NUI Galway
OÉ Gaillimh

cornmarket
group financial services ltd

The NUI Galway Voluntary Life Assurance Plan

Standard application form

Eligibility – For use only by members under age 65

To be eligible to apply for membership of the NUI Galway Voluntary Life Assurance Plan using this form you must be:

- A pensionable employee of NUI Galway ***and***
- Under age 65.

Job/work sharers: Job/work sharing employees of NUI Galway who satisfy the eligibility conditions above may also apply to join the Voluntary Life Assurance Plan. The level of contribution and benefits which apply for them may differ from those relevant for the full-time members.

IMPORTANT: Medical Details Requirements

Are you joining the Plan **within the first three months** of becoming eligible to join? Yes ☐ No ☐

If you have answered Yes, you do not need to complete either Section 4 or Section 5.
You must still complete and sign both declarations contained in Section 8 and Section 9.

If you have answered No, you must complete Section 4.
If you answer Yes to any of the questions in Section 4, you must also complete Section 5.

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1 Personal Details

Title: _____ First Name: _____ Surname: _____ Date of Birth: / / 19

Home Address: _____

Tel: Home: _____ Mobile: _____

Email: _____ Gender: Male ☐ Female ☐

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Partnered ☐ Civil Partnered ☐ Widowed ☐

2 Employment Details

Employer: NUI Galway ☐ Occupation: _____

Work Address: _____

_____

Current Annual Salary: € _____

Are you working as a job sharer?
(Working 50% or less of the full-time working week?) Yes ☐ No ☐

When did you start working in the Public Sector? / / 20

If you entered **Public Sector employment** after 1st April 2004 or re-entered Public Sector employment after 1st April 2004 with a break of more than 26 weeks, that was not due to a career break or unpaid leave, please provide the date here if different to above: / / 20

3 Material Facts Notice and other Important Information

When completing this application form you must disclose all Material Facts.

A Material Fact is any fact that the insurer would regard as likely to influence the assessment and acceptance of the proposal. Failure to disclose all Material Facts, including full disclosure of your medical details and history, may delay or prevent the issue of your policy; cause it to be cancelled at a later date; and/or invalidate future claims. If you are in any doubt as to whether a fact is a Material Fact you should disclose it.

You are not required to disclose any genetic test results you may have had and we will disregard any genetic tests that come into our possession.

You are, however, required to provide us with full details (other than genetic tests) in answer to all health questions, including full details about your family history (see Sections 4 & 5).

You must advise us of any changes in your health or circumstances which happen between now and the date your application is confirmed as accepted by Friends First, which would make any of the answers on this form wrong or incomplete. Failure to do so may invalidate future claims.

4 Basic Medical Details

Please note: In answering the questions in either this Section or in Section 5, if required, you do not need to disclose details relating to the following ailments: Acne, Anal fissure (single episode only), Hayfever (without asthma), Ganglion, Minor allergies, Thrush/Candidiasis, Chickenpox, Colds/Influenza, Food poisoning, Measles, Heat stroke/Sunburn/Sunstroke, Laryngitis, Lockjaw (provided full recovery has been made), Mumps, Pharyngitis, Stomach bug (including gastroenteritis once fully recovered), Glandular fever (provided fully recovered), IGTN, Haemorrhoids/Piles, Verucca, Childhood bronchitis, Pregnancy (assuming no complications), Miscarriage (assuming no complications), Sinusitis/Nasal Polyps, Tonsillitis/Quinsy.

1. Have you been absent from work due to illness or injury for more than 5 consecutive working days in the last 2 years? YES ☐ NO ☐

2. Are you currently taking any prescribed drugs or medication or receiving any treatment, or have you done so in the last 6 months? YES ☐ NO ☐

3. Have you attended, or been advised by your GP to attend, any doctor, specialist, consultant, counsellor, hospital or clinic for any medical check-up, blood, saliva or urine test, treatment, investigation or operation in the last 4 years? YES ☐ NO ☐

4. Has any application for life, critical illness or salary protection cover (disability benefit) on your life to any insurer ever been declined, postponed, accepted at an increased premium or with an exclusion imposed? YES ☐ NO ☐

If you answered Yes to any of the above questions, please complete Section 5 – Health Details (below and overleaf). If you answered No to all of the above questions, you need not complete Section 5. You must still complete the declarations contained in Section 8 and Section 9.

5 Health Details

You are not required to disclose any genetic test results you may have had and we will disregard any genetic tests which may come into our possession. You are, however, required to provide us with full details (other than genetic test) in answer to the health questions including full details about your family history as required in the health details section.

