

PROPOSAL FORM FOR LOSS OF FLYING LICENCE

Your attention is drawn to the declaration at the foot of this form. It is important for renewal or for an amount additional to an existing insurance. You should declare or mention investigations where you have been told that the result is satisfactory.

A. SUR NAME _____ RANK _____
FIRST NAMES _____
ADDRESS (in full) _____
_____ POSTCODE _____
TELEPHONE (Home) _____ (Work) _____
DATE OF BIRTH _____ HEIGHT: _____
WEIGHT : (current) _____ (12 months ago) _____
ANNUAL SALARY (including bonuses): _____

B. (i) EMPLOYER: _____

(ii) TYPE OF DUTIES / AIRCRAFT : (please tick all which apply).

Commercial	<input type="checkbox"/>	Fixed Wing	<input type="checkbox"/>
Private	<input type="checkbox"/>	Rotor Wing	<input type="checkbox"/>
Instruction	<input type="checkbox"/>		

(iii) ARE YOU A MEMBER OF ANY AIRCREW ASSOCIATION?

C. ALL CURRENT LICENCES HELD : _____
(please specify type, number and country of issue) _____

D. (i) SUM TO BE INSURED: _____

(ii) ARE MONTHLY BENEFITS REQUIRED WITH A WAITING PERIOD OF LESS THAN 365 DAYS ?

YES NO

If YES, specify the waiting period required :

90 Days 180 Days

E. Please state if this Proposal is :

a) your first proposal to this Company,

or b) for renewal or an additional amount to an existing Insurance
 (if (b) state existing Policy No. and amount Insured and Agent).

F. Are you entitled to benefit from any other Loss of Licence, Permanent Health or Aircrew Disability Insurance ?

YES NO

If YES, state type and the amounts Insured.

G. Do you hold a current medical certificate ?

YES NO

Has any limitation or endorsement been imposed on any Licence you hold or have held ?

YES NO

If YES, give details _____

INSURANCE

That all sections of this proposal form should be fully completed even if it is for all conditions even though you have been declared fit. You should not omit or Failure to disclose material information may invalidate the policy.

- H. (i) Date of last aircrew medical examination - -
- (ii) Date of last electrocardiograph taken as required by the Licensing Authority - -
- (iii) Were you advised of any abnormality in or revealed by the examination?
 YES NO

If YES give details _____

- I. Have you ever been grounded or had any licence invalidated for medical reasons?
 YES NO

If YES give details _____

- J. Have you ever been required to take additional tests at or after medical examination, been referred for specialist investigation, had the issue or renewal of any medical certificate deferred, had to return for examination at less than the normal interval of time or ordered to take drugs or follow any special diet or treatment?
 YES NO

If YES give details _____

- K. Have you consulted any medical practitioner or attended hospital during the last FIVE years other than for the purpose of obtaining or renewing your licence?
 YES NO

If YES give details _____

L. MEDICAL HISTORY :

All medical conditions must be stated giving all disabilities, illnesses and accidents, with appropriate dates. If you have no medical history to declare, state NONE _____

M. Are you aware of any deterioration in your health including hearing, eyesight and blood pressure?

YES NO

If YES give details _____

N. What is your average daily consumption of alcohol? _____

O. Have you smoked cigