

University College Cork

Supplementary Life Assurance Scheme Application

HOW TO COMPLETE THIS FORM

If you are completing this application within 2 months of joining service and are aged 55 or younger, you need only complete sections 1,4 and 5. Otherwise please complete all sections.

1. Personal Details

Title:	<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Ms	<input type="checkbox"/> Other																	
Surname:	<input type="text"/>																				
First Name(s):	<input type="text"/>																				
Home Address:	<input type="text"/>	Work Address:	<input type="text"/>																		
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Date of birth:	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table>	D	D	M	M	Y	Y	Y	Y	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
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Staff No.:	<input type="text"/>	PPS Number:	<input type="text"/>																		
Mobile Number*:	<input type="text"/>	Work Number*:	<input type="text"/>																		
Salary:	€ <input type="text"/>	Date joined UCC:	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table>	D	D	M	M	Y	Y	Y	Y	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
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Current Appointment Start Date:	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table>	D	D	M	M	Y	Y	Y	Y	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
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Permanent: <input type="checkbox"/>	Indefinite: <input type="checkbox"/>	Fixed Term: <input type="checkbox"/>	Date to be included in Plan	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table>	D	D	M	M	Y	Y	Y	Y	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>														
Precise Occupation:	<input type="text"/>																				
Email:	<input type="text"/>																				
Consent to seek information** from other insurers:	<input type="checkbox"/> Yes	<input type="checkbox"/> 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

Please answer fully the questions in section 3. You are legally obliged to tell us all relevant information (material facts) in answering the questions on this application form.

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 contract, the resulting cover 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 may not be paid

- if you do not tell us all material facts
- if any of the information you provide is not true and complete,
- if you do not inform us of any changes in your medical and/or other information before the cover starts.

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 the policy 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 the medical details questions in section 3.

3. Health 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:

In answering any of the following questions you need not tell us about colds, influenza, contraception, uncomplicated pregnancies or screening for employment purposes provided that the results were normal.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Have you been absent from work through illness or injury for more than 5 consecutive working days in the last 2 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you currently under medical care of any kind, taking any prescribed drugs, medication or tablets or other treatment or have you done so in the last 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you attended or been advised by your doctor to attend any specialist or consultant, hospital or clinic for any medical check up, scans or tests, treatment, investigation or operation in the last 4 years or are you intending on doing so now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had an application on your life declined, postponed, accepted at an increased premium or with an exclusion imposed for any death, specified or critical illness or disability benefit? If yes, please give date and reason for the revised terms. | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered yes to any of the above questions please give details in the table below. Use a separate signed and dated sheet of paper if you require more space.

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.

Question	Nature of Illness	Treatment	Dates & duration of time off work	Name & address of Doctor/ Specialist(s) attended

4. 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 understand that

- 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.
- the cover under this Scheme will not commence until this application has been accepted by New Ireland
- any changes to the statements in this application before the proposed contract comes into force must be notified in writing to New Ireland.
- 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 Supplementary Life Assurance Scheme.

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 Scheme.

I understand and consent that New Ireland and its duly authorised agents may 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 regulatory, administration, customer care and service purposes.

I agree that New Ireland or a duly authorised agent of New Ireland may contact me in person, by phone, or by letter if it considers that my financial planning arrangements need to be reviewed or my level of cover needs to be revised. Yes No

I agree that the Information may be held and used by New Ireland for Marketing purposes. 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.

"Data Controller" for the purposes of the Data Protection Acts 1988 - 2003 is 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.

"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.

SIGN HERE	Applicants Signature: <input type="text"/>	Date:	D	D	M	M	Y	Y	Y	Y
			<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

5. Salary Deduction Mandate for UCC Supplementary Life Assurance Scheme

Please deduct until further notice from my pay the appropriate amount of my gross salary in respect of my contribution under the UCC Supplementary Life Assurance Scheme 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:

