

# Life Cover: application and amendment form

National Health Service

Additional Voluntary Contributions Facility

Name of scheme	<input type="text"/>			
Scheme reference number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

(Please refer to your AVC benefit statement if you have one)

Please read the key features document as this will provide you with important information regarding the key risks and benefits of the product to help you make a decision.

## Part 1 – Personal details

**I wish to** (please tick appropriate box)

- a) Apply for life cover (where this is currently zero)  complete all except Part 4A
- b) Change the level of my life cover  complete all except Part 3
- c) Stop my life cover  complete Part 4A
- d) Amend my life cover and AVC contribution  complete all except Part 3

**Please note that parts 1, 2 and 7 should be completed in all cases.**

Title      Mr       Mrs       Miss       Other

First name(s)

Surname

N. I. number

Date of birth

Gender      Male       Female

Status      Married       Single       Civil partnership

Address

Postcode

Email address

Telephone number (please include area code)

## Part 2 – Employment details

Employer's name

Payroll office address

Postcode

Payroll office contact name and telephone number (if possible) including area code

Payroll reference number (see last payslip)

Current annual salary

When did you first join the main NHS Pension Scheme?

On or before 31st March 2008

On or after 1st April 2008

### Occupation:

General practitioner

Dental practitioner

Special class retirement age 55

Special class MHO who joined pre 6/3/95

Other

## Part 3 – Life cover

Please complete this part if you are currently not covered for life cover under the NHS AVC facility. The total life cover is subject to an overall scheme limit, and you should refer to your main scheme administrator for details on the limits applicable.

Total benefit (£5,000 minimum)

I would like this total benefit to be paid in the following way, in the proportions specified below:

to be paid as a lump sum\*

to be used to buy dependants' pensions

I understand that the cost of providing these benefits will increase in three year bands based on my age on the next scheme anniversary. These will be deducted either from my existing level of AVCs, or from the amended level of contribution I have specified in Part 4B unless my application is subject to underwriting.

\* You should refer to your main scheme administrator to confirm the maximum level of cover allowable.

### Part 3 – Life cover – continued

I understand that life cover will stop when I retire, leave service or stop paying.  
If Prudential underwriters find that cover cannot be started at normal rates you will be informed of their decision and of any options available to you.

### Part 4A – Amendments to life cover

I wish to amend my life cover under the facility as follows:

<b>From</b>	Lump sum	<input type="text" value="£"/>
	Dependants' pension	<input type="text" value="£"/>
<b>To</b>	Lump sum	<input type="text" value="£"/>
	Dependants' pension	<input type="text" value="£"/>

Where you wish to end your life cover under the facility, please enter NIL in the boxes above. If you are applying to increase your life cover please complete Part 5 – Medical information. If you are not actively at work please defer your application until you have been actively at work for a period of at least two months (excluding maternity leave).

## Part 4B – Amendment of contributions

If you are currently paying AVCs to provide life cover only, you will need to adjust the level of AVCs to be monetary amounts and not a percentage of salary.

### Please amend my AVCs as follows:

Existing regular contributions

% of salary **or**  £ gross

New contribution level

% of salary **or**  £ gross

Please state how you are paid. Your contributions will be deducted with the same frequency as you are paid.

Weekly  Fortnightly  Four-weekly  Monthly  Quarterly

### Important information

The government limits the amount that can be contributed every year before incurring tax penalties. This is called the "Annual Allowance". Further details can be found in your Key Features Document.

Tax relief is available up to 100% of earnings, however tax relief will only apply to age 75.

Pension income will be taxed as earned income.

This information is based on our understanding, as at September 2014, of current taxation, legislation and HM Revenue & Customs practice, all of which are liable to change without notice. The impact of taxation (and any tax reliefs) depends on individual circumstances.

### Important notes

Please use **block capitals** and tick or complete answers as appropriate. Please help us by filling in the application form honestly and in full. If you miss any information out, or give us misleading information, it may mean that we do not pay your claim. In addition, this could also delay the processing of your application. If you are uncertain about whether any particular fact would influence our decision, you should include it. If you do not, it may mean that a claim in the future will not be paid. You should not assume that we will obtain a report from your doctor.

Please check that all the details are correct before you sign the declaration. You are responsible for your answers. If you make a mistake please cross it out, put in the correct word or words and initial next to the correction. Do not use any kind of correction fluid.

It is very important that you tell us if there is a change to your health between completion of this form and your plan starting. If you do not, a claim in the future may not be paid.

