NEW IRELAND ASSURANCE

UCC Coláiste na hOllscoile Corcaigh, Éire University College Cork, Ireland

University College Cork

Income Continuance Plan Application

1. Personal Details (Person to be covered)

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ _____ Other

First Name(s):

Surname:

Home Address:

Work Address:

Date of Birth: D D M M Y Y Y Y

Staff No.: PPS No.:

Mobile Number: Work Number*.:

Salary: € Date joined UCC: D D M M Y Y Y Y

Current Appointment Start Date: D D M M Y Y Y Y

☐ Permanent ☐ Indefinite ☐ Fixed Term Date to be included in Plan: D D M M Y Y Y Y

Precise Occupation:

Email:

Consent to seek information** from other insurers: ☐ Yes ☐ No

* By providing your phone number(s) you are consenting to New Ireland or a duly authorised Agent of New Ireland phoning you if required for information in connection with your application.

** Information means medical and other details given to an insurer by me or any doctor in connection with a life insurance application on my life.

2. Material facts notice and other important information

You are legally obliged to inform us of all relevant information (material facts) in the application process.

Material Facts are those, which an insurer would regard as likely to influence the assessment and acceptance of a proposal for insurance.

If you are in doubt as to whether certain facts are material, such facts should be disclosed.

If you proceed with this plan, the resulting plan will be based on the information provided:

- in this application form
- in any Tele-interview you complete
- in any other form related to your application
- in any notice by you of changes required in advance of the policy start date, and
- in any questionnaire completed by you or by a medical examiner and signed by you.

The plan may be cancelled and any claim on the policy may not be paid

- if you do not inform us of all material facts
- if any of the information you provide is not true and complete,

or

- if you do not inform us of any changes in your medical and/or other information before the cover starts.

2. Material facts notice and other important information - cont'd

You may submit answers to any medical questions directly to the Chief Medical Officer at 11-12 Dawson Street, Dublin 2. Please indicate in your letter your name and application number to which the information applies. All information will be treated in the strictest confidence.

We may not necessarily contact your doctor(s). Even if we do, you must still disclose all material facts. We may ask you to have a medical examination with your own doctor or an independent doctor.

Material Facts Exemption in Relation to Genetic Tests

You are not required to disclose any genetic tests you may have had and we will not have regard to any genetic tests which may come into our possession. You are however required to provide us with full details (other than genetic tests) in answer to all of the health and lifestyle questions including full medical details about your family history.

3. Doctor/Clinic Details

Please give the name and address of your present GP. If you have changed your GP in the last 12 months then please also give the name and address of your previous GP.

Current:

Other:

4. Health and other details

Please remember that failure to answer the following questions truthfully and fully may result in a claim being declined and the policy being cancelled. If you are in doubt about whether a fact is material it should be disclosed.

1. a. Have you smoked cigarettes, cigars, or pipe tobacco in the last 12 months? ☐ Yes ☐ No

b. If "Yes", how much do you smoke each day or if you have stopped smoking in the last 12 months how much did you smoke each day?

Cigarettes ☐ per day
Cigars ☐ per week
Pipe tobacco ☐ per day

2. How much alcohol do you drink each week?

Unit guide:
Bottle beer = 1.5 units
Pint beer = 2.0 units
Measure spirits = 1.0 units
Bottle wine = 7.0 units
Glass wine = 1.0 units

☐ units per week

3. a. What is your height? ft ☐ ins ☐ or cm ☐

b. What is your weight? st ☐ lbs ☐ or kg ☐

4. Have any of your biological parents, brothers, or sisters suffered or died before age 60 from any of the following:

a. Heart Disease, Heart Attack, Cardiomyopathy, Stroke or Haemochromatosis? ☐ Yes ☐ No

b. Multiple Sclerosis, Parkinson's Disease, Motor Neurone Disease, Huntington's Disease, Alzheimer's Disease, Muscular Dystrophy? ☐ Yes ☐ No

c. Diabetes or Kidney Disease (including Polycystic Kidney Disease)? ☐ Yes ☐ No

d. Breast and/or Ovarian Cancer, Colon (i.e. bowel or rectum) cancer, Polyposis of the colon or other cancer? ☐ Yes ☐ No

e. Any other hereditary/familial disorder? ☐ Yes ☐ No

f. Have you ever had, or been advised to have any check-up/screening because of any family history? (you do not need to disclose any genetic tests you have undergone). ☐ Yes ☐ No

4. Health and other details - cont'd

Condition (If cancer, specify the part of the body affected first, eg. bowel) (If heart disease, specify exact nature of heart disease)	Relative	Age at diagnosis	Details of any check-up/screening

If you answer "Yes" to any of the questions below, please provide details such as exact condition, when diagnosed, results of any tests or investigations, treatment and current medication and date of last review with your GP/Specialist. If we require further information about a particular condition(s), we may arrange for a Nurse to call you to gather this information. These calls will be recorded and will take no longer than 10 minutes to complete.

