wishes.
- You will have 21 days to arrange with the doctor to see the report before it is sent to the Insurer.
- You have the right to ask the doctor, in writing, to amend any part of the report which you consider incorrect or misleading and you can ask him to attach a statement of your views on any part he refused to amend.

Exemptions

- The doctor does not have to let you see any part of a report that he considers would be likely to cause serious harm to the physical or mental health of yourself or others, or that would indicate his intentions towards you. He also does not have to let you see any part that would be likely to disclose information about, or the identity of, another person who has supplied information about you, unless that person has consented or the information relates to, or has been supplied by, a health professional caring for you. If the doctor does not let you see any part of the report, he must notify you of that fact.

Time Limit

- Once the report has been supplied, the doctor must keep a copy of it for six months and you are entitled to inspect it or receive a copy of it during that time.

Procedures

- If you indicate in the Declaration that you do not wish to see any report, the doctor can send it to the Insurer immediately.
- If at any time within the six months time limit you change your mind, you should notify the doctor that you wish to see the report and arrange with him to do so or to supply you with a copy. If you indicate in the Declaration that you do not wish to see any report the Insurer will notify you if they apply for one and you will then have 21 days to arrange with the doctor to see the report before he sends it to them. This could, of course, delay the processing of medical information. The doctor is entitled to charge you a fee for any copy report supplied to you.

Declaration

I have been informed of my rights under the Access to Medical Reports Act 1988 and hereby consent to the Insurer and/or BALPA Financial Solutions Limited obtaining medical reports in connection with this application.

If you do **not** wish to see the report before it is sent to the Insurer, please tick this box.

If you **do** wish to see the report before it is sent to the Insurer, please tick this box.

Signed Dated
(dd/mm/yyyy)

Full Name (please print) Date of Birth

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PART 6 – SUPPLEMENTARY INFORMATION:

Which question does this information relate to?

Date of occurrence (if more than one episode, please give all dates):

Diagnosis (suspected or confirmed):

Details of any treatment/medication received:

Periods off work (if no time off work, the duration of the problem):

If you had time off work, were the Licencing Authorities advised of your condition? **YES/NO** (please delete as applicable). If **YES**, please give details of all formal groundings and any licence limitations imposed:

Is any further problem or treatment anticipated? **YES/NO** (please delete as applicable). If **YES** please give further details:

If no further problem or treatment anticipated, has a full recovery been made? **YES/NO** (please delete as applicable). If **NO** please give further details:

Which question does this information relate to?

Date of occurrence (if more than one episode, please give all dates):

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If no further problem or treatment anticipated, has a full recovery been made? **YES/NO** (please delete as applicable). If **NO** please give further details:

FREE TEXT AREA BELOW FOR ANY ADDITIONAL INFORMATION TO BE DECLARED:

Empty text area for additional information to be declared.