Disability Application

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Individual Disability Application (Accident and Illness)

Before any question is answered, please read carefully the declaration at the end of this Proposal, which must be signed and dated. Please ensure that the person to be insured answers all questions fully and correctly. Any question left unanswered or only answered with a dash will delay the assessment of this Proposal for assurance. **NO ASSURANCE IS IN FORCE UNTIL THIS APPLICATION HAS BEEN ACCEPTED BY UNDERWRITERS AND THE FIRST OR SINGLE PREMIUM PAID.**

Please remember to review your answers to the questions above carefully

- If you fail to answer questions truthfully and accurately it is very likely that a claim will be declined and the policy, cancelled.
- If you are unsure as to whether information is material then you should disclose it.
- You must not assume that we shall be asking your doctor for confirmation of what you have told us.
- If your health or other circumstances change prior to your plan starting then you should advise us.

Section 1: Details of the person to be assured

◯ New Client ◯ Existing Client *Policy #* *(If known)*

Title *(Mr, Mrs, Miss, other)*		**Surname**		**Forenames**	
Address where coverage is requested					
Postcode		**Contact telephone number**		**Email address**	
Date of birth (mm/dd/yy)	**Sex** *(M, F)*		**Marital status** *(married, single, divorced, separated, widowed, in civil partnership)*		**Nationality**

Section 2: Personal information

Please provide your height and weight	**Height**		**Weight**	
Has your weight changed over the past 2 years?	◯ Yes ◯ No			
Body Mass Index (BMI)				
What is your occupation?				
What is your job function?				

Section 3: Employment, travel and activity information

What is the name of your employer?			
What is your job title?			
What is your employment status? **E.g.: employed / self-employed / contractor**			
What are your gross yearly earnings from your occupation stated above? *(if self-employed, please provide earnings as the amount assessable for income tax after allowable business expenses)*			
What is your average monthly income?			
	Yes	**No**	*If yes, please give full details*
Do your duties involve you in any way (other than clerical) with:			
a. working at heights, offshore, aviation (other than on scheduled flights), diving, or the fishing or mining industries, work requiring special safety precautions or any other activity which may be regarded as hazardous?	◯	◯	
Do you anticipate travel outside your normal country of residence or host country?	◯	◯	
Do you engage in hazardous sports, such as aviation, motor sports, diving, climbing or mountaineering etc.?	◯	◯	
Have you ever been convicted of a felony or misdemeanor or do you have any charges pending?	◯	◯	
Have you or any business in which you have had any ownership filed for bankruptcy in the last 5 years?	◯	◯	

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Section 4: Smoking and alcohol details

	Yes	No	If yes, please state average consumption per day
Have you smoked or used any form of tobacco or nicotine product within the last 12 months?	◯	◯	
Do you drink alcohol?	◯	◯	
Have you ever been medically advised to reduce your alcohol consumption?	◯	◯	*If yes, please give details*

Section 5: Benefits Requested

Please select the coverage options you want:	◯ **Temporary Total Disability (TTD)**	◯ **Permanent Total Disability (PTD)**	◯ **Both**
Commencement date required:			
Monthly Benefits for temporary total disability- TTD (if applicable)			
o Monthly Benefit requested (up to 60% monthly salary or $20k whichever is lower)*			
o Waiting Period requested (choose between 30-730 days):			
o Benefit Period requested (12 months - 120 months):			
Lump Sum Benefit for permanent total disability- PTD (if applicable)			
o Principle Sum requested (maximum 5x annual salary or $750k whichever is lower):			
o Waiting Period requested (choose between 6 months - 12 months):**			

** The policy will not pay more than 60% of the Pre-Disability Earnings of the Insured Person in respect of Total Disability monthly benefit less any amount received as Accident and/or Sickness benefit under any state or private scheme or insurance from any source.*

*** If you are purchasing both TTD and PTD Benefits, please make sure the minimum "Waiting Period" under PTD is equivalent to the "Benefit Period" selected under TTD . PTD benefit is only payable after TTD is paid out.*

**** Benefits limited at Age 58 and above. Please refer to quote for details.*

Section 6: Health Disclosures

	Yes	No	
Have you been absent from work for reasons of ill-health or injury for more than 15 consectutive days in the preceding 6 months?	◯	◯	***If you have answered Yes this question, please proceed to Section 7: Medical Questions. Otherwise proceed to Section 8.***
Are you actively at work?	◯	◯	***If you have answered No to this question, please proceed to Section 7: Medical Questions.*** **Otherwise proceed to Section 8.**
To the best of my knowledge, I am not suffering from illness of any kind.	◯	◯	***If you have answered No to this question, please proceed to Section 7: Medical Questions. Otherwise proceed to Section 8.***

Section 7: Medical Questions

Name of doctor who currently holds your medical records, or last healthcare provider seen			
Address and telephone number of medical provider listed above			
	Yes	**No**	
Within the last 5 years have you had or been advised to have a surgical operation or hospitalization?	◯	◯	
Have you received or requested benefits or payments because of an injury or illness or disability?	◯	◯	
Are you taking any medicine or drugs, whether or not prescribed by a medical practitioner, or are you receiving any treatment?	◯	◯	
Do you currently have or have you ever had:			
a. asthma, bronchitis, breathlessness or any chest or lung disorder?	◯	◯	
b. anxiety, depression, stress or other mental or nervous disorder?	◯	◯	

