LIFE AND DISABILITY

PERSONAL HISTORY QUESTIONNAIRE (PHQ) - AIARC

This form should be completed by new Members whose life assurance amount exceeds USD 1,350,000, or (in respect of LTD cover) any new Member whose Earnings exceeds USD 270,000.

In addition, this form should be completed by existing Members who are specifically requested to do so.

STRICTLY PRIVATE & CONFIDENTIAL

ISSUED BY
UTMOST WORLDWIDE LIMITED

A WORLD *of* DIFFERENCE

utmost™
CORPORATE SOLUTIONS

Please complete all questions. Should a question be irrelevant, please indicate "N/A" in the section (do not leave any blank response).

Please complete all sections in BLOCK CAPITALS or tick the boxes, where appropriate.

As you answer the following questions, please remember that you must disclose, in writing to us, all material facts. These are facts which an insurer would regard as likely to influence the assessment of an application. If you are in any doubt as to whether any facts are material, you should disclose them to us, as failure to do so may result in the loss of benefits, in the event of a claim, under the Policy.

Please remember that should you choose not to complete this form or not to undergo any additional examination and/or tests, we will be unable to assess the risk and, as a result, your insurance cover may be restricted.

Due to the nature of the information which is requested, you may elect to return this form and any associated information directly in a sealed envelope, marked Private and Confidential and addressed to The Chief Underwriter, Utmost Worldwide Limited, P.O. Box 613, Utmost House, Hirzel Street, St Peter Port, Guernsey, GY1 4PA. Alternatively, you may send a scanned copy, signed and dated to underwritingandclaims@utmostworldwide.com.

In the event that we need to clarify any data or omissions within this form and/or to keep you updated with the progress of the application, we will do so by e-mail, using the address you provide on this form.

Name of Employer:

PART A – PERSONAL DETAILS

Surname: Title: (Mr, Mrs, Miss etc)

First Name(s):

Former Name (if changed):

Are You: Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Long Term Partner ☐

Residential Address:

Telephone Number (Home): E-mail Address (Home):

Telephone Number (Work): E-mail Address (Work):

Date of Birth: D D M M Y Y Sex: Male ☐ Female ☐

Nationality: Place of Birth:

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What is your precise occupation/ job title?

Does your occupation involve activities or duties involving manual work, heavy machinery or tools, working at heights, underground, underwater, offshore, explosives, aviation other than as a fare paying passenger on a scheduled flight or anything else which could be considered hazardous? Yes ☐ No ☐

If 'Yes', please provide details.

Name and FULL address of your Doctor plus your Patient/ Clinic ID number (if known):

Telephone Number (of Doctor):

Fax Number (of Doctor):

E-mail Address (of Doctor):

Have you changed your Doctor in the last two years? Yes ☐ No ☐

If 'Yes', please provide name and FULL address of your previous Doctor(s) plus your Patient/ Clinic ID number (if known):

Telephone Number (of previous Doctor):

Fax Number (of previous Doctor):

E-mail Address (of previous Doctor):

Dates registered between: D D M M Y Y and D D M M Y Y

We may ask you to be examined by an independent examiner appointed by us or our agents. If we do this, in which city would you prefer this to take place? **Please confirm preferred geographical location (if possible include post/ zip code).**

Do you expect to be unavailable to attend an examination within the next 60 days? Yes ☐ No ☐

If 'Yes', please provide dates when available.

If you have undergone a health screening or a pre-employment medical within the last six months and would like us to consider this information, please provide, or ask your employer to provide, a copy in a sealed envelope marked "Private & Confidential", addressed to The Chief Underwriter, Utmost Worldwide Limited, PO Box 613, Utmost House, Hirzel Street, St Peter Port, Guernsey, GY1 4PA or by email to underwritingandclaims@utmostworldwide.com.

This may avoid the need for us to seek additional medical information.

Please tick the box if you are forwarding a report. ☐

PART B – HEALTH AND OTHER INFORMATION

If you need additional space for any answer, please use **PART C**.

