

Medical application form

Instructions

Please complete this form in English using CAPITAL letters.

Please take reasonable care to answer all the questions accurately. If you do not answer all the questions or withhold information, this may affect the assessment or acceptance of the policyholder's application for insurance and as a result the cover may be cancelled or its terms changed or a claim may be rejected in full or part.

Policy details

Policy holder

Policy number

Private and confidential

1 Personal details of group member

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other (please give details)

Forename(s)

Family name

Date of birth

Start date of employment

Job Title

How many hours a week do you work?

2 Contact details

Telephone number

Email address

By providing my email address I authorize Zurich to contact me and send me information or data by email.

3 Medical history

Please ensure the following questions are answered fully and honestly as incorrect information could invalidate your insurance claim.

(a) How many days have you been unable to work due to illness or accident in the past 2 years? _____ days

(b) Where you have been unable to work for more than 5 consecutive days, please provide the specific nature of the condition(s) that have caused the time off work and any treatment due to illness or accident.

Condition	Treatment

(c) What is your weight and height? Weight in kgs Height in cms

(d) Do you currently smoke or consume tobacco?

☐ Yes ☐ No

If 'Yes' please state the amount per day (cigarettes, cigars, gram(s) of pipe tobacco)

(e) Do you drink alcohol?

☐ Yes ☐ No

If 'Yes' please state the amount per week litres/beer glasses/wine measures/spirits

(f) In the last 5 years, have you ever taken any non-prescription or recreational drugs?

☐ Yes ☐ No

If 'Yes' please provide details

(g) Do you have or have you ever been diagnosed as having any of the following common medical conditions

i. Diabetes, raised blood sugar, blood pressure or cholesterol? ☐ Yes ☐ No

ii. Any disease of the heart, brain or any neurological disorder e.g. heart attack, stroke, multiple sclerosis, epilepsy? ☐ Yes ☐ No

iii. Any respiratory, digestive, renal or abdominal disorder e.g. asthma, Crohns, gallstones, fatty liver, kidney stones? ☐ Yes ☐ No

iv. Any blood disorder, infectious disease or any disorder related to the glands or reproductive system e.g. anaemia, hepatitis, thyroid disorders, testicular disorders, ovarian disorders? ☐ Yes ☐ No

v. Any cancer, growth, tumour (benign or malignant) including fibroadenoma and/or dysplastic naevus? ☐ Yes ☐ No

vi. Any musculoskeletal, connective tissue disease or any disorder of the eyes, ears and skin e.g. arthritis, back pain, lupus, blindness? ☐ Yes ☐ No

Medical history (continued)

Please ensure the following questions are answered fully and honestly as incorrect information could invalidate your insurance claim.

vii. Depression, anxiety or any sleep or mood disorder?

☐ Yes ☐ No

viii. Are you experiencing a persistent cough, fever and/or raised temperature?

☐ Yes ☐ No

If you have answered 'Yes' to any of the above common medical conditions, please provide the following details for each one:

Specific condition	Date of diagnosis	Duration of condition	Amount of time off work	Treatment, results and current status
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[illegible]

(h) Other than for the above, in the last 5 years, have you had any medical treatment including surgeries and/or periods of hospitalization or are you intending to seek medical treatment in the near future?

Treatment	Date of treatment	Specific condition	Results and current status
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4 Privacy Notice

The personal information requested in this form is collected and used by Zurich as Data Controller under applicable data protection laws. Full details of our privacy notice can be found at www.zurichinternational.com/im/legal/privacy.

5 Additional information

6 Declaration and consent

Declaration

- I declare that the information and statements made in this form, to the best of my knowledge, are true and complete.
- I understand that Zurich will only communicate with me using the contact details that I have supplied. Where I have provided more than one form of contact details, the most appropriate method of communication will be used depending on the urgency and sensitivity of the information.
- I understand that the insurance cover is subject to the terms and conditions between Zurich and the policyholder. It does not constitute any legal basis for a direct claim by me against Zurich.
- I understand that Zurich will communicate the terms of providing cover, including any exclusion, or any refusal or postponement of cover or any loading to be applied resulting from Zurich's medical underwriting decision to the policyholder or their broker or intermediary.

Consent

- I consent to Zurich processing my medical and health information provided in this form, and in any supplemental form, to underwrite the insurance cover requested by the policyholder
- I understand I have the right to withdraw this consent at any time and that such withdrawal will not affect the data processing carried out prior to such withdrawal.
- If I do not give my consent then I understand that Zurich will be unable to provide the proposed level of cover requested by the policyholder and may result in the loss of benefits.

Date

Signature of group member

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