pg mutual
Protecting Healthcare Professionals

Income Protection Plus

Cover Variation Application Form

Private & Confidential

IMPORTANT NOTE

It is important that you answer all the questions fully and honestly. All **Material Facts** must be disclosed since non-disclosure or misrepresentation may result in the rejection of a claim under this Plan and to your expulsion from the Society.

A **Material Fact** is one which is likely to influence the Society's assessment or acceptance of your application. If you are in any doubt as to whether a fact is **Material**, you should disclose it.

Information which is incorrect, misleading or missing could lead to the loss of all or part of the cover either when the Plan is taken out or when you make a claim.

Terms and Definitions
'You', 'Your' - the applicant named upon this form
'PG Mutual', 'We', 'Us', 'Our', 'the Society' - Pharmaceutical & General Provident Society Ltd

March 2024

Please answer all the questions clearly and tick where appropriate.

1. Your Details

1.1 Personal Details

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

PG Mutual Membership Number:

First name:

Surname:

Previous name: (if applicable)

Date of birth:

Home address:

Postcode:

1.2 Contact Details

Daytime:

Evening:

Mobile:

Email address:

2. Your Occupation

2.1a What is your main occupation? Please state your job title:

2.1b In what industry does your occupation take place?

2.2 Are you: (please tick all that apply)

Employed ☐ Owner/director ☐ Self-empolyed ☐ Locum ☐

2.3 Please state the essential duties of your main occupation:

2.4 How is your main occupation split in % terms:

Manual: Administrative: Supervisory:

Other:

2.5 How many days a week do you work?

2.6 How many hours a week do you work?

2.7 Has there been a change in your working pattern in the past 12 months?

Yes ☐ No ☐ (tick as appropriate, if yes, please provide details:)

2.8 Have you more than one occupation?

Yes ☐ No ☐ If yes, please note your secondary job title and details of the work involved:

2.9 How is your secondary occupation split in % terms:

Manual: Administrative: Supervisory:

Other:

2.10 How many days a week do you work?

2.11 How many hours a week do you work?

2.12 Has there been a change in your working pattern in the past 12 months?

Yes ☐ No ☐ If yes, please provide details:

2.13 Is your working pattern likely to change in the near future?

Yes ☐ No ☐ (tick as appropriate)

3. Your Income

3.1 If an employee, what are your gross earnings for PAYE tax purposes in the last full tax year?

3.2 If all, or part, of your gross earnings are related to self-employed activities, please note your share of pre-tax profits in the last full tax year.

3.3 Have your earnings varied significantly since the last full tax year?

Yes ☐ No ☐ (tick as appropriate)

If yes, please state how they have varied.

3.4 In the event of making a claim, please confirm that you will be able to provide evidence that supports the earnings you have told us about in Section 3.

Yes ☐ No ☐ (tick as appropriate)

If you select no, please be aware that the benefits we pay you in the event of a claim may be restricted.

3.5 Would you receive any sick pay, over and above Statutory Sick Pay (SSP), if you were absent from work?

Yes ☐ No ☐ (tick as appropriate)

3.6 If yes, for how long would you receive sick pay from your employer?

3.7 FOR OWNERS OR DIRECTORS ONLY. Will you be using your income protection with PG Mutual to cover the cost of a locum in YOUR absence?

Yes ☐ No ☐ (tick as appropriate)

If yes, please state how much your daily NET locum fees are on average.

Important: In the event of a claim, we may need to see original documentary evidence of your earnings in the 12-month period immediately before you became unable to work through your incapacity:

- If you are employed, we may require printed payslips, P60 and, if applicable, your P11D
- If you are self-employed or in partnership, we may require your most recent business accounts and latest agreed HM Revenue & Customs Tax Assessment
- If you are employed as a shareholder director within a private limited company, we may require proof of income plus other benefits you receive
- It is important to select the deferral option that is appropriate to your circumstances.

Important Note: Please read our Key Features Document before completing this section.

4. Cover Required

4.1 Weekly level of cover required £

Please note: This cannot exceed the income you would lose by being incapacitated. We can cover up to 70% of your gross earnings.

4.2 Deferment period:

Nil ('day one') ☐ 7 days ☐ 14 days ☐
1 month ☐ 3 months ☐ 6 months ☐
12 months ☐

4.3 Benefit option:

Level/Premium ☐ Reducing/Standard ☐

4.4 Share ratio option: (if applicable)

1:4 ☐ 1:12 ☐ 1:20 ☐

Please complete the following as fully and honestly as possible. Failure to do so may result in any future claims not being paid.

5. Your Health

If you answer 'yes' to any of the following questions, please give further details. Please also include details of any other circumstances which might increase the risk of sickness, disability or accident or might be regarded as **'Material Facts'** to your application. Please use Further Information or a separate piece of paper to write your replies if necessary.