Height: (Metres) (Feet/ Inches)

Weight: (in indoor clothing) (Kilos) (Lbs)

1. Have you consulted a doctor or any other member of the medical profession in the last five years? Yes ☐ No ☐
(There is no need to disclose colds, flu, routine vaccinations, wisdom teeth extraction, employment medicals and (for females only) routine advice about contraception or uncomplicated pregnancy.)

OR

Have you ever been an in-patient or out-patient at a hospital, clinic or nursing home for any condition or illness which required medical, surgical or psychiatric advice, treatment, investigations, tests, x-rays or electrocardiograph? Yes ☐ No ☐

If you have answered 'Yes' to either question, please complete this section. Please complete **ALL** boxes, giving as much information as possible about each and every condition, ailment, investigation and visit.

Please continue on a separate sheet if necessary, detailing the same information as below, for each.

Date of onset/ diagnosis	Diagnosis or full description of symptoms if diagnosis unknown*	Investigations/ tests undertaken (with dates and results, if known)	Past treatment (with date ceased)	Current treatment (if any)	Number of days taken off work for this condition

***Such as nature/ severity of the symptoms experienced, duration and frequency of recurrence, if any.**

Date you last consulted your doctor: D D M M Y Y

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Please provide details of outcome/ results of follow up/ details of treatment, if any.

2. Have you ever been advised that your blood pressure or cholesterol is too high?

If 'Yes', please provide details: Yes ☐ No ☐

Cholesterol	**Please confirm latest reading, if known:**
Blood Pressure	**Please confirm latest reading, if known:**

3. Are you taking tablets, medicine or drugs of any kind, whether prescribed or otherwise, or are you receiving any form of treatment (other than as disclosed in Question 1)? Yes ☐ No ☐

If 'Yes', please state the drug name, strength, condition & dates, or what treatment you are receiving:

4. **a)** Have you ever tested positive for HIV/ AIDS or are you awaiting the results of such a test? Yes ☐ No ☐
   b) Have you ever tested positive for Hepatitis B or C or are you awaiting the results of such a test? Yes ☐ No ☐
   c) Have you ever been tested/ treated for any sexually transmitted diseases? Yes ☐ No ☐

If you have answered 'Yes' to **a)**, **b)** or **c)**, please provide full details including dates:

5. Before attaining the age of 65, have either of your parents or brothers or sisters suffered from or died from any of the following?

	Yes	No	Don't Know
Stroke			
Heart disease			
Cancer			
Diabetes			
Multiple sclerosis			
Alzheimer's disease			
Muscular dystrophy			
Parkinson's disease			
Motor neurone disease			
Haemochromatosis			
Huntington's disease			
Polycystic kidney disease			
Polyposis of the colon; or			
Any other potentially hereditary disease or disorder?			

If yes, please provide full details:

Relationship (i.e. father, mother, brother or sister)	Diagnosis or cause of death	Age when diagnosed or died	Current age, if applicable

6. Do you consume alcohol? Yes ☐ No ☐

If 'Yes', please state weekly average, **as a unit.**
A pint of beer is 3 units, 125ml glass of wine 1.5 units and 25ml spirit 1 unit.

Beer (units) | **Wine (units)** | **Spirits (units)**

7. a) Do you or have you smoked, any cigars, cigarettes, a pipe or used chewing tobacco, or other nicotine based products, in the last twelve months? Yes ☐ No ☐

If 'Yes', please provide details including daily consumption:

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b) Have you ever been advised to give up using tobacco products on medical grounds? Yes ☐ No ☐

If 'Yes', please provide details including dates and reasons:

c) Have you stopped smoking in the last twelve months? Yes ☐ No ☐

8. Have you ever received benefit from an income protection, disability or critical illness contract, whether sponsored by your employer or yourself? Yes ☐ No ☐

If 'Yes', please give full details below:

Insurer	Policy number (if known)	Type of policy	Date of application	Claim details
			D D M M Y Y	

9. Have you ever had any of the following, undergone any investigation in connection with them or are you awaiting any investigations?

