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: .....

..... Email: .....

Mobile number: ..... Home number: .....

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

Country where you will be living/working: ..... How long have you lived here? ..... years

Start date required

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

Please note that your application is only valid for 90 days from the date you signed the form. Cover cannot be backdated.

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, accident 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 working from home? ◯ Yes ◯ No

If **NO**, please itemise your ordinary work duties, including the percentage of work time ordinarily spent on each duty:

.....

.....

Your occupation (continued)

Do you ever work offshore? (e.g., in the air, on water, underwater, on oil rigs) ◯ 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: .....

.....

.....

The cover afforded by your plan may be affected if your occupation is not 100% office-based and/or working from home or 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. We reserve the right to decline cover depending on your occupation and activities.

Hazardous activities include (but are not limited to) off-piste or freestyle skiing/snowboarding; scuba diving; rock climbing; mountaineering, potholing or caving; hang-gliding or parachuting (including tandem); bungee jumping; kite surfing or windsurfing; hunting or competitive horse-riding; driving or riding a motorised vehicle in any kind of race or competition; riding or riding pillion on a motorcycle, motor scooter, moped or quad bike; flying other than as a passenger in a commercial aircraft aeroplane; competitive and/or offshore sailing; contact sport or any other activity which has a similar degree of danger as any of those mentioned here. If you are uncertain about whether an occupation is higher risk or whether an activity would be classed as hazardous, please provide the information as requested and we will confirm if we require anything further.

Please select the cover you require

Please select the plans below (e.g., life, accident, income protection) for which you require cover.

If you have one, please state the quote illustration reference for the quote you wish to accept: .....

a) Life plan

The life plan lets you choose the cash lump-sum that your nominated beneficiary would receive if you were to die whilst your plan is in force. **Your total life benefit, including any other life insurance cover you have, must not exceed 20x your current annual earnings. The maximum benefit available under this life plan is US$2,000,000 or £1,500,000 or €1,700,000.**

Please state the life benefit you require: .....

Please state your reason for cover: ◯ Family protection ◯ To cover a loan ◯ Other (please give details):

.....

b) Optional accident benefit

The optional accident benefit pays out an additional cash lump-sum in the event of death or permanent disability following an accident. **The optional accident benefit is only available in conjunction with the life plan. The maximum accident benefit available is US$500,000 or £375,000 or €500,000. The accident benefit you have selected must not exceed the life benefit.**

Please state the accident benefit you require: .....

c) Income protection plan

The income protection plan provides you with the replacement income you will need if an illness or injury prevents you from working, for longer than your deferment period. **The income benefit we pay will be restricted to 80% of your pre-disability earnings, less any other income you are entitled to receive whilst you are disabled. The maximum income benefit is US$144,000 or £108,000 or €144,000.**

Please state the income benefit you require: .....

Please state the required deferment period (the period during which no benefit is paid): ◯ 3 months ◯ 6 months

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] Half-yearly premiums are subject to a 3% surcharge.

[3] Quarterly or monthly premiums are subject to a 5% surcharge.

Beneficiary nomination

You only need to complete this section if you have selected a life plan.

I hereby nominate the following person(s) as beneficiary of my life benefit (and accident benefit, if applicable) in the event of my death:

Full name	% of benefit to be paid	Address	Relationship to policyholder

If the death of one or more of the above named beneficiaries precedes your own, the proportion of that benefit that otherwise would have been paid will be shared between any surviving beneficiaries, in proportion with the percentages specified above. If this is not your wish, or if you would like to nominate any alternative beneficiary/beneficiaries, please state your wishes here:

.....

.....

.....

.....

If you are diagnosed with a terminal illness, then, subject to the terms of the plan agreement, your life benefit will be paid directly to you. If you would prefer otherwise, please state your wishes here:

.....

.....

.....

.....

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 .....
Have you smoked cigarettes/cigars in the last 12 months? If **YES**, please give the average number a day:	◯ Yes ◯ No .....
Do you drink alcohol? 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 Please answer the following:

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

b) Within the last five years have you been exposed to the risk of HIV infection? (HIV can be contracted through unsafe sex, intravenous drug abuse, or blood transfusions, or surgery undertaken outside Europe) ◯ Yes ◯ No

If **Questions 2 a)** and/or **2 b)** were answered 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.

Health declaration (continued)

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.

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 of 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, please give full details

Question no: ..... Month/year of onset: ..... Month/year of last symptoms: .....

Frequency of symptoms: .....

Condition and cause if known: .....

.....

.....

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

.....

.....

Treating physician name and address: .....

.....

.....

Question no: ..... Month/year of onset: ..... Month/year of last symptoms: .....

Frequency of symptoms: .....

Condition and cause if known: .....

.....

.....

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

.....

.....

Treating physician name and address: .....

.....

.....

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.

Health declaration (continued)

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

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) ....

....

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) ....

....

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) ....

....

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) ....

....

Health declaration (continued)

You only need to complete Question 6 if you are applying for an income protection plan.

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

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: .....

.....

.....

How we use your information

Please read this section carefully.

- We'll use the information you give us on your application form for the purposes of administering your plan, 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 information for longer than is necessary.
- We may share your information with other organisations in relation to the above purposes (e.g., the insurer of your plan, our payment service providers). This may involve transferring your information outside the EU.
- We may record your telephone calls to and from William Russell for training and monitoring purposes.
- We'll process your personal information (including sensitive information such as details about your health) in accordance with our privacy policy.
- Our privacy policy also contains information about who to contact if you have any questions about how we use your information, or if you would like to request a copy of the information we hold about you. For full details, please visit william-russell.com/privacy or read your plan agreement.

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. You can read our privacy policy at william-russell.com/privacy.

Opt in to the following communications from us:

- ◯ Email
- ◯ Newsletter
- ◯ Telephone
- ◯ Text message/SMS

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 by letter, 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 my employer has 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:** .....

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

Platinum Trusted Service Award 2024 feefo