William Russell

Personal Protection Insurance

Application form for individuals

Please complete this form in **BLOCK CAPITALS** using black ink, and return it to us by email or post. You can find our contact details at the end of this form.

Broker/intermediary details

If you were introduced to us through an intermediary or broker, please state their name and company:

.....

Your personal details

First name: ..... Surname: ..... Title: .....

Address where you will be living/working: .....

..... Country where you will be living/working: .....

How long have you lived here? ..... years Nationality: .....

Date of birth (dd/mm/yy): ..... Gender: ◯ Male ◯ Female

Email: ..... Phone number .....

Your policy

Please state the reference of the quote you wish to accept: .....

When would you like your policy to start? ◯ On acceptance of your application ◯ Specific date: .....

Please note your application is only valid for 90 days from the date you sign it. We cannot backdate your insurance cover.

Previous/current insurance

1 Have you **ever** applied for a plan or been insured with William Russell? ◯ Yes ◯ No

If **YES**, please state the plan number: ..... Date of expiry of plan: .....

2 Have you **ever** had an application for insurance declined or accepted with special terms, or had an insurance policy cancelled by any insurance provider? ◯ Yes ◯ No

If YES, please provide details: .....

.....

3 Do you currently have any other life, Accidental death & permanent disablement, critical illness or income insurance? ◯ Yes ◯ No

If **YES**, please state the name of insurer: .....

Type of insurance: ..... Amount of cover: .....

Policy number: ..... Date of expiry of plan: .....

Your occupation

Occupation: ..... Industry: .....

Are you self-employed? ◯ Yes ◯ No

Please state your current annual earnings (including the currency): .....

Please state the name and registered address of your business/employer: .....

.....

Is your occupation 100% office-based and/or a home office environment? ◯ Yes ◯ No

If **NO**, please describe your duties that are non-office based in detail. How much of your time as a percentage do you spend carrying out these duties that are not office-based? .....

Your occupation (continued)

Do you ever work at heights, underground, in the air, on water, underwater, or offshore? (eg oil rigs, mines, diving, etc) ◯ Yes ◯ No

If **YES**, please give full details: .....

.....

.....

Does your work require a license which depends on your state of health? ◯ Yes ◯ No

If **YES**, please give full details: .....

.....

.....

Do you ever participate in hazardous activities? ◯ Yes ◯ No

If **YES**, please give full details of any activities and how often you participate in them: .....

.....

.....

Hazardous activities

The cover afforded by your plan may be affected if your occupation is not 100% office based and/or working from home, of if you participate in Hazardous activities. Cover for higher risk occupations or hazardous activities may be subject to a premium loading and/or special terms.

Hazardous sports and activities include (but are not limited to) off-piste or freestyle skiing/snowboarding; rock climbing; mountaineering, potholing or caving; hang-gliding or parachuting (including tandem); bungee jumping: kite surfing or any other activity which has a similar degree of danger.

If you want to know more, please follow this link.

If you participate in a hazardous sport or activity and want this covered. Depending on the type of cover applied for, the sports/activities involved and the level of participation, we may be able to provide cover on our normal terms or with a premium loading or an exclusion. If you are uncertain about whether a sport or activity would be classed as hazardous, please contact us.

Do you ever participate in hazardous activities? ◯ Yes ◯ No

If **YES**, please give full details of any activities and how often you participate in them: .....

.....

.....

Beneficiary nomination

If you have selected a life insurance plan, please complete our beneficiary nomination form.

Paying for your plan

Please select the currency in which you would like to pay your premiums. The currency you select will also be the currency in which your plan benefits will be denominated.

◯ US dollars ◯ Pounds sterling ◯ Euros

Please select your payment method and frequency:

Credit/debit card	◯ Annually	◯ Half-yearly[2]	◯ Quarterly[3]	◯ Monthly[3]
Direct debit[1]	◯ Annually	◯ Half-yearly[2]	◯ Quarterly[3]	◯ Monthly[3]
Bank transfer	◯ Annually			

[1] Direct debit payments are only available when you pay in pounds sterling from a UK bank account.
[2] We apply a 3% surcharge to half-yearly premiums.
[3] We apply a 5% surcharge to quarterly or monthly premiums.