a) Disease or disorder of the heart, arteries or veins, including heart attack, angina, cardiomyopathy, heart murmur, heart valve defect? Yes ☐ No ☐

b) Diabetes, raised blood sugar or sugar in the urine? Yes ☐ No ☐

c) Cancer, leukaemia, Hodgkin's disease, lymphoma, melanoma or brain or spinal tumour? Yes ☐ No ☐

d) Any form of mental illness that has required hospital treatment or referral to a psychiatrist? Yes ☐ No ☐

e) Stroke, Transient Ischaemic Attack (TIA) or brain haemorrhage, recurrent headaches or migraine? Yes ☐ No ☐

f) Disease or disorder of the brain, spinal cord or nerves including multiple sclerosis, epilepsy or fits or paralysis? Yes ☐ No ☐

g) Any neurological symptoms including numbness and tingling of the limbs or face, visual disturbance including blurred vision or double vision, dizziness or optic neuritis? Yes ☐ No ☐

h) Any chronic tiredness, fatigue, post viral fatigue or myalgic encephalopathy (ME)? Yes ☐ No ☐

If you have answered 'Yes' to any of parts **a)** to **h)**, please give full details indicating the question number (e.g. **9. a)**.

Please continue on a separate sheet if necessary, detailing the same information as below, for each.

Question (e.g 9. a)	Condition (e.g. angina)	Symptoms	Date of diagnosis	Date of last major attack	Number of days taken off work for this condition
			DD MM YY	DD MM YY	
			DD MM YY	DD MM YY	
			DD MM YY	DD MM YY	

Question (e.g 9. a)	Date last taken off work for this condition	Are you receiving treatment for this condition?	If Yes, provide full details	If Yes, provide name & address of specialist	Are you completely recovered?
	DD MM YY	Yes/No			Yes/No
	DD MM YY	Yes/No			Yes/No
	DD MM YY	Yes/No			Yes/No

10. Has any application for life, disability or critical illness assurance ever been postponed, declined, withdrawn or accepted on special terms at any time or have you withdrawn an application? Yes ☐ No ☐

If 'Yes', please give full details including company applied to and policy number (if known), type of policy, date of application, reason for decision (if known):

PART C – FURTHER INFORMATION

Please use this space to tell us anything else we need to know. If you use it to give more information about any of the questions, please give us the Part and Question number that you are referring to. (For example: Part **B**, Question **5**.)
Please continue on a separate sheet if necessary:

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PART D – DATA PROTECTION

Utmost Worldwide Limited is registered with the Office of the Data Protection Commissioner in Guernsey and must comply with the Data Protection (Bailiwick of Guernsey) Law, 2017 ("the Law").

Data protection legislation protects the privacy rights of individuals and provides certain statutory rights that are explained in our 'Data Privacy Notice', which you can access via our website at **utmostworldwide.com**

As part of this application, you are required to disclose to us certain Personal Data about you, which we will use only in managing and administering your membership under the Policy and to comply with our statutory and regulatory obligations. If you object to or withdraw consent for the use of your Personal Data in this respect, you will be required to terminate your membership because we cannot operate the Policy without reference to your Personal Data.

Personal Data records held by us will typically comprise of, but not be limited to, hard copy documents, scanned documents, transaction information, e-mail communications, telephone voice recordings, where applicable, and CCTV images, if you visit our premises, that are stored on electronic and/or manual systems.

All Personal Data is held by us on a strictly confidential basis but may be transferred or disclosed by us in the following circumstances:

- with other companies in our corporate group;
- to a Medical Practitioner or any third party as may be authorised by you;
- to our service providers, meaning any agent, contractor or third party service provider, including but not limited to our administration and claims outsourcing partners, investment fund managers, investment trustees and custodians, fiscal representatives or re-insurers, that provide services to us in connection with the provision of our insurance products and services to you, wherever they are located in the world;
- to statutory authorities such as regulators, tax authorities and law enforcement agencies in accordance with applicable law, including in connection with tax information exchange and the prevention and detection of money laundering, terrorist financing, fraud and other financial crimes.

