

**Metropolitan Police Friendly Society**

Berwick House, 8-10 Knoll Rise, Orpington, Kent, BR6 0EL

Despatch: MPFS Orpington - Phone: 01689 891454 - Metphone: 28192

Email: enquiries@mpfs.org.uk - Web: www.mpfs.org.uk

**Incapacity Cover Plans – Application Form**

**Please complete this form, print and sign then return to us**

Title Mr/Mrs/Ms/Miss

Surname

Forename

Date of Birth  Gender M  F  Height  Weight

Do you smoke, or have you in the last 12 months? Yes  No  If yes, how many do you smoke each day?

Constabulary

Date service commenced  Date of last promotion

Warrant / Pay No MPFS or City only  Rank / Grade

Station/Branch  Home Address

Daytime Tel No  Mobile No

Post Code

Preferred Email Address

**COVER DETAILS**

I wish to apply for: Income Protection Plan  Critical Illness & Retirement Cover Plan

Monthly Gross Basic/National Pay (line 1 on payslip MPS) only £  Monthly London weighting/Location Allowance (line 2 on payslip MPS) only £

Are you in receipt of Competency Related Pay? Yes  No  Are you a member of the police pension scheme? Yes  No

**How did you obtain this brochure:**

Requested by: Phone  Website  Aware

metfriendly Representative  metfriendly Display Unit  Location  Event

Please answer the following questions very carefully:

	Yes	No
1. Do you drink more than 30 units of alcohol each week or have you ever regularly done so? (for an explanation of units of alcohol, see for example <a href="http://www.drinking.nhs.uk">www.drinking.nhs.uk</a> )	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever taken any drugs for recreational purposes	<input type="checkbox"/>	<input type="checkbox"/>
3. Dangerous/hazardous activities which are part of your duties are covered under the policy; however, hazardous sports, pastimes and activities (e.g. scuba diving, private flying) are not covered unless specifically endorsed on the policy. If you intend to engage or have any intention of engaging in any such activity please tick the "yes" box and give full details overleaf or on a separate piece of paper	<input type="checkbox"/>	<input type="checkbox"/>
4. During the last 5 years have you ever been absent from work due to Injury or sickness for a period exceeding 5 consecutive days?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you currently on restricted or recuperative duties?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you hold any other policies covering incapacity due to accident or illness except those taken out to cover a loan?	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you at present applying, or have you applied within the last 2 years, for Critical Illness Insurance?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever tested positive for HIV / AIDS, Hepatitis B or C or been tested or treated for any other sexually transmitted disease or are you awaiting the results of such a test?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever sought, or are you currently seeking or intending to seek, medical advice for:	<input type="checkbox"/>	<input type="checkbox"/>
a. any disease or disorder of the heart or circulatory system including raised blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
b. stroke, transient ischaemic attack or any form of brain haemorrhage?	<input type="checkbox"/>	<input type="checkbox"/>
c. cancer (including leukaemia, lymphoma and Hodgkin's disease) or any mole or skin marking that has bled, changed or become painful or any form of tumour or lump?	<input type="checkbox"/>	<input type="checkbox"/>
d. diabetes, sugar in the urine or raised cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
e. any disease or disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>
f. Multiple Sclerosis, Parkinson's disease, Alzheimer's disease, Motor Neurone disease, optic neuritis, numbness, paralysis, loss of feeling, blurred or double vision or any hereditary disorder?	<input type="checkbox"/>	<input type="checkbox"/>
10. Before the age of 65 have your parents, brothers or sisters (including half brothers or half sisters) ever suffered from heart or circulatory disease (including heart attack or angina), cancer, stroke, high blood pressure, diabetes, paralysis, a disorder of the nervous system, eye disease, familial polyposis of the colon, Huntington's disease, Motor Neurone disease, Kidney disease or any hereditary disease?	<input type="checkbox"/>	<input type="checkbox"/>
11. During the last 5 years have you suffered from any other illness or injury requiring investigation, consultation, treatment, tests (including blood tests) or advice by a specialist, clinic, hospital or doctor or do you have any current symptoms or complaint for which you have not sought medical advice but intend to (you do NOT need to disclose matters related to uncomplicated pregnancy, fertility treatment, hayfever, common colds and flu or vaccinations)?	<input type="checkbox"/>	<input type="checkbox"/>

**IMPORTANT NOTE – Question 12 has to be answered ONLY if you have answered YES to Question 11 above. We may forward a questionnaire appropriate to your medical history, but please still provide any further information which you think may help us in making a speedy decision**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 12. During the last 3 years have you suffered from:  | <input type="checkbox"/> | <input type="checkbox"/> |
| a. epilepsy, fits or blackouts?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. mental illness, anxiety, stress, post traumatic stress disorder, depression or any other psychiatric or nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. arthritis, rheumatism, gout or trouble with your bones, joints or muscles?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. asthma, bronchitis, pneumonia or other respiratory disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. any disorder of the stomach, digestive system, liver or bowel?  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. any kidney or bladder disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| g. any gynaecological disorder or abnormality of the breast, uterus or cervix?   | <input type="checkbox"/> | <input type="checkbox"/> |
| h. any form of allergy, skin complaint or any problem with sight or hearing?   | <input type="checkbox"/> | <input type="checkbox"/> |

**IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS 1 TO 12, PLEASE PROVIDE DETAILS OVERLEAF OR ON A SEPARATE PIECE OF PAPER. If you do not do so, the processing of your application will be delayed while we obtain this information from you – we cannot consider your application without full details.**

Please note, when signing the declaration below that all relevant or material facts should be disclosed, even if you are unsure whether they are material to this insurance. A material fact is defined as one likely to influence an insurer's decision as to the acceptance of the proposal. Failure to do this may result in the insurance cover being ineffective, even if the proposal has been accepted by the insurer. Do not assume that we will obtain a report from your Doctor. We rely on you to disclose all relevant information. A copy of the terms and conditions of the proposed insurance contract and also a copy of the completed proposal form is available on request.

**Declaration – Please read this carefully**

I declare that the foregoing statements are to the best of my knowledge and belief true and complete. I agree to abide by the Rules of the Society. I authorise the deduction from my monthly salary of all contributions that may become due.

Signed  Dated

The liability of the Society does not begin until the application has been accepted. Any medical condition that arises prior to the policy start date must be notified to the Society or your claim may be denied.

If you have answered YES to any of the above questions, please use this space to provide details.