5.1 Your GP's details

Name:

Address:

Postcode:

Telephone:

If you have been registered for less than six months, please provide details of your previous GP.

Name:

Address:

Postcode:

Telephone:

Have you seen a doctor in the last two years?

Yes ☐ No ☐ (tick as appropriate)

If yes, please give details (consultations without treatment, e.g. for advice, must be included).

Have you seen any other medical practitioner such as a chiropractor or osteopath in the last two years?

Yes ☐ No ☐ (tick as appropriate)

If yes, please give details (consultations without treatment, e.g. for advice, must be included).

Do you intend to consult any doctor or other medical practitioner in the near future?

Yes ☐ No ☐ (tick as appropriate)

If yes, please give details.

In the **last three years**, have you undergone any specialist investigation and/or treatment or been recommended to have any operation, X-ray and/or other investigation or treatment, including routine tests?

Yes ☐ No ☐ (tick as appropriate)

If yes, please give details.

Have you ever been diagnosed as having (or been suspected of having) any of the following?

Joint problems, muscular, rheumatic or arthritic problems such as arthritis, rheumatism or gout?	Yes ☐	No ☐
Backache, slipped disc, lumbago or sciatica or any other disorder of the spine?	Yes ☐	No ☐
Diabetes or any abnormality in your urine, e.g. the presence of sugar, albumin or blood?	Yes ☐	No ☐
Asthma, bronchitis or any other respiratory disorder?	Yes ☐	No ☐
Digestive or bowel disorders?	Yes ☐	No ☐
Multiple Sclerosis or any disorder of the central nervous system or genetic disorder?	Yes ☐	No ☐
Glandular problem or blood disorder?	Yes ☐	No ☐
Any tumour, cyst or lump?	Yes ☐	No ☐
High blood pressure, heart disease, circulatory disorder, rheumatic fever, chest pain or other cardiovascular disorder?	Yes ☐	No ☐
Kidney, liver or bladder disorder?	Yes ☐	No ☐
Any form of eye or ear disease or any impairment of vision or hearing?	Yes ☐	No ☐
Any skin disorder, including allergies?	Yes ☐	No ☐
Any symptoms of gynaecological, menstrual or breast disorder?	Yes ☐	No ☐
Any symptoms of prostate disorder?	Yes ☐	No ☐
Varicose veins or surgery to veins?	Yes ☐	No ☐
Migraine attacks (common or classic)?	Yes ☐	No ☐
Any other serious illness not listed above?	Yes ☐	No ☐
Have you ever experienced a mental health condition or symptoms including but not limited to stress, anxiety or depression or any functional somatic disorder such as chronic fatigue?	Yes ☐	No ☐

If you have answered 'yes' to any of the questions above, please give further details.

Are you taking any prescribed drugs, pills or tablets or are you currently receiving any other form of medical treatment?

Yes ☐ No ☐ (tick as appropriate)

If yes, please give details.

In the **last five years**, have you been medically advised to receive treatment for any condition for a period exceeding three weeks?

Yes ☐ No ☐ (tick as appropriate)

If yes, please give details.

In the **last three years**, have you been absent from work for a consecutive period of more than five working days due to sickness, accident or disability?

Yes ☐ No ☐ (tick as appropriate)

If yes, please give details.

5.2 Do you smoke?

Yes ☐ No ☐ (tick as appropriate)

If you were a smoker but have now stopped, please give the month/year when you stopped.

/

5.3 What is your height?

Feet: Inches: (or) Metres:

5.4 What is your weight?

Stones: Lbs: (or) Kgs:

5.5 Do you take part in, or are considering taking up, hazardous sports?

Yes ☐ No ☐ (tick as appropriate, if yes, please provide details:)

Further Information

Important notes

- Your Plan will not start until we have assessed and accepted your application, and the initial subscriptions (or part of the first month's subscriptions, if applicable) have been paid.
- You are under a legal duty to take reasonable care when making representations to an insurer. If you fail to take reasonable care when providing information to us your insurance policy could be canceled and any future claim refused.
- You must inform PG Mutual of any change in your medical condition or occupation between the date of the submission of this application and the date of acceptance by PG Mutual.
- You are entitled to ask for a copy of our Memorandum and Rules and Policy terms, and a copy of your Application Form.

Your data agreement

In order for PG Mutual to process and assess your application and, if admitted to membership, administer your membership and your policy, PG Mutual (the Data Controller) and its supporting third parties (Data Processors) will need to process the personal data you have provided, or may provide at PG Mutual's request in the future. Please see PG Mutual's Privacy Policy at **https://www.pgmutual.co.uk/Privacy-Policy/** for further details, a copy of which can be provided to you at your request.