Health declaration

We rely on the information you give us in the form to decide whether or not we can accept your application, and if so, whether or not we need to apply any special terms to your cover. Please complete the following health declaration and provide us with full details of any medical conditions. Pre-existing medical conditions and related conditions will not be covered by your plan, unless you have told us about them and we have agreed to cover them.

Please answer the following questions fully, accurately, and to the best of your knowledge. If you answer YES to any question, please supply full details in the spaces provided. If there is insufficient space please continue on an additional sheet of paper. If, after you have submitted the application, we find that you have not answered the questions fully and accurately, your plan may be cancelled, claims may be rejected, or special terms may be applied retroactively.

If you are in any doubt as to whether you should tell us anything, please tell us anyway. It better to provide information that turns out not to be relevant than to miss out something that causes problems later. If something changes after you have sent us the form but before we have confirmed your cover has started, you must write in and update us.

	Details
What is your height? (cm)	
What is your weight today? (kg)	
Has your weight changed by more than 10 kg in the last 2 years? If **YES**, please provide details	◯ Yes ◯ No .....
In the last 12 months have you smoked cigarettes, cigars or used any nicotine products? (nicotine products include electronic cigarettes, patches, lozenges, inhalers and sprays) If **YES**, please give the average number a day:	◯ Yes ◯ No .....
Do you regularly drink more than 15 alcoholic drinks per week? If **YES**, how many of the following do you drink each week? • Pints of regular-strength beer/cider • Pints of strong beer or cider • 175ml glasses of wine • 250ml glasses of wine • 35ml measures of spirits	◯ Yes ◯ No ....

1 Have you consulted a healthcare practitioner in the last 3 years? ◯ Yes ◯ No

If **YES**, please give full details including the date and reason for each consultation, details of any diagnosis, investigations, medication or treatment and whether any treatment or medication is ongoing (continue on an additional sheet of paper if required):

.....

.....

2 Have you **ever** tested positive for hepatitis B or hepatitis C, or are you awaiting the results of such a test? ◯ Yes ◯ No

If **YES**, please provide full details:

.....

.....

3 Have you **ever** suffered from, or been diagnosed with, treated for or prescribed drugs for:

a) **Auto-immune disorders?** ◯ Yes ◯ No
For example: HIV/AIDS, rheumatoid arthritis, systemic lupus erythematosus, scleroderma.

b) **Cancer, growths or tumours?** ◯ Yes ◯ No
For example: any type of cancer, pre-cancerous conditions, lymphomas, polyps, benign growths or cysts.

c) **Back, joint, muscular or skeletal problems?** ◯ Yes ◯ No
For example: back or joint pain, whiplash, sciatica, degenerative changes, osteoarthritis, osteoporosis, gout, bunions, joint replacements, fractures, cartilage or ligament problems.

d) **Diabetes, thyroid or any other endocrine disorder?** ◯ Yes ◯ No
For example: diabetes type 1 or 2, overactive or underactive thyroid, pituitary or adrenal problems, obesity.

e) **High blood pressure, cardiac or circulatory conditions?** ◯ Yes ◯ No
For example: angina/chest pains, heart attack or failure, abnormal heartbeat, palpitations, varicose veins, stroke, deep vein thrombosis, high cholesterol.

Health declaration (continued)

f) **Breathing or respiratory conditions?** ◯ Yes ◯ No
For example: asthma, bronchitis, pneumonia, chronic obstructive pulmonary disease (COPD), emphysema.

g) **Stomach, liver, gall bladder, or digestive system conditions?** ◯ Yes ◯ No
For example: ulcers, irritable bowels, Crohn's disease, colitis, reflux/heartburn, abdominal pain, hepatitis, cirrhosis, gallstones, hernias, haemorrhoids/piles.

h) **Any depression, anxiety or other psychiatric or psychological conditions?** ◯ Yes ◯ No
For example: anxiety, bipolar disorder, schizophrenia, stress, low mood, depression, eating disorders.

i) **Any urinary, kidney or prostate conditions?** ◯ Yes ◯ No
For example: chronic kidney disease, kidney stones, recurrent kidney, bladder or urine infections, prostate conditions, raised PSA level.

j) **Any alcohol and/or drug dependency problems?** ◯ Yes ◯ No

k) **Any other medical condition not mentioned above?** ◯ Yes ◯ No

If you have answered YES to any of the above questions...