### Genetic test results

- › If this application, taken together with any other insurance policies you already have, is for life insurance up to a sum of £500,000 you need not disclose any genetic test you may have had.
- › You need not disclose the result of any genetic test undertaken in the context of research.
- › Genetic test results need only be disclosed where the sum exceeds £500,000 and their use by insurers has been independently approved.
- › You may, of course, disclose any genetic test result that is in your favour.
- › If you have a family history of, are receiving treatment for or experiencing symptoms of a genetic condition, you must tell us.
- › If you wish to disclose to us a negative genetic test result, which shows that you have not inherited a genetic disorder, we will take this into account in setting your premium, providing your clinical geneticist confirms that the test result indicates a reduced risk of developing the inherited disease.
- › Further information is available on request, which fully explains this policy and details those genetic tests approved for use by insurers.

Name, address and telephone number of your usual doctor

Name

Current address

<input type="text"/>
<input type="text" value="Postcode"/>

Telephone number  
(please include area code)

How long has he/she been your doctor?  years

**Important:** If you answer Yes to any of the questions, please give details in the space provided. If you need more space there is room at the end of this section. This section must be completed with full answers to the questions. Please answer all questions applicable to you.

1. What is your height?

What is your weight?

2. a) Have you in the last five years consulted a doctor or any other medical professional for any form of advice, operation, x-ray, check-up or any other investigation or test or are you intending to do so? (colds, influenza, minor injury and routine pregnancy consultations may be excluded). Yes  No

b) Are you currently, or have you been in the last 5 years prescribed medication, counselling, therapy or any other form of treatment? (oral contraception can be disregarded). Yes  No

If you have answered Yes to question 2a or b, please give full details including dates, treatment and periods off work.

## Part 5 – Medical information – continued

3. a) Have you ever tested positive for HIV, Hepatitis B or C or are you awaiting the results of such a test? Note: If the result is negative, the fact of having an HIV test will not, of itself, have any effect on your acceptance terms for insurance. Yes  No

If Yes, please give full details.

Name of doctor, hospital or clinic

Date

D	D	M	M	Y	Y	Y	Y
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Details or description

- b) Within the last five years have you been exposed to the risk of HIV infection? (This can be caught through unsafe sex, intravenous drug abuse, or blood transfusions or surgery undertaken outside the EU). Yes  No

If Yes, please give full details including dates.

- c) Within the last five years have you tested positive or been treated for any disease, which was transmitted sexually? Yes  No

Name of doctor, hospital or clinic

Date

D	D	M	M	Y	Y	Y	Y
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If Yes, please give full details.



**Part 5 – Medical information – continued**

4. Have you ever been declined (refused cover), charged extra or offered non-standard terms for life, health, accident or critical illness insurance by any company? Yes  No

If Yes, please give full details including decision, date and company.

5. Have you been continually absent from work for two months or more? Yes  No

Date first absent

D	D	M	M	Y	Y	Y	Y
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Reason for absence

**Note:** If you have answered Yes to question 5 above, you cannot apply for additional life cover until you have been continuously and actively at work for two months.

## Supplementary medical questions

6. Has your father, mother or any brother or sister suffered, or died, prior to age 65 from:

cancer Yes <input type="checkbox"/> No <input type="checkbox"/>	heart disease or disorder Yes <input type="checkbox"/> No <input type="checkbox"/>	stroke or diabetes Yes <input type="checkbox"/> No <input type="checkbox"/>	multiple sclerosis or Alzheimer's disease Yes <input type="checkbox"/> No <input type="checkbox"/>
muscular dystrophy Yes <input type="checkbox"/> No <input type="checkbox"/>	motor neurone disease Yes <input type="checkbox"/> No <input type="checkbox"/>	Huntington's disease Yes <input type="checkbox"/> No <input type="checkbox"/>	polycystic kidney disease Yes <input type="checkbox"/> No <input type="checkbox"/>
polyposis of the colon Yes <input type="checkbox"/> No <input type="checkbox"/>	any other potentially hereditary disease or disorder Yes <input type="checkbox"/> No <input type="checkbox"/>		

If Yes, please complete this table.

Relationship			
Illness (if cancer, which part of the body was affected?)			
Age at onset			
Age at death (if applicable)			

7. Have you ever had, or suffered from, any of the following:

- > Alcohol or substance abuse
 Yes  No
- > Asthma, bronchitis or chest complaint
 Yes  No
- > Arthritis, joint pain or blood disorder
 Yes  No
- > Back or spinal problems, rheumatism or musculo-skeletal problems
 Yes  No
- > Cancer, growth, tumour, cyst or enlarged glands
 Yes  No
- > Diabetes or thyroid disorder
 Yes  No
- > Digestive or bowel disorder
 Yes  No

## Supplementary medical questions – continued

- › Ear or eye disorder Yes  No
- › Heart condition, chest pain or palpitations Yes  No
- › Kidney, bladder, urinary or liver disorder Yes  No
- › Nervous or mental disorder including anxiety, depression, stress or psychiatric disorders Yes  No
- › Raised blood pressure, stroke or epilepsy Yes  No
- › Paralysis or multiple sclerosis Yes  No

If Yes, please give full details for each condition including dates when first diagnosed.

