

Declaration of Health FOR EXISTING MEMBER

Date

Plan number

Please answer all of the questions on this form honestly and in full. If you miss any information out, or give us misleading information, this could mean that we do not pay your claim. If you are not sure whether to include any information, then please include it.

The information you have given us on your original application has formed part of your existing contract with Holloway Friendly. If any of the information has changed from your original application form or within the previous 5 years where indicated, you must tell us.

Please contact us if you:

- need reminding of the information you put in your application form and would like us to send you a copy
- are unsure whether to include any information on this form

Please remember that you must tell us if your health changes, or any other detail affecting your reinstatement changes between you completing this form and sending it back to us, and your plan restarting. If you need more space for any information, please use a blank page.

1. About your personal details

a: Your full name	
b: Since you completed your original application have you applied for any other Income Protection cover with any other insurance company?	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details)

2. Your job, hazardous leisure activities and lifestyle

a: Since you completed your original application have you continued to reside within the UK and/or has there been any change in your intention of working, travelling or residing outside the UK?	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details)
b: Has there been any change in your job, or the activities involved in your job since you completed your original application? <i>e.g. You now work at heights, your job now involves hazardous duties or an increase in manual or driving work</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details)
c: Have you become a member of the TA or Armed Forces reservists since you completed your original application?	<input type="checkbox"/> No <input type="checkbox"/> Yes
d: Since you completed your original application have you taken up any hazardous leisure activities? <i>e.g. Aviation, caving or potholing, hang-gliding, motor sports, parachuting, rock climbing, underwater diving or yachting.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details)
e: Has there been a change to your smoker status since you completed your original form? <i>A smoker is anyone who has used any form of tobacco or nicotine replacement products in the last 12 months.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details)

3. Your Health

Please answer all of the questions in this section from the date you completed your original application or within the previous 5 years, whichever is the shorter

a: Has your weight increased or decreased by 7lbs (3kg) or more.	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details)
b: I. Have you become certified by a doctor as unfit for work? II. Are you experiencing any symptoms or complaints for which you have not consulted a doctor? III. Are you waiting for, or been advised to seek, any medical or surgical consultation or follow-up?	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details)
c: Have you: <ul style="list-style-type: none"> • Attended any medical appointment • Taken any test or medication or • Received any other treatment? <i>Tick Yes even if you are awaiting the result of any test or currently receiving any treatment.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details)
f: Have you had exposure to the risk of HIV infection? <i>This exposure could be through unsafe sex, intravenous drug abuse, or blood transfusions or surgery undertaken outside the EU.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details)
<p>You do not need to tell us about any of the following treatments and confirmed conditions: acne, athlete's foot, blisters, cold sores, common colds, conjunctivitis, contraception, ear wax or syringing, food poisoning, haemorrhoids, hayfever, infected or extracted wisdom teeth, infertility treatment, influenza, ingrowing toenails, miscarriage, sinus trouble, tonsillitis, uncomplicated pregnancy, vaccinations or vasectomy.</p>	

4. Declaration

I declare that

- The answers given in this declaration of health form are true and complete, to the best of my knowledge and belief

I agree that:

- This declaration of health form, together with my original application form, the quote and the plan details shall form the basis of the reinstatement between me and Holloway Friendly
- If my health changes or any other detail affecting the reinstatement, before the date the plan restarts, I will inform Holloway Friendly in writing. I understand Holloway Friendly will then have the right to reconsider terms if appropriate.

I understand that:

- If I do not give Holloway Friendly complete and accurate answers to any of the questions on this form, they may cancel my plan or amend the terms and they may also refuse any claim.

Signature	Date
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