

Corporate GlobalProtection

EMPLOYEE APPLICATION FORM



WILLIAM RUSSELL
Peace of mind wherever you are

YOUR PERSONAL DETAILS

First Names:

Surname: Mr / Dr / Mrs / Ms / Miss

Postal address:

E-mail address:

Tel No:

Fax No:

Date of birth:

Sex: Male Female

Nationality: (Please enclose a copy of your passport)

Your country of overseas residence:

Name of your employer:

Please state your current salary: (Proof of your salary will be required in the event of a claim)

What is your occupation?

Is your occupation 100% office based? YES NO

If no, please provide a full job description:

Do you ever work offshore? YES NO

If yes, please give details:

Do you participate in any hazardous activities? YES NO

If yes, please give full details of any hazardous activities you participate in including how often you participate:



HEALTH DECLARATION

It is very important that you make a full and accurate disclosure of your full medical history. We rely on the information you give in this form when we are assessing your application for cover.

1. Your height (cms) Your weight (kgs)

2. Have you ever:

- A. Undergone a surgical operation? YES NO
- B. Been a patient in a hospital clinic or sanitorium? YES NO
- C. Been advised to have any medical tests or investigations? YES NO
- D. Been tested HIV positive? YES NO
- E. Had an application for insurance turned down or accepted at special terms? YES NO

3. Are you aware of any symptoms present now which may give rise to a claim? YES NO

4. Are you currently taking any drugs or medication? YES NO

5. Have you ever been advised to follow any special diet? YES NO

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

- A. Conditions of the eyes, ears, nose or throat? YES NO
- B. Fainting, blackouts or fits? YES NO
- C. Any high blood pressure, heart or circulatory conditions? YES NO
- D. Diabetes? YES NO
- E. Any rheumatic or arthritic conditions? YES NO
- F. Any spine, bone, muscle or joint conditions? YES NO
- G. Asthma, respiratory or allergic conditions? YES NO
- H. Genito-urinary or renal conditions? YES NO
- I. Stomach, liver or bowel conditions? YES NO
- J. Cysts, tumour or cancer? YES NO
- K. Any skin conditions? YES NO
- L. Any gynaecological conditions? YES NO
- M. Any physical defect, infirmity or congenital illness? YES NO
- N. Any nervous, mental or psychiatric condition? YES NO
- O. Any alcohol and/or drug dependency problem? YES NO
- P. A higher than normal cholesterol level? YES NO
- Q. Any other type of disease, injury or medical condition? YES NO

7. (Females only) Have you ever suffered from any pre or post natal complications, complications of childbirth or suffered any miscarriage? YES NO

If you have answered YES to any question, please give full details on page 3.

PLEASE GIVE DETAILS OF THE DOCTOR(S) WHO IS/ARE MOST FAMILIAR WITH YOUR MEDICAL HISTORY

Name: _____

Practice Name: _____

Address: _____

Tel No: _____

Name: _____

Practice Name: _____

Address: _____

Tel No: _____



HEALTH DECLARATION

Question No.	State the diagnosis of the illness, or, if an injury, give details	Name and address of the treating physician	Date(s) on which the illness/injury occurred	Full details of the treatment/tests performed and the results	When did you last suffer from symptoms or receive treatment relating to this condition?	Is there any foreseeable need for further consultation or treatment for this condition? If yes, please give full details.



IMPORTANT

If we need to contact you for further information, please give us a personal contact number we can use:-

Telephone: _____

Fax: _____

E-mail: _____

BENEFICIARY NOMINATION

If you are applying for life insurance, we strongly recommend that you nominate a beneficiary.

NOMINATED BENEFICIARY/BENEFICIARIES

I hereby nominate the following person(s) as beneficiary (or beneficiaries) in the event of my death:-

Full name: _____ % of benefit to be paid: _____

Address: _____

Full name: _____ % of benefit to be paid: _____

Address: _____

Full name: _____ % of benefit to be paid: _____

Address: _____

Full name: _____ % of benefit to be paid: _____

Address: _____

Full name: _____ % of benefit to be paid: _____

Address: _____

IN THE EVENT OF THE DEATH OF ONE OR MORE OF THE ABOVE MENTIONED BENEFICIARIES

If one or more of the above named beneficiaries dies, we will divide the proceeds proportionately among the surviving beneficiaries. If this is not your wish, or if you would like to appoint an alternative beneficiary or beneficiaries in the event of the demise of the above beneficiary or beneficiaries, please state your wishes here:-

Your alternative instructions in the event of the death of one or more of the above named beneficiaries

DECLARATION

I hereby apply for cover under my company's Corporate Global Protection plan. I declare that the information I have given in this application form is true and complete.

I authorise the doctor(s) named above and any other doctor or medical practitioner who has attended me to provide William Russell Limited with any information they may require in connection with this application and/or in connection with any claim on my Global Protection plan.

ACTIVELY AT WORK DECLARATION

I declare that I am actively at work, i.e. consistently working my contracted number of hours and undertaking my normal duties and I am not working contrary to medical advice.

I agree that William Russell Limited and the Insurer may rescind this plan and release themselves from any liability whatsoever if it is proved that I have omitted to declare any relevant information, or have given incorrect, incomplete or misleading information.

Signature of applicant: _____

Date: _____

PLEASE ENSURE YOU HAVE GIVEN AN ANSWER TO EVERY QUESTION. AN INCOMPLETE FORM WILL DELAY YOUR APPLICATION.



WILLIAM RUSSELL
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