Name and Address of Doctor

1. Are you due to have any check-up in the next 12 months in connection with any medical condition or symptoms, or are you waiting for the result of any medical investigation? If yes, please provide details in Section 6. YES ☐ NO ☐

2. Are you taking any prescribed drugs or medication or are you experiencing any signs of ill health or disability for which you have not yet consulted a doctor? If yes, please provide details. YES ☐ NO ☐

3. Have you in the last five years lived or worked abroad, are you currently doing so or do you intend to in the future? (Holidays, travel to, or residence in the EU, North America, Switzerland, Scandinavia, Australia or New Zealand can be ignored). If yes, please tell us where and for how long. YES ☐ NO ☐

4. Have you ever tested positive for HIV/AIDS, Hepatitis B or C or have you been tested/treated for any other sexually transmitted disease, or are you awaiting the results of any such tests? If yes, please provide details or, if you prefer, details may be sent to our Chief Medical Officer at Friends First House, Cherrywood Business Park, Loughlinstown, Dublin 18. YES ☐ NO ☐

5 **Health Details** (continued)

5. Has any application for life, critical illness or salary protection cover (disability benefit) on your life to any insurer ever been declined, postponed, accepted at an increased premium or with an exclusion imposed? If yes, please give details. YES ☐ NO ☐

6. Have either of your parents, or any brothers or sisters, died or suffered from heart disease, cardiomyopathy, a stroke, diabetes, high blood pressure, kidney disease, cancer, multiple sclerosis, nervous disorder, motor neurone disease, polycystic kidneys, polyposis of the colon or any hereditary disease such as Huntington's disease before age 65? If yes, please give full details i.e. which family member and age at diagnosis. If cancer, please advise site of same (e.g. colon, breast etc). YES ☐ NO ☐

7. Please tell us your height (without shoes) in feet/inches. ☐ feet ☐ inches

8. Have you smoked any cigarettes, cigars, pipes or tobacco in the last 12 months? If yes, how many per day? ☐

9. Please tell us your weight (in indoor clothes) in stones/lbs. ☐ stones ☐ lbs

10. How many units of alcohol do you consume weekly? (1 unit = 1/2 pint of beer or a glass of wine or standard spirit measure) ☐

11. Have you ever been treated for alcohol abuse, or been advised by a doctor to cease or reduce your alcohol consumption, or taken drugs such as cannabis, cocaine, heroin or any non-prescribed drugs? YES ☐ NO ☐

12. Do you, or do you intend to, engage in hazardous or extreme sports or pastimes of any kind e.g. mountaineering, motor sports, diving, equestrianism or aviation (other than as a fare paying passenger)? If yes, please provide details. YES ☐ NO ☐

13. Are any of the following an important part of your occupation or working environment? If yes, please provide details, including your occupation title.

– Manual or physical activity or working at heights or depths YES ☐ NO ☐

– Working in extreme temperatures YES ☐ NO ☐

– Working with machinery or tools or with explosives or chemicals YES ☐ NO ☐

– Working in the armed forces YES ☐ NO ☐

– Working at sea/offshore YES ☐ NO ☐

14. Have you ever had, or been suspected of having, or consulted anyone, for example doctors, specialists, hospitals, clinics, counsellors, osteopaths or physiotherapists, about any of the following, listed a - q? If you answer "Yes" to any of these questions, please give relevant details, e.g. description of condition, medication being taken, doctors/counsellors etc. consulted, and current status of condition.

a) Cancer or any other growth be it malignant or benign (innocent), leukaemia, lymphoma, Hodgkin's disease, brain or spinal tumour, lumps, bumps, tumours or moles, including any mole or freckle that has bled, become painful, changed colour or increased in size, whether seen by a doctor or not? YES ☐ NO ☐

b) Any disease or disorder of the heart or circulatory system, irregular heart beat, or raised cholesterol, fainting, palpitations, undue shortness of breath, chest pain, rheumatic fever or raised blood pressure? YES ☐ NO ☐

c) Stroke or a Transient Ischamemic Attack (TIA), brain haemorrhage or permanent brain injury? YES ☐ NO ☐

d) Diabetes? YES ☐ NO ☐

e) Asthma, bronchitis, pneumonia, pleurisy, tuberculosis, sarcoidosis or any other respiratory disorder? YES ☐ NO ☐