	Yes	No
5. Do you currently have or have you ever had any of the following:		
a. schizophrenia, bipolar affective disorder, manic depression, psychosis, paranoia, an eating disorder or any other mental illness which has required consultation(s) with a psychiatrist or other medical specialist?	☐	☐
b. Rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or any form of neck, back or joint surgery?	☐	☐
c. Any disease or disorder of the neurological system including Multiple Sclerosis, paralysis or brain injury or cerebral palsy?	☐	☐
d. Any disease or disorder of the heart, arteries or veins or a stroke or brain haemorrhage?	☐	☐
e. Diabetes, or any disease or disorder of the liver or kidneys?	☐	☐
f. Cancer, leukaemia, Hodgkins disease, lymphoma or a brain or spinal tumour?	☐	☐
6. Do you currently have or in the last 5 years have you had any of the following:		
a. Back or neck pain or any other symptoms, disease or disorder affecting the back or neck (including arthritis, slipped disc, sciatica or whiplash)?	☐	☐
b. Joint pain, arthritis or any other disease or disorder of your joints, ligaments, bones or muscles (including any conditions affecting either knee, shoulder, hip, ankle, wrist or hand or any form of repetitive strain injury)?	☐	☐
c. Mental illness or mental problems including low mood, depression, stress, anxiety, panic attacks or persistent or recurrent fatigue?	☐	☐
d. High blood pressure or high cholesterol, chest pain, irregular heart beat or blood disorders?	☐	☐
e. Numbness, pins and needles or other changes in skin sensation, facial pain, muscle weakness or difficulty walking?	☐	☐
f. Dizziness, tremor, blurred or double vision or eye pain?	☐	☐

4. Health and other details - cont'd

If you answer "Yes" to any of the questions below, please provide details such as exact condition, when diagnosed, results of any tests or investigations, treatment and current medication and date of last review with your GP/Specialist.

	Yes	No
g. Epilepsy or fits, blackouts, balance problems, migraine or recurrent headaches?	☐	☐
h. Asthma, bronchitis or any other lung or breathing disorder?	☐	☐
i. Any disease or disorder of the digestive system (including Crohn's disease, colitis, ulcers, pancreatitis, irritable bowel syndrome or problems with stomach acid)?	☐	☐
j. Any disease or disorder of the skin (including psoriasis, eczema or dermatitis)?	☐	☐
k. Any impairment of vision or hearing or any disorder of the eyes or ears? (You may ignore fully corrected sight problems but you must tell us about all hearing problems even if fully corrected by hearing aids)	☐	☐
7. In the last 5 years:		
a. Have you attended a hospital as an in-patient or an outpatient or are you awaiting such a referral?	☐	☐
b. Have you had any medical investigations, scans or tests (e.g. MRI or CT scans or ECG) or are you awaiting such a referral?	☐	☐
c. Have you had more than 10 consecutive days off work due to health issues or are you currently off work?	☐	☐
8 In the last year have you taken or been advised to take any medicines or drugs or any other types of treatment?	☐	☐
9. Have you ever used any recreational drugs including but not limited to cannabis, cocaine, heroin, ecstasy, amphetamines, hallucinogens, anabolic steroids, or non-prescription sedatives?	☐	☐
10. Has a doctor or medical professional ever advised you to cease or reduce your alcohol consumption?	☐	☐
11. Have you ever tested positive for HIV, Hepatitis B or C or are you awaiting the results of any test relating to these conditions?	☐	☐
Travel and interests:		
12. Do you take part in or intend to take part in any hazardous leisure activities or sports such as scuba diving, motor sports, aviation, water sports, horse riding, martial arts, mountaineering, caving or winter/ice sports?	☐	☐
13. In the last 10 years, have you spent more than 6 months outside of Ireland, the EU, North America, Japan, Singapore, Hong Kong, New Zealand or Australia?	☐	☐
Previous Application(s)		
14. Have you ever had an application on your life declined, postponed, accepted at an increased premium or with an exclusion imposed for any death, critical illness or disability benefit? If Yes, please advise date, type of cover and reason for adverse terms.	☐	☐

5. Declarations/Data protection consent

I declare that:

all statements made in this application form, in any Tele-interview I complete or in any questionnaire completed by me or by a medical examiner in connection with this application and signed by me are true and complete and shall be the basis of the proposed contract.