We are required to hold your Personal Data during the lifetime of your membership to the Policy and we will retain it for a period of up to 10 years after our business relationship with you ceases, at which time it will be erased or otherwise put beyond use.

Subject to the terms of our Data Privacy Notice, we will provide you with a copy of the Personal Data that we hold about you upon request and we will correct any Personal Data identified as being inaccurate or out of date. You should keep us informed of any change in the Personal Data that we hold and let us know immediately if you become aware of any errors or omissions in that data accordingly.

By signing this form, or any relevant section, the signatory(ies) provides express consent to any Personal Data, including, where necessary, Sensitive Personal Data (as defined under the Law (including medical data), being transferred or disclosed in the circumstances outlined above.

PART E – IMPORTANT NOTES

1. The full amount of your cover may not be provided until we have assessed and accepted the application.
2. Cover may be restricted to the Free Cover Limit provided under the policy, if applicable.
3. Cover may be offered on special terms but occasionally we may be unable to offer terms.
4. We may ask you to contact your doctor to speed up the completion of reports that we have requested.
5. If we ask you to attend a medical examination it may be necessary to share the application information with an authorised third party who will arrange for the examination to take place.
6. It may be necessary to share medical information obtained from a medical examination report or from a health screening report with your doctor.
7. We will hold your medical information in a secure location, treat it as confidential and ensure access to it is strictly limited.
8. All answers to questions in this form, and any questions we subsequently ask, must be correct with all relevant information provided. Any failure to do so may result in the wrong terms being quoted or a claim being rejected or reduced.

9. It is important that we are told about anything that might affect our judgement and acceptance of this application. Please disclose such information, even if you have doubts about its relevance.
10. It may be necessary to send your application and relevant medical reports to our reinsurers for their approval.

PART F – ACCESS TO MEDICAL RECORDS

We seek your express consent in order that we may approach any doctor for medical information about anything which affects your physical or mental health. This is applied at the initial application, at renewal and in the event of any claim.

If you decide not to allow us to contact your doctor, it may mean that we are unable to proceed with this application.

PART G – YOUR DECLARATION AND CONSENT

To the best of my knowledge and belief all statements made, which include all verbal disclosures, have been recorded accurately in this application or are enclosed in a sealed envelope marked "Private and Confidential", and are true and complete.

Please tick this box if you have attached a Private and Confidential envelope. ☐

I will inform you immediately of any changes that occur before acceptance terms have been issued. I understand that any failure to do so may result in my coverage being declared void and any benefits may not be paid.

I expressely consent to Utmost Worldwide or its agents obtaining medical information from any doctor about anything which affects my physical or mental health. They may also obtain relevant information from other insurers about previous or concurrent applications for any insurance that I have applied for.

I authorise those asked for such information to provide it on the production of a copy of this consent. This consent allows Utmost Worldwide or its agents to obtain medical records at any time before or after my death to support any claim made on the benefits due under the policy.

I expressely consent to medical information being shared with my Doctor.

I understand that you may share information about any claim with other insurers and that you may, in response to searches you make in connection with any claim, receive information from other insurers.

I agree that a copy of this declaration will have the validity of the original.

I acknowledge and accept that if any statements are inaccurate or I have withheld relevant information, any payment of benefit may be refused.

If any inaccurate statement or withheld information is discovered, Utmost Worldwide may investigate this before electing what action they may wish to take.

Relevant information is information which may influence the assessment and acceptance of this application. It is the information on which the underwriters would rely in considering the application. If there is any doubt as to the relevance of any information, it should be disclosed.

EMPLOYEE'S DECLARATION AND CONSENT

I have read and understood **PARTS D**, **E**, **F** and **G**.

Employee Signature: _____ Date: D D M M Y Y

Name in Block Capitals: _____

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CONTACT US

To find out more please contact us.

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CORPORATE SOLUTIONS

Utmost Corporate Solutions is the trading name used by Utmost Worldwide Limited and a number of Utmost companies.

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