

Declaration of Health Application

This form may be used:

- To update an application that you submitted within the previous 12 months.
- When reapplying to recommence cover on a lapsed policy

Application/Policy Number

1. Details of Life(s) Assured

First Life Assured

Name

Date of Birth

Telephone No.*

Second Life Assured

(DD/MM/YYYY)

Consent to seek
information from
other insurers**☐

Yes

☐

No

☐

Yes

☐

No

* By providing contact details you are consenting to New Ireland or a duly authorised agent of New Ireland phoning you if it considers it necessary to obtain further medical or other information relating to your application or revival.

** Information means medical and other relevant details given to an Insurer by you or any doctor/nurse in connection with a life assurance application on your life

2. Important Information in relation to Material Facts

You are legally obliged to inform us of all relevant information (material facts) in this Declaration of Health Form. Material facts are those, which an insurer would regard as likely to influence the assessment and acceptance of the application for which this Declaration of Health Form is being used. If you are in doubt as to whether certain facts are material, such facts should be disclosed.

The policy may be cancelled, any claim on the policy may not be paid and you may have difficulty purchasing insurance elsewhere:

- If you do not inform us of 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 which occur before the policy commences or revives.

You may submit answers to any medical questions direct to the Chief Medical Officer, New Ireland Assurance, 11-12 Dawson Street, Dublin 2. Please indicate in your letter your name and the application or policy number to which the information applies. All information will be treated in strictest confidence.

Where you have a doctor you are required to provide details below. We may not necessarily contact your doctor. Even if we do, you are still required to disclose all material facts as part of your application. We may ask you to attend a medical examination with your own doctor, an independent doctor or nurse.

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) including investigations and/or symptoms of any genetic disease or disorder, in answer to all the questions set out below.

3. Doctor/Clinic Details

First Life Assured

Do you have a doctor?
(in Ireland or abroad)

☐

Yes

☐

No

If yes, please provide

Name of doctor

Address

Have you attended any other
doctor (in Ireland or abroad)
in the last 12 months?

☐

Yes

☐

No

If yes, please provide

Name of doctor

Address

Second Life Assured

☐

Yes

☐

No

☐

Yes

☐

No

4. Health Details

Please answer the following questions.

If you tick "Yes" below, please provide details such as: name of condition, when diagnosed, results of tests/ investigations, treatment/medication and date of last review with your GP/specialist.

	First Life Assured	Second Life Assured	First Life Assured	Second Life Assured
1. In the last 12 months	Yes No	Yes No		
a) have you attended or been advised to attend any doctor, specialist or consultant, hospital or clinic for any medical advice, check up, medical scans or medical tests, medical treatment, medical investigation or surgical procedure? (You may ignore colds, flus, contraception and uncomplicated pregnancy)	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
b) have you been prescribed any new medication or treatment or has there been a change to any regular prescribed medication or treatment?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
c) has there been any deterioration in any medical condition?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		

4. Health Details - cont'd

	First Life Assured		Second Life Assured		First Life Assured	Second Life Assured
	Yes	No	Yes	No		
2. Are you awaiting any medical referral or medical investigation, medical test results or surgical procedure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
3. Have you had or do you have any symptoms for which you have yet to seek medical advice or treatment? (for example unexpected weight loss, change in bowel habit, a growth, cyst or lump)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

5. Declarations/Data protection consents

1. I declare that all statements made in this Declaration of Health Form, in any statements written at my request or in any questionnaire completed by me or by a medical examiner in connection with the application for which this Declaration of Health Form is being used and signed by me are true and complete and shall form the basis on which the proposed contract is effected or existing policy is revived.
2. I confirm that I have read and understand the important notes in relation to material facts and understand that if I fail to disclose all material facts in this Declaration of Health Form, in any statements written at my request, in any questionnaire completed by me or by a medical examiner in connection with the application for which this Declaration of Health Form is being used, the contract with New Ireland Assurance could be void, any claim may not be paid and I may have difficulty purchasing insurance elsewhere.
3. I consent to New Ireland Assurance 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 Assurance such information. I understand this authority shall remain in force after my death.
4. 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 Assurance seeking and receiving medical and other relevant details given to an insurer by me or any doctor/nurse in connection with a life insurance application on my life.
5. I understand that any changes to the statements in this Declaration of Health Form or any other statements made by me in connection with the application for which this Declaration of Health Form is being used before the proposed cover comes into force/is revived must be notified in writing to New Ireland Assurance.
6. I understand and agree the details provided in this form may be held by New Ireland Assurance on computer file, in any other dematerialised form or in written hard copy and may be used or passed to third parties for administration, regulatory, statistical analysis, market research, customer care and service purposes.

First Life Assured

Signature

Date

 (DD/MM/YYYY)

Second Life Assured

 (DD/MM/YYYY)

First Policy Owner

(if different from First Life Assured)

Signature

Date

 (DD/MM/YYYY)

Second Policy Owner

(if different from Second Life Assured)

 (DD/MM/YYYY)