I have read and understand the notes in relation to material facts and understand that if I do not tell you all material facts this contract could be void

In this application I have disclosed all material facts.

I consent to New Ireland Assurance Company plc ("New Ireland") seeking information from any doctor, now or in the event of a claim, who has attended me and I authorise them to give New Ireland such information. I agree that this authority will remain in force after my death.

I confirm that if I have answered yes to the "Consent to seek information from other insurers" question that I am consenting to New Ireland seeking and receiving medical and other details given to an insurer by me or any doctor in connection with a life insurance application on my life.

I agree that if I have provided a telephone number, New Ireland or a duly authorised agent of New Ireland may contact me in person, by phone, if it considers it necessary to obtain further medical or other information relating to this application.

I confirm that I have had

(i) the meaning of disability as defined in the policy,

(ii) the benefits available under the policy,

(iii) the general exclusions that apply to the policy,

(iv) the reductions that will be applied to the benefit where there are disability payments from other sources,

explained to me and I understand these provisions.

I understand that

a) in the event of my application not proceeding, information provided in connection with my application will be retained by New Ireland for a period of six years to facilitate any future application by me and as a protection against non-disclosure of material facts.

b) the cover under this Plan will not commence until this application has been accepted by New Ireland

c) any changes to the statements in this application before the proposed contract comes into force must be notified in writing to New Ireland.

d) any incomplete or inaccurate information set out in the transcript of any Tele-interview completed by me must be notified to New Ireland within ten working days of receipt of the transcript.

I declare that

a) I am an employee of UCC and am eligible to join the UCC Income Continuance Plan

b) I am actively at work, or capable of being actively at work on the date of signing this application form.

c) I have never had any application for life, critical illness or disability benefit declined, postponed or accepted on special terms by an Insurer.

I confirm that I have received, read and understand the Member Booklet, and I hereby apply to join the Plan.

The "Data Controller" for the purposes of the Data Protection Acts 1988-2003 is New Ireland Assurance Company plc (New Ireland). The personal data being collected on this form is for the purposes of processing your application and may be disclosed in accordance with and to other parties as identified and consented to in the paragraphs below.

"EEA" means the European Economic Area and consists of the 28 EU Members States as well as Norway, Iceland and Liechtenstein.

"Information" means any information including medical and non-medical given by me or on my behalf in connection with this application or any further information which may be given at a later stage either in writing, by email, at a meeting or over the telephone.

"Marketing" means direct marketing and cross-selling of the services and/or products provided by New Ireland or arranged by New Ireland with a third party.

I understand and consent that New Ireland and its duly authorised agents may:

- contact me by phone or by letter in relation to the administration (including any contractual review) of the contract;
- hold and use the Information on computer file, in any other dematerialised form or in written hard copy on its own behalf and may use or pass the Information to third parties for administration, regulatory, customer care and service purposes;
- disclose and/or transfer my Information to other countries, including countries outside of the EEA, for any of the purposes specified, to persons who have been approved by New Ireland and in a manner compliant with applicable data protection legislation;
- use my Information to carry out statistical analysis and market research.

I agree that New Ireland or a duly authorised agent of New Ireland may contact me in person, by phone, letter, e-mail or other electronic means if it considers that my financial planning arrangements need to be reviewed, my level of cover needs to be revised, and/or to provide me with general information relating to the contract by e-mail or other electronic means with New Ireland at any time.

☐ Yes ☐ No

I agree that the Information may be held and used by New Ireland for Marketing purposes, including Marketing by e-mail or other electronic means.

☐ Yes ☐ No

I understand that I may write to advise New Ireland to cease to hold and use the Information for Marketing purposes at any time.

SIGN HERE Signature of Applicant: _____ Date: D D M M Y Y Y Y

6. Salary Deduction Mandate for UCC Income Continuance Plan

Please deduct until further notice from my pay the appropriate amount of my gross salary in respect of my contribution under the UCC Income Continuance Plan and remit this amount to New Ireland Assurance Company plc.

I recognise that these deductions are being made solely as a measure of convenience to me and that they may be terminated at any time. I also recognise that the ultimate responsibility for ensuring that these deductions have in fact been made from my salary rests with me and that beyond making remittances on foot of sums deducted, my employer accepts no responsibility of any kind in this matter.

Name & Address of Department:			
Staff No.:		PPS No.:	
Your Title (Signed):			
Name in Block Capitals:			
Date:	D D M M Y Y Y Y		

New Ireland Assurance Company plc.,

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