

**AFTER FILLING OUT THIS APPLICATION
PLEASE MAIL, FAX, OR EMAIL SCAN TO:**

**Good Neighbor Insurance
690 E. Warner Rd. Suite 117
Gilbert, AZ 85296, USA**

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Term Life Insurance Application

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 INSURANCE WILL BE IN FORCE UNTIL THIS APPLICATION HAS BEEN ACCEPTED BY UNDERWRITERS AND THE FIRST OR SINGLE PREMIUM IS PAID.**

Please remember to review your answers to the questions below 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 insured

Title (<i>Mr, Mrs, Miss, other</i>)		Surname		Forenames	
Address					
Postcode		Contact telephone number		Email address	
Date of birth	Sex (<i>M, F</i>)	Marital status (<i>married, single, divorced, separated, widowed, in civil partnership</i>)		Nationality	

Section 2: Policy details

Term Requested (1 – 10yrs):	Insured Sum Requested :
Effective date required	Reason for policy
Total sum assured under existing life assurance policies:	
Country of Assignment:	
Are you currently taking out or intending to take out any other life assurance cover, or have you done so within the last 12 months? If so, please give details of companies, dates and sums assured	

Section 3: G.P. details

Name of doctor who currently holds your medical records	
Address and telephone number	
If you have changed doctors within the last 3 months, please give the name, address and telephone number of your previous doctor	

Section 4: Occupation, 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? (if self employed, please provide earnings as the amount assessable for income tax after allowable business expenses)			
	Yes	No	<i>If yes, please give full details</i>
Do your duties involve you in any way (other than clerical) with:			
a.			the licensed trade or entertainment industry?
b.			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, Western Europe, North America or Australasia?			
Within the last 10 years, have you lived for longer than 1 month in any country outside either your normal country of residence, Western Europe, North America or Australasia?			
Do you engage in hazardous sports, such as aviation, motor sports, diving, climbing or mountaineering etc.?			

Section 5: Smoking and alcohol details

	Yes	No	<i>If yes, please state average consumption per day</i>
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?			
			<i>If yes, please give details</i>

Section 6: Personal details

Please provide your height and weight	Height:		Weight:
	Yes	No	<i>If yes, please provide details, including name of doctor or hospital, dates, duration, test results etc.</i>
Has your weight changed over the past 2 years?			
Have you consulted any doctor, hospital or clinic within the last 5 years?			
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?
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?			<i>If yes, please provide full details.</i>
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 or a nervous disorder?			<i>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.</i>
Has any application for assurance on your life been declined, withdrawn by yourself or accepted at special terms?			<i>If yes, please give details of companies and dates.</i>
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			<i>If yes, please give details including dates - for confidentiality these may be sent direct to the Chief Medical Officer.</i>
Within the last 5 years have you been exposed to the risk of HIV infection? <i>(Note: This can be caught through unsafe sex, injecting drug use, blood transfusion, therapeutic injections, or surgery undertaken in some countries outside the EU.)</i>			<i>If yes, please give details including dates - for confidentiality these may be sent direct to the Chief Medical Officer.</i>

<p>Within the last 5 years have you tested positive or been treated for any infection which was transmitted sexually?</p>		<p><i>If yes, please give details including dates - for confidentiality these may be sent direct to the Chief Medical Officer.</i></p>
<p>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.</p>		

Section 7: Important notes

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.

Cover will not start until we have assessed and accepted your application, and the first premium has been paid. If you have a birthday while your application is being processed, the terms may differ from those originally quoted.

- In most instances your payments will be as originally quoted. Revised terms may be offered to you, but occasionally we may be unable to offer any terms.
- We may ask you to contact your doctor to speed up the completion of reports that we have requested.
- If we ask you to attend a medical examination, it will be necessary for us to share the application information with another company authorized by us. They will make the arrangements for the examination to take place.
- It may be necessary to send your application and relevant medical reports to our Reassurers for their opinion or agreement of the terms offered, or to other Lloyd's Life Syndicates if they are to participate in cover. You can obtain details of general reinsurance principles from our Head Office, together with details of any company or Lloyd's Syndicate to whom this information may be sent.
- On occasion the faxing of medical reports may help to ensure a speedier assessment of your application. We only accept faxed information direct to a fax machine in a secure part of our building. This ensures that we maintain strict confidentiality. If you do not agree to allow the faxing of information, please indicate by deleting the appropriate section of the Declaration.
- Clements has a Confidentiality Policy in place which means that your medical information is held securely and access is limited to authorized individuals who need to see it.
- You are entitled to ask for a copy of our standard plan terms and conditions and a copy of your application form at any time.

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.
- Please tick if you have attached a Private and Confidential envelope.
- 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.
- This information can also be used to maintain management information for business analysis.
- I/We agree that a copy of the agreement given in this declaration will have the validity of the original.
- I/We agree to Clements accepting medical reports faxed directly to the company from my doctor's surgery. I/We also 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 wish us to fax information.)

Section 9: BENEFICIARY INFORMATION

Full Name		Address:	
Date of Birth:			
Phone:		Email:	
Fax:		Nationality:	
Relationship to Beneficiary:			

By signing this declaration 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/We have read the Declaration, Important Notes and information relating to my/our rights under the Access to Medical Reports Act 1988.

Life to be Insured:

Signature _____ **Date** _____ **Country of signing** _____