8. Do you, or do you intend to, participate in any sport or pastime that involves any additional risk of accident such as, but not limited to, motor/motorcycle sports, mountaineering, underwater activities, private flying or hang gliding? Yes  No

If Yes, please give full details including number of events or hours you undertake per annum.

9. Have you ever travelled or resided abroad, other than for normal holidays, or do you intend to do so in the future? Yes  No

If Yes, please give full details including countries concerned, duration and reason.

## Supplementary medical questions – continued

### 10. Habits

- a) What is your average weekly consumption of alcohol in units?  
(1 unit = 1 measure spirit/wine or 1/2 pint beer)

Have you ever been advised to reduce or cut  
down your alcohol intake?

Yes  No

If Yes, please give details.

- b) Have you ever taken recreational drugs? (i.e. drugs  
taken other than as treatment for a medical condition)

Yes  No

If Yes, please provide full details.

- c) Have you smoked or used any tobacco products in the  
past 12 months? (Includes cigars, cigarettes, any  
nicotine replacement therapy etc).

Yes  No

If you smoke cigarettes, how many do you smoke per day?

**You may be asked to undergo a test to confirm your non-smoking status.**

**Additional information**

### Access to medical reports

We may need to get medical reports to support your application. Before we can ask any doctor that you have consulted to fill in a report, we need your permission under the Access to Medical Reports Act 1988. Your rights under the act are as follows.

You do not need to give your permission, but if you do not, we may not be able to go ahead with your application. This does not prevent you from applying to other companies for insurance.

You can ask to see the report before the doctor returns it to us. If this is the case, we will tell the doctor to keep the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.

If you choose not to see the report at this stage, you may ask the doctor for a copy within six months of it being sent to us. We can send a copy of the report to your doctor if you ask to see it at a later date.

If you think that any part of the report is not correct or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him or her to attach a statement outlining your views, which will then accompany the report.

Your doctor can withhold access to the report if he or she feels that it would cause physical or mental harm to you or others.

### The medical report your doctor fills in asks about the following:

Your current health:

- any care, medication or treatment you are currently receiving
- the results of referrals or tests you are waiting for

Any time off work in the last three years.

Your past health:

- details (excluding minor self limiting ailments/conditions) of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your doctor or any other medical adviser, therapist or counsellor, in particular whether you have a history of:
  - malignancy (cancer), cardiovascular (heart) disease, diabetes, and degenerative (gradually worsening) diseases
  - musculo-skeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles

## Part 5 – Medical information – continued

- anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue
- suicidal thoughts or attempts at suicide
- conditions related to drug or alcohol misuse or smoking or chewing tobacco
- › details of any biopsies, blood tests, electrocardiograms (heart tests), diagnostic genetic test results, height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations
- › any blood pressure readings in the last three years
- › any history of disease among your parents or brothers or sisters that you have told your doctor about.

We have asked your doctor not to reveal information about:

- › negative tests for HIV, Hepatitis B or C
- › any sexually-transmitted diseases unless there could be long-term effects on your health
- › predictive genetic test results.

The information you and your doctor provide about your health may result in us:

- › refusing to provide insurance
- › setting exclusions or postponing cover
- › increasing premiums above standard rates
- › setting premiums at standard rates.

If you have any questions about your rights under the act or questions relating to the process of getting, assessing or storing medical information please write to:

The Chief Medical Officer, Prudential, Lancing, BN15 8GB.

I do not want to see the report before it is sent to Prudential.

I want to see the report before it is sent to Prudential.

(Tick one box only)

Signature

X

Date

D	D	M	M	Y	Y	Y	Y
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### Important notes

In most instances your payments for life cover will be as originally quoted. We may offer you revised terms, but occasionally we may not be able to offer any terms.

We may ask you to contact your doctor if we are waiting for reports which we have asked for.

If we ask you to come for a medical examination, we will need to share the application information with another company we have authorised. They will make the arrangements for the examination to take place.

We may need to send your application and relevant medical reports to our reassurers for their opinion or agreement of the terms offered, or we may need to send them at a later stage for purposes relating to managing the policy. You can get details of general reinsurance principles and details of any company we use to assess your application from our Head Office.