f) Any problems or abnormalities with your kidneys or bladder, or any abnormality of your urine e.g. the presence of sugar, albumin or blood, or recurrent infections? YES ☐ NO ☐

g) Crohn's disease, ulcerative colitis, ulcer, gallstones, or any disease of your stomach, pancreas, bowels or liver? YES ☐ NO ☐

h) Multiple sclerosis, tremor, Parkinson's disease, paralysis, Alzheimer's disease, dementia or cerebral palsy, numbness, loss of power or tingling in any of your limbs or face, or any other disorder of the central nervous system? YES ☐ NO ☐

i) Epilepsy, fits, seizures, blackouts or migraine? YES ☐ NO ☐

j) Any problem with your eyes or vision (not wholly corrected by spectacles) including blurred or double vision and optic neuritis? YES ☐ NO ☐

k) Any problem with your ears, hearing or balance? YES ☐ NO ☐

l) Depression, stress, anxiety, chronic fatigue, ME, exhaustion or other nervous or mental disorder? YES ☐ NO ☐

m) Anaemia or any blood disorder? YES ☐ NO ☐

n) Back pain, disc problem, lumbago, sciatica, arthritis, neck pain, gout or any other muscular, rheumatic, bone or other joint problem? YES ☐ NO ☐

o) Psoriasis, eczema, dermatitis, or any other skin problem? YES ☐ NO ☐

p) A CT scan, MRI scan or any other X-ray examination within the last 5 years? YES ☐ NO ☐

q) A blood test, special investigation or any surgical operation* within the last 5 years? YES ☐ NO ☐

*Note: The following operations can be ignored: Tonsillectomy, Appendectomy, Vasectomy, Adenoidectomy, Wisdom teeth extraction, Traumatic orchidectomy, Caesarean Section (assuming not currently pregnant), Cosmetic surgery (unless reconstructive after illness), Corrective laser surgery for Myopia, IGTN.

6 Health Details (continued)

Additional Details

If you answered 'Yes' to any of the questions in Sections 4 & 5, please give details. Please use a separate sheet if you do not have enough room below.

7 Salary Deduction Mandate

To: The Finance Officer, Employer: NUI Galway

Please deduct until further notice from my pay the appropriate amount of my pensionable pay in respect of my contribution under the NUI Galway Voluntary Life Assurance Plan and remit this amount to Cornmarket Group Financial Services Ltd. 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 the correct deductions have in fact been made, and that deductions are cancelled when appropriate, rests with me and that beyond making remittances on foot of sums deducted as stated, my employer accepts no responsibility of any kind in this matter. I further understand that should I wish to amend or cancel this deduction I will submit this request in writing to Cornmarket Group Financial Services Ltd.

Applicant's Signature: Date: / /20

Applicant's Name (BLOCK CAPITALS):

Workplace Name & Address:

Employee Number: | | | | | | |

(Please refer to your Payslip)

8 Data Protection Consent: employee's declaration and application

Data Protection Notices

1 The information that you provide to Friends First Life Assurance Company Limited ("Friends First") and Cornmarket will be held on a computer database and/or any other way and will be used to administer this Plan and any other products and services supplied to you and any future agreements, contracts or arrangements you may have with Friends First.

2 You have the right of access to your personal data held by Friends First and/or Cornmarket by sending a written request and on payment of a small fee to the relevant company.

3 You also have the right to require Friends First and/or Cornmarket to correct any inaccuracies in the personal data that they hold about you.

4 You also have the right to question the purpose for which your data is held.

Data Protection Consents

I declare that I consent:

A) To the processing and holding (on computer or otherwise) of all information disclosed by me, or on my behalf, in relation to the Plan by Cornmarket and Friends First, its servants and agents (together with such other information supplied or obtained by Friends First) including sensitive personal data (being medical records and/or financial details) and the holding or processing of same for underwriting, administrative, customer care and service purposes ***and***

B) To the disclosing of my personal data (personal and sensitive) to persons necessary in connection with the above purposes, to regulatory authorities or as required by law, to reinsurers and health professionals and other companies in the Friends First Life Assurance Company Limited Group. This may involve the transfer of personal data, including sensitive personal data, to countries outside the European Economic Area ***and***

C) That this information may be used in the future by Cornmarket to contact me (by mail/email/SMS/telephone/mobile phone) about Cornmarket services which may be of interest to me. I understand that the information provided by me will not be passed on to third parties for the purposes of direct marketing. I also understand that I may at any stage, at no cost, instruct Cornmarket in writing to no longer hold my data for the purpose of sending me such information.