Please tick to confirm that you agree to PG Mutual using your personal data for this purpose ☐

If you would like to receive information from time to time about other products and services available from PG Mutual and its subsidiaries, please confirm how you would like to here from us:

Email ☐ Text ☐

Your agreement

☐ I agree to be bound by the Memorandum and Rules and Policy terms of PG Mutual.

☐ I confirm I have read and understood PG Mutual's Service and Costs Disclosure Document.

☐ I confirm I have read and understood the Key Information Document for Income Protection Plus and the Policy Terms.

☐ I consent to MorganAsh, PG Mutual's underwriting partner, contacting me with regards to my PG Mutual Income Protection Plan Application, if required by PG Mutual. View/download Your Guide to Tele-Interviews.

☐ I confirm that I have made my own decision to apply for Income Protection cover with PG Mutual. I have not asked for, nor received any financial advice from PG Mutual regarding the suitability of its Income Protection product to my circumstances, and that PG Mutual therefore takes no responsibility for the product's suitability to my circumstances.

Print Full Name: _____

Signature: _____

Date: _____

Please Note: You must complete the *Your data agreement* and *Your agreement* sections for your application to be considered.

Your rights under the access to Medical Reports Act 1988

(The Access to Personal Files and Medical Reports (NI) Order 1991)

It may be necessary for us to apply for a medical report/sight of your medical records from a doctor who has cared for you, but before we can do this we need your consent, by signing the declaration below. Under the Access to Medical Reports Act 1988 (The Access to Personal Files and Medical Reports (NI) Order 1991) you have certain rights relating to any report prepared by him and these are summarised below:

1 **You do not have to give your consent. However, if you do not, this may result in us being unable to process your application/claim.**

2 **Your doctor is required to retain a copy of the medical records/ medical report for at least 6 months. During this time you may ask your doctor to see a copy of this report.**

3 **If, before the medical records/report is sent to us you write to your doctor saying that you wish to see the records/ report, you then have 21 days in which to contact him to arrange access. We will notify you at the same time we write to your doctor to tell him you wish to see the medical records/ medical report.**

4 **If you wish to see the medical records/ report before it is sent to us, the doctor cannot submit it until he has your consent.**

5 **You may ask the doctor to amend any part of the medical records/report which you consider incorrect or misleading. If your doctor is not in agreement, you may append your comments to the report.**

6 **The doctor can withhold access to any part of the medical records/ report if he feels you or others would be harmed by seeing it. In such cases, he must notify you and you will be limited to seeing only the remaining part of the report. If the whole medical record/report is affected, he must not submit it unless you give your consent.**

Whether or not you complete the declaration below, upon request to your doctor you have the right to see a copy of the medical records/ report up to six months after it has been submitted. However if you are provided with a copy the doctor can charge a reasonable fee to cover his costs. You should be aware that if you indicate that you wish to have access to any copy of medical records/ medical report it may result in a delay of processing your application or claim.

I have read the notes above and am aware of my rights under the Access to Medical Reports Act 1988 (The Access to Personal Files and Medical Reports (NI) Order 1991) and that:

I *do not/*do wish to see a copy of the medical records/ report and or sight of my medical records that my medical practitioner may provide before it is submitted (*DELETE AS APPROPRIATE).

Declaration

I hereby consent to the request for a medical report and or sight of my medical records relating to me by PG Mutual and authorise the release to and use by of any information required by them in connection with this application OR as a result of the sickness or/and injury which is subject to a claim.

Signature: _____

Date: _____

Instruction to your bank or building society to pay by Direct **Debit**

1 Name and full postal address of your bank or building society

To the Manager
Bank or building society:

Address:

Postcode:

2 Name(s) of account holder(s)

3 Branch sort code
(from the top right-hand corner of your cheque)

4 Bank or building society account number

5 PG Mutual Member Number (For office use only)

6 Instruction to your bank or building society

Please pay PG Mutual Direct Debits from the account detailed on this Instruction, subject to the safeguards assured by the Direct Debit Guarantee.

I understand that this Instruction may remain with PG Mutual and, if so, details will be passed electronically to my bank/building society.

Signature(s):

Date: / /

Banks and building societies may not accept Direct Debit Instructions for some types of account.

Tel: **01727 840095** Fax: **01727 832710** Email: **info@pgmutual.co.uk**

pg mutual Protecting Healthcare Professionals

Please detach and keep this Guarantee before sending the Instruction to PG Mutual.

The Direct Debit Guarantee

- **This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits**
- **If there are any changes to the amount, date or frequency of your Direct Debit, PG Mutual will notify you 7 working days in advance of your account being debited or as otherwise agreed.**
- **If you request PG Mutual to collect a payment, confirmation of the amount and date will be given to you at the time of the request**
- **If an error is made in the payment of your Direct Debit, by PG Mutual or your bank or building society, you are entitled to a full and immediate refund of the amount paid from your bank or building society**
- **If you receive a refund you are not entitled to, you must pay it back when PG Mutual asks you to You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.**