We have a confidentiality policy in place which means we hold your medical information securely and access is limited to authorised individuals who need to see it.

On occasion the faxing of medical reports may help to ensure a speedier assessment of your application. Prudential only accepts faxed information direct to a fax machine in a secure part of its customer services office. This ensures that strict confidentiality is maintained. If you do not agree to allow the faxing of information, please indicate this in the appropriate section of the Declaration.

If you are applying for life assurance 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, we will ask for your specific written permission before doing so.

A copy of the completed form, is available on request.



## Part 7 – Declaration

- › I authorise the deductions from my earnings of any level of Additional Voluntary Contributions (AVCs) specified above.
- › I confirm that I am a contributing member of the National Health Service Pension Scheme (NHSPS). I authorise the deductions from my earnings of any level of Additional Voluntary Contributions (AVCs) specified on this AVC application form.
- › I declare that the total of my contributions does not exceed the limits described in Part 4.
- › I understand that any benefits which become payable will be paid in accordance with the National Health Service Pension Scheme (Additional Voluntary Contributions) Regulations. I also accept the provisions listed in Part 6.
- › I understand that the AVC arrangements are governed by the provision of the National Health Service Pension Scheme (Additional Voluntary Contributions) Regulations.
- › I understand that due to restrictions imposed by HM Revenue & Customs, I cannot receive tax relief on more than 100% of my total remuneration in any tax year as contributions. This includes the cost of my life cover and any contributions that I make to my other pensions.
- › I understand that my life cover will be subject to medical checks carried out by Prudential and will only commence on successful completion of these checks. I will receive a letter confirming the start date of my cover when Prudential are satisfied that I have complied with all their criteria.
- › I understand that the life cover will cease on my retirement, leaving service, or failure to make premium payments.
- › I understand that this application is subject to written acceptance by Prudential.
- › I agree to you asking any doctor I have consulted about my physical or mental health to provide medical information so you can assess my application. You may gather relevant information from other insurers about any other applications for life, critical illness, sickness, disability, accident or private medical insurance that I have applied for. I authorise those asked to provide medical information when they see a copy of this consent form. This form allows you to gather medical reports within six months of the start of the plan, or after my death, to support any claim made on the plan proceeds.

## Part 7 – Declaration – continued

- › I declare that nothing material has been withheld and that the information given on this form is true. I understand that failure to disclose a material fact, which may influence the assessment and acceptance of this Declaration, may result in the contract being declared void and that a claim for the proceeds may not be paid.
- › To the best of my knowledge and belief all the statements made, which includes anything I may have said, have been recorded accurately in this application and are true and complete. This disclosure will form the basis of the contract and benefits may be lost if material facts are not disclosed.
- › I will inform you immediately of any changes that occur before the plan starts.
- › I agree to Prudential accepting medical reports faxed directly to Prudential from my doctor's surgery. I do not\* object to copies of the report being faxed to any other company that I have applied to at their request.  
**(\*Delete the word "not " if you do not want us to fax information.)**
- › This information can also be used to maintain management information for business analysis.
- › I consent to the company requesting a medical report from my doctor after the contract has commenced and agree that if I have not disclosed all information relevant to my application, the company may need to reconsider the terms offered to me or cancel my cover.
- › By signing this declaration I am allowing you to process my application using the information that I have given. You may also use this information to process any claim made on this policy.
- › I have read the declaration, important notes and information relating to my rights under the Access to Medical Reports Act.

For your own benefit and protection, you should read carefully the documentation provided before signing this form. You should also read carefully any further documentation provided to you in the future. If there is anything you do not understand, please ask us for further information.

**How we use your personal data**

The Prudential Assurance Company Limited, its group companies\*, its business partners and the trustees or managers of the scheme will use your information together with other information for administration, customer services and profiling your purchasing preferences. We will pass your information to them (including our service providers and agents) for these purposes. We will pass your information to any legal or regulatory body if required to do so.

For certain products, we will need to process your sensitive personal data, such as health data. It may also be necessary, for the above purposes, to transfer your information to countries that provide a different level of data protection from the UK. In such circumstances, we will put a contract in place to ensure your information is protected. By completing and submitting this form, you consent to us processing your sensitive data and to the processing mentioned above.

You have a right to obtain a copy of your personal information (for which we may charge a fee) and to have any inaccuracies corrected by writing to: The Information Risk & Security Team, The Prudential Assurance Company Ltd, Lancing, BN15 8GB. To make sure we follow your instructions correctly and to improve our service to you through training of our staff, we may monitor or record communications.

Signature

X

Date

D	D	M	M	Y	Y	Y	Y
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