If you do not wish to receive information about preferential Cornmarket deals available to you, please tick here ☐

Applicant's Signature: Date: / /20

Confirmation of Plan membership

If you are accepted, your cover will commence from the date that Friends First accepts your application. You will receive a formal acceptance letter confirming that you have been included as a member of the NUI Galway Voluntary Life Assurance Plan. Friends First will assess the potential risk of insuring you before membership of the Plan can be confirmed. This may involve attending a medical examination. In a small percentage of cases membership of the NUI Galway Voluntary Life Assurance Plan may be refused. In such cases applicants will receive a letter confirming that they have not been accepted into the Plan. In these circumstances, applicants may seek additional clarification from their own doctor who can contact Friends First to request reasons for their decision.

Warning: The current premium may increase after the next NUI Galway Voluntary Life Assurance Plan review on 1st November 2018*

*Please note: in the interim the premium rate will remain at the current 0.53% of salary. However, your individual monetary contributions will increase or decrease in line with your salary if you are contributing directly from salary.

9 Declaration – you must read this carefully before signing it

WARNING: Please read this declaration carefully and ensure that you fully understand it before signing it. In the event that any part of the declaration is untrue or incomplete in any respect, your cover may be rendered void and any claim you make may not be paid. If you cannot complete this declaration, please contact your local Cornmarket Consultant or call (01) 408 4137 for further information.

I wish to join the NUI Galway Voluntary Life Assurance Plan. I confirm that I am an employee of NUI Galway and a member of the NUI Galway Pension Scheme. I understand that membership of this Plan is conditional upon my continued pensionable employment with NUI Galway. I understand that it is a condition of membership that I accept that NUI Galway may amend the terms of the Plan or terminate the Plan altogether and that decisions of NUI Galway in such matters are binding on all members. I understand that I will receive a 'Guide to your Benefits' document and a Cornmarket Terms of Business document on being accepted into the Plan, and I will review them within the 30 day cooling off period (please review the 'Guide to your Benefits' document prior to joining the Plan online at www.cornmarket.ie). I understand the benefits available and the exclusions, restrictions and conditions that apply to the Plan. I understand that as I have not undergone a financial factfind with one of Cornmarket's consultants, no advice has been given to me pertaining to this product, therefore my application is on an execution only basis.

I declare that I am actively at work today, or capable of being actively at work today.*

I have read over the answers I have given in this application form and declare that to the best of my knowledge and belief, all information given is true and includes all material facts, and I understand that failure to disclose all relevant facts, including full disclosure of my medical details and history (where applicable), may delay or prevent the acceptance of this policy and/or may invalidate future claims. If you are in any doubt as to whether a fact is a material fact you should disclose it.

I understand that the benefits for which I apply herein will commence on the date my application is confirmed as accepted by Friends First.

I understand that I must tell Friends First of any changes in my health or circumstances which happen between now and the date my application is confirmed as accepted by Friends First.

I understand that in the interest of customer service and to ensure the accuracy of records, telephone conversations between Friends First and me may be recorded. I undertake to inform Friends First of any change in my country of residence during the life of the policy.

Please note that failure to consent to the above will prevent Friends First from processing your application further, furthermore, failure to answer any question contained herein may result in Friends First refusing to accept your application or denying a claim.

I consent to Friends First, verbally or otherwise, seeking and receiving additional information from me or Cornmarket where this information has not been provided on the application or where further information, including medical information, is required in order to process the application and such information will be deemed to be incorporated into this application.

I understand that Friends First will not refund premiums retrospectively, prior to me advising Friends First of the cancellation or alteration of this policy. It is my responsibility to notify Friends First of any change in my circumstances.

A member of Cornmarket staff may correct/amend my details entered into Sections 1, 2 and 7 (not including signatures or dates) in order to ensure my application is processed in a timely manner. A copy of any such amendment will be sent to me when my policy is processed and I undertake to advise Cornmarket without delay should any such amendment be incorrect.

***Actively at work means that you:**

- Are working your normal contracted number of hours
- Have not received medical advice to refrain from work
- Are not restricted from fully performing the normal duties associated with your occupation. Those on paid and unpaid maternity leave can be considered actively at work and are eligible to complete this form.

PLEASE TAKE TIME TO REVIEW THE ABOVE STATEMENTS AND YOUR ANSWERS TO THE QUESTIONS IN SECTIONS 4 & 5 (if applicable).

Applicant's Signature: Date: / /20