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	Yes	No	
c. arthritis, joint pains or inflammation, rheumatism or gout?	○	○	
d. epilepsy, seizures, fits, fainting or blackouts?	○	○	
e. any disorder of the digestive system, liver, stomach, pancreas or bowel (including ulcers, hepatitis, colitis or Crohn's disease)?	○	○	
f. diabetes, sugar in the urine, kidney, prostate or bladder problem?	○	○	
g. heart disease, heart attack, angina, heart defect, murmur, rheumatic fever, irregular heart beat or chest pain?	○	○	
h. high blood pressure or high cholesterol?	○	○	
i. stroke, brain haemorrhage or transient ischaemic attack?	○	○	
j. cancer, Hodgkin's disease, lymphoma, leukaemia, brain tumour or spinal tumour?	○	○	
k. lump, tumour, growth or any mole or freckle that has bled, changed colour, increased in size or become painful?	○	○	
l. multiple sclerosis, visual disturbance, optic neuritis, numbness, tingling, dizziness, balance problems, pins and needles, facial pain or paralysis?	○	○	
m. any disease or disorder of the veins or arteries (including disease in the legs or of the aorta)?	○	○	
n. any blood disorder, anaemia or blood clotting disorder?	○	○	
o. any thyroid disease or an overactive thyroid?	○	○	
p. (for females only) a cervical smear, gynaecological disorder or breast problem that has required further test or investigation?	○	○	
q. any operation, X-rays or special investigations including any investigation of the brain, nervous system or heart e.g. MRI scan, CT scan, angiogram?	○	○	
Are you due to have any check-ups in connection with any medical condition, or are you waiting for the result of any medical investigations?	○	○	*If yes, please provide full details.*
Have either of your parents or any brothers or sisters died from or suffered from heart disease, stroke, raised blood pressure, kidney disease, diabetes, hereditary disease, cancer, a nervous disorder, or mental illness?	○	○	*If yes, please provide details including which family members, the nature of the condition, their age when the condition was diagnosed, and state if death resulted. If the condition was cancer, please state which part of the body was affected.*
Within the last 5 years have you had any procedures, examination or tests recommended which have not been completed?	○	○	
Has any application for assurance on your life been declined, withdrawn by yourself or accepted at special terms?	○	○	*If yes, please give details of companies and dates.*

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	Yes	No	
Have you ever tested positive for HIV, hepatitis B or hepatitis C, or are you awaiting the results of such a test? If the result of an HIV test is negative, the fact of having the test will not, of itself, have any effect on your acceptance terms for insurance	◯	◯	*If yes, please give details including dates - for confidentiality these may be sent direct to the Chief Medical Officer.*
Within the last 5 years have you been exposed to the risk of HIV infection? *(Note: This can be caught through unsafe sex, injecting drug use, blood transfusion, therapeutic injections, or surgery undertaken in some countries outside the EU.)*	◯	◯	*If yes, please give details including dates - for confidentiality these may be sent direct to the Chief Medical Officer.*
Within the last 5 years have you tested positive or been treated for any infection which was transmitted sexually?	◯	◯	*If yes, please give details including dates - for confidentiality these may be sent direct to the Chief Medical Officer.*
Are you using or have you ever used drugs other than those prescribed by a doctor or obtained over the counter from a pharmacy? E.g. recreational drugs such as ecstasy, cocaine, heroin, etc. or herbal remedies.	◯	◯	

Section 8: Declaration

Please sign this Declaration once you have read it together with the Important Notes. 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 Declaration 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/We will inform you immediately of any changes that occur before the plan starts. I/We understand that failure to do so may result in the contract being declared void, and that a claim for the proceeds may not be paid.
- To the best of my/our knowledge and belief all the statements made, which includes anything I/we may have said, have been recorded accurately in this application or are attached in a sealed Private and Confidential envelope, and are true and complete. This disclosure will form the basis of the contract.
- I/We agree to Clements obtaining medical information from any doctor whom I/we have consulted about my/our physical or mental health, in order to assess my/our proposal. 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/we have applied for. I/We authorize those asked for such information to provide it on the production of a copy of this consent. This consent allows Clements to obtain medical reports at any time during the life of the cover or after my death to support any claim made on the cover proceeds.

IT IS UNDERSTOOD AND AGREED BY THE INSURED:

1. That all answers to the questions on this application, to the best of my knowledge and belief, are complete and true,
2. That all answers on this application shall for the basis of the issuance of any coverage hereunder,
3. That in the event of any fraud, misstatement, concealment, or failure to disclose information in response to any question on this application, whether intentional or inadvertent, any insurance coverage issued based upon this application may become void, and no benefits shall be payable, and
4. I have read or had read to me and understood each of the questions and statements on this entire application.
5. No one has prevented me from spending as much time as I felt was necessary to understand this application.

By typing your name below you are signing this declaration that I am/we are allowing Clements to process my/our application using the information that I/we have provided. This information can also be used to process any claim made on this policy. I declare that the answers to the questions on this proposal are true and complete to the best of my knowledge and belief and shall form the basis of my contract between Clements and me.

Individual to be assured:

Signature	**Date** *(mm/dd/yy)*	**Country of signing**
_____	_____	_____

Submit Completed Application to medicalservices@clements.com