

To avoid delays in processing this document please write clearly and in English using block capitals.

Name: _____ Date of birth: (dd/mm/yyyy) _____

Address: _____

Telephone no: _____

Facsimile no: _____

E-mail: _____

Post code: _____

Employer's name: _____

Address: _____

Telephone no: _____

Facsimile no: _____

E-mail: _____

Post code: _____

Name of plan, arrangement, scheme etc. to which this statement relates: _____

A. GENERAL DETAILS

1. Birth place: _____

2. Nationality: _____

If "Yes", please give full details:

3. Have any of your parents, brothers or sisters died or had any serious or hereditary disorder (e.g. heart disease, high blood pressure, stroke diabetes, cancer) before 60 years of age? Yes No _____

4. Have you been off work due to illness or accident for more than 5 continuous working days in the last 12 months? Yes No _____

5. Are you taking any medication, receiving treatment or following a special diet, or have you done so within the past 12 months? Yes No _____

6. Has any proposal for insurance on your life been declined, postponed, accepted at an extra premium or on special conditions? Yes No _____

7. Do you take part in, or have you any intention of taking part in, any hazardous activities or sports? Yes No _____

A. GENERAL DETAILS

8. Do you already hold, or are you planning to take out, cover of a similar nature to that to be provided by this insurance? Yes No

If "Yes", please provide full details of the amount and type of cover and state whether it is to remain in force:

B. OCCUPATION DETAILS

1. Job title: _____
2. How many hours do you normally work each week? _____
3. Do you undertake purely administrative work? Yes No
- If "No", please provide full details (e.g. of any driving, manual labour, height work, diving, using explosives etc.)
- _____
- _____
- _____
4. In which countries will you be working? _____
5. Days of business travel per annum? _____
6. Mode and frequency of business travel? (Number of flights, boat trips) Mode: _____ Number per annum: _____
- _____
- _____
- _____

C. RESIDENCE DETAILS

1. In which countries will you be living? _____
2. Estimated length of stay? _____
3. Please describe the areas where you will mainly stay (e.g. big cities, rural or remote areas): _____
4. Where are the nearest medical facilities? _____
5. What type of medical facility is it? (e.g. doctor, clinic, hospital etc.) _____
6. How would you assess the overall medical care and sanitary conditions where you will stay? _____
- _____
- _____

D. EMPLOYER MEDICAL DETAILS

1	When did you last undergo an Employer Medical examination?	Date: (dd/mm/yyyy) _____
2.	Has the doctor at an Employer Medical examination (in the last 3 years) ever raised any medical concerns, given you specific advice etc.?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If "Yes", please give full details: _____ _____	
3.	How often do you attend Employer Medicals?	_____

E. MEDICAL DETAILS

Have you ever had, or are you currently suffering from:		If "Yes", please supply, where relevant, full details including dates, treatment given and time off work. Use box in Section F for additional information:
(a)	Heart disease, tightness or pains in the chest, angina, swollen legs, palpitation of the heart, irregular pulse or breathlessness?	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____
(b)	High blood pressure (blood pressure readings)? Stroke? Hardening of the arteries or any other disease of the heart or any circulation problems?	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____
(c)	Asthma, bronchitis or any infection of the lungs?	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____
(d)	Recurring indigestion, disease of the liver or pancreas, ulcer, colitis or other bowel problem?	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____
(e)	Infection or disease of the kidneys or urinary tract? Symptoms of the prostate?	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____
(f)	Albumen or sugar in the urine? Diabetes?	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____
(g)	Rheumatism, arthritis or other disease or impairment affecting the joints or muscles?	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____
(h)	Sciatica, prolapsed disc, discomfort or pains in the back, neck or arms?	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____
(i)	Tumours? Disease of the lymph glands? Disease of the blood?	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____
(j)	Epilepsy, convulsions, paralysis or any other disease of the nervous system? Vertigo? Fainting attacks?	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____
(k)	Stress, depression/anxiety state, insomnia, mental illness or any psychiatric disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____
(l)	Alcohol problems?	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____

E. MEDICAL DETAILS (CONTINUED)

(m)	Disease of the eyes? Disease of the ears? Poor sight or hearing? If wearing glasses state the strength of the lenses.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
(n)	Disease of the skin, eczema or other allergic disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
(o)	Thyroid disease, hormonal disorder, or disturbance of the metabolism?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
(p)	Disease of the genital organs, or for females only, any gynaecological illness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
(q)	Any other serious or chronic disease? Any physical handicap or abnormality? Any psychological problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
2.	Do you use or have you ever used any stimulant or sedative drugs (including narcotics)? If yes, which stimulants, sedative drugs, during which time and when was the last time? Name and address of attending doctor, if any?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
3.	Have you ever been tested positive for HIV/AIDS or Hepatitis B, C or have you been tested or treated for other sexually transmitted diseases, or are you awaiting the result of such a test?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	If you have, then specify when and where, name and address of doctor and results.			
4.	Have you ever received treatment or been examined by any other medical institution or by any other doctor or other medical personnel than stated above? If yes, for what reason and when? Please give name and address details and in case of hospital treatment, please indicate at which department and whether as an in or out-patient.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
5.	Do you smoke? If "Yes", state average DAILY quantity. If "No", for how long have you been a non-smoker?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
6.	Do you drink alcohol? If "Yes", state average WEEKLY alcohol intake.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
7.	Are you at present pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
8.	What is your height and weight?	Height: m cms Weight: kg		

F. FURTHER INFORMATION

G. HOW WILL THIS DOCUMENT BE USED?

Nordben Life and Pension Insurance Co. Limited will use this document and other details (for example, reports from a Doctor, your occupation, residence) to decide whether and on what terms to offer insurance. For these purposes this document will be disclosed to relevant Nordben staff and to the Company's Consultant Medical Officer and to third party life reinsurers and their retrocessionnaires. It might also be necessary to obtain additional details from the doctors and insurance companies, referred to in this document, for the purpose of reaching the insurance decision. By signing the 'Declaration' below you will have given your consent to our disclosing appropriate details from this document to them. No sensitive data is passed on to a third party unless the correct legal procedure is followed. The document will be held on file as it forms part of the insurance contract and will be disposed of in accordance with the terms of the contract.

The document will be reviewed should you make a claim under the insurance to ensure that you have not withheld information that would have been relevant to our insurance decision.

Nordben Life and Pension Insurance Co. Limited takes the privacy and security of data held on its clients very seriously. We have published a guide to ensure that our clients are informed about their rights and our obligations under The Data Protection (Bailiwick of Guernsey) Law. The guide is on our website www.nordben.com/data-protection.

Important note

Material facts are facts which Nordben Life and Pension Insurance Co. Limited would regard as likely to influence the decision whether or not to accept the application for insurance. Failure to disclose any material fact may result in the insurance being ineffective, even if the application for insurance was accepted by Nordben Life and Pension Insurance Co. Limited. You should disclose any fact if you are unsure whether or not it is material to the proposed insurance.

H. DECLARATION

I declare to the best of my knowledge and belief that the statements in this document are true and complete and that I have not withheld any material facts (see important note above). I consent to Nordben Life and Pension Insurance Co. Limited seeking medical information from any doctor who has attended me concerning anything which affects my physical or mental health and seeking information from any insurance office to which an application has been made for insurance on my life and I authorise the giving of such information. I confirm that I have checked and found correct any statements in this document that are not in my own handwriting.

Date: (dd/mm/yyyy) _____ Name: _____

Signature: _____

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