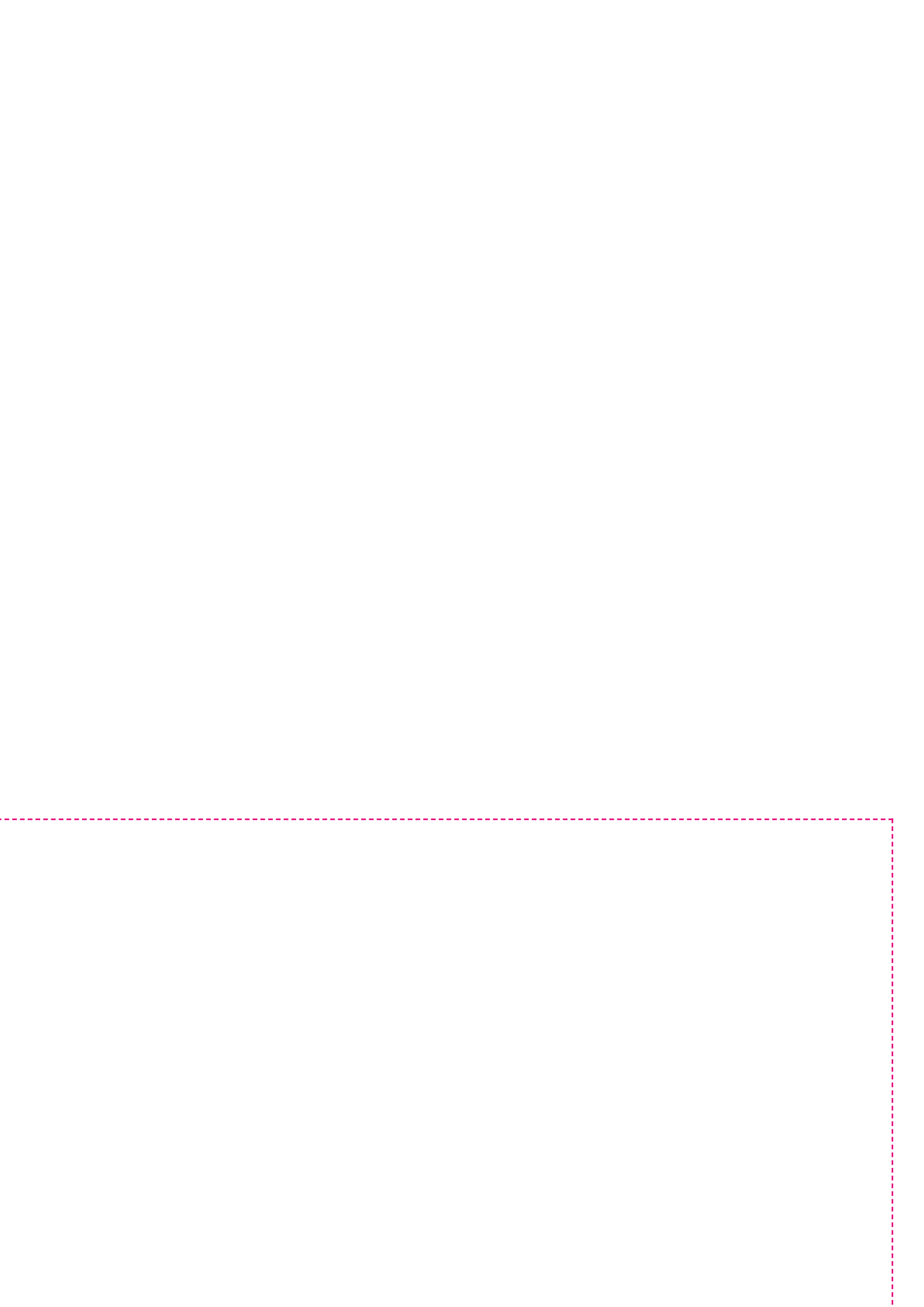
Staff Number: PPS Number:

Your Title (Signed):

Name in Block Capitals:

Date:

D	D	M	M	Y	Y	Y	Y
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>





New Ireland Assurance Company plc.,
11-12 Dawson Street, Dublin 2.
T: (01) 617 2000 F: (01) 617 2075.
E: info@newireland.ie W: www.newireland.ie

New Ireland Assurance Company plc is regulated by the Central Bank of Ireland. A member of Bank of Ireland Group.

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