If you have answered **YES** to any of the above questions, please provide full details for each condition. If full details are not provided, this may delay or prevent us from putting your cover in place.

No.	Diagnosis	Date of onset of condition	Frequency and severity of symptoms and date of last symptoms	What investigations have you had? (include date and result)	Treatment and medication (include start and end date)	Current status

If you require more space, please continue on a separate sheet of paper. If you are attaching any supporting medical documents, please note that we can only accept them in English.

4 In the last 3 years, have you been told the result of any medical test you have had was abnormal? ◯ Yes ◯ No

Month/year	What was the test?	What was the reason for it?	Have you had a subsequent test that you have been told was normal?

5 Do you have any other signs, symptoms, conditions, disabilities or impairment for which the following apply: ◯ Yes ◯ No

- You are waiting to see/ still under follow-up by a GP or specialist
- You are waiting to have tests or investigations or to receive the results
- You are due to have surgery
- You are on medication prescribed or otherwise
- You routinely use any type of aid except spectacles and lenses

If **YES**, please give full details:

Month/year of onset: ..... Month/year of last symptoms: ..... Duration of symptoms .....

Number of days off work: ..... Condition and cause if known: .....

.....

.....

Treatment and medication (please state if ongoing) .....

.....

.....

(If you require more space, please continue on a separate sheet of paper)

Health declaration (continued)

6 Have you been absent from work for more than 5 consecutive days in the last 5 years for reasons other than annual leave? ◯ Yes ◯ No

If **YES**, when was each absence period?

From: ..... To: ..... Reason: .....

.....

From: ..... To: ..... Reason: .....

.....

Are you fully recovered from the illness/injury that caused each absence? ◯ Yes ◯ No

If **NO**, please provide full details: .....

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(If you require more space, please continue on a separate sheet of paper)

How we use your information (please read this section carefully)

- We use the data you provide for the purposes of administering your insurance cover, processing your claims, identifying and preventing fraud, complying with our legal and regulatory obligations, and carrying out research and statistical analysis to help us improve our services. We won't retain your data for longer than is necessary.
- We may share your data with other organisations in relation to the above purposes (e.g., the insurer of your plan, our payment service providers). This may involve us transferring your data to countries outside the European Union.
- We may record your telephone calls to and from William Russell for training and monitoring purposes.
- We'll process your personal data (including sensitive data such as details about your health and well-being) in accordance with our privacy policy.
- Our privacy policy contains information about who to contact if you have any questions about how we use your data, or if you would like to request a copy of the data we hold about you. Please see our privacy policy for full details.

Marketing communication preferences

We'd like to stay in touch with you in ways we think you might find helpful. Every now and then, we share information about international healthcare and expat life, plus other useful content we think could be of interest to you. We also send occasional emails that promote our products and services.

We won't spam you or share your details with third parties, and you can unsubscribe at any time. Please see our privacy policy for full details.

Opt in to the following communications from us:

◯ Email
◯ Newsletter
◯ Telephone
◯ Text message/SMS

Free Accidental Death cover

If you are applying for Life Cover, we understand how important this protection is in providing piece of mind should the worse happen, which is why we provide Free Accidental Death cover for those applying with us for the first time.

◯ If you wish not to benefit from Free Accidental Death cover, you are able to opt-out by ticking this box.

Declaration for your plan (please read this section carefully and sign below)

- I understand that my application for a life and/or income protection plan is subject to written acceptance by William Russell.
- I declare that I have taken reasonable care to answer every question fully, accurately, and to the best of my knowledge and belief.
- I understand that misrepresentation could result in claims being rejected or not fully paid, and/or my plan being cancelled.
- I understand that the plan I am applying for does not cover medical conditions that existed before the proposed start date of the plan, unless I have provided full details of any such medical conditions to William Russell and William Russell has agreed to cover them. I also understand that I will be advised of any medical conditions that are not covered by the plan, based on the information I have provided on this form.
- I understand that I must inform William Russell, in writing, of any changes in the facts provided in my application occurring before the start date of my plan.
- In order to process my claims, I understand that William Russell may need to obtain details of my medical history.
- I authorise William Russell to send all insurance documents as PDF files to the email address I have provided on this form. If I have applied through a broker or intermediary, I understand these documents may be sent via email to that broker or intermediary.
- I hereby apply for membership of the William Russell Association for Health, Financial Protection and Well-Being and agree to the Association membership rules.

Some important notes

Please make sure that this form and all supplementary documents are legible. Your completed application form is valid for 90 days from the date you signed the form. If cover has not commenced within 90 days, you may have to complete a new form. If your health changes after you submit this form but before your plan starts, you must let us know immediately.

You must provide us with a copy of your passport and a utility bill less than four months old confirming your residential address. If you are applying for a life plan, please also provide proof of your salary.

Please return this form to us by post or email using the contact details below. If you wish to use email, we can accept a printed, signed, and scanned copy of this form or we can accept a digitally-completed copy of this form saved and returned to us as a PDF. If you have completed this form digitally, please make sure that the email accompanying the return of this form contains the following text: -

"I, [your name], have completed and signed the application form myself and I am happy to be bound by the terms, conditions, and exclusions of the personal protection plan agreement."

You must use the same email address to return the digitally-completed form that you provided on the first page of this form.

Name of applicant: .....

Signature of applicant: ..... **Date:** .....

Application checklist	Attached	To follow
Passport: Either a scanned copy or a clear colour photograph of your passport.		
Proof of Address: Either a scanned copy or a clear colour photograph of an official document that shows your home address.		
The below only if applying for life cover above US$200,000 (£160,000/ €180,000)		
Proof of Earnings: Either a scanned copy or a clear colour photograph of an official document that shows the applicants proof of earnings.		

Contact details
T +44 1276 486 477
E sales@william-russell.com
william-russell.com

William Russell Europe SRL
Place Marcel Broodthaers, 8
B-1060 Saint-Gilles
Brussels

William Russell

Beneficiary nomination form

Please complete this form in **BLOCK CAPITALS** using black ink, and return it to us by email. You can find our contact details at the end of this form.

Your personal details (the insured person must complete this form)

Full name of insured person: ..... Title: .....

Policy number: .....

If you're receiving your insurance cover as an employee benefit provided by your employer, please state the name of the company:

.....

Beneficiary nomination

I hereby nominate the following person(s) as beneficiary of my life benefit, my accidental death & disablement benefit (if applicable to my insurance cover), and my funeral costs & repatriation benefit (if applicable to my insurance cover) in the event of my death.

No.	Full name	% of benefit to be paid	Address	Relationship to insured person
1.				
2.				
3.				

Important information

- If you have not appointed a beneficiary at the time of your death, the beneficiary of your insurance cover shall be:
  - your spouse; failing them
  - your legally declared child(ren) in equal shares; and failing them
  - your estate.
- By spouse, we mean your legal spouse by marriage or civil partnership, or your partner living as your *de facto* spouse on a genuine, domestic basis. A partner making a claim in the event of your death may not have the same rights attributed to a legal spouse. If you wish your insurance benefit to be paid to your partner, we suggest that you name that partner as beneficiary.
- If your insurance cover includes the funeral costs & repatriation benefit, we'll pay the benefit to the beneficiary occupying the first row of the above table. This beneficiary will be known as the 'lead beneficiary'.
- If the death of one or more of your beneficiaries precedes your own, we will share the proportion of your insurance benefit that otherwise would have been paid to those deceased beneficiaries between any surviving beneficiaries, in proportion with the percentages you've specified for those surviving beneficiaries.
- If you are diagnosed with a terminal illness, we will pay your life benefit directly to you.
- Please state your wishes below if you would like to nominate alternative beneficiary/beneficiaries in the event that the death of any of the beneficiaries in the above table precedes your own, or if you would like us to pay your life benefit to your beneficiaries in the event of your diagnosis with a terminal illness.

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Declaration

- In the event of a claim, I instruct William Russell to distribute the proceeds of my life benefit, my accidental death & disablement benefit (if applicable to my insurance cover), and my funeral costs & repatriation benefit (if applicable to my insurance cover) in accordance with the instructions I have given in this form.
- I understand that, by signing this form, I am cancelling any and all previous beneficiary nominations that I may have made.
- I understand that I may change my beneficiary nomination at any time by completing and submitting a new form.
- I understand and agree that the instructions I have specified in this form will apply not only to the policy specified in this form, but to all subsequent renewals of my insurance cover—unless and until I complete and submit a new beneficiary nomination.

Name of insured person: .....

Signature of insured person: ..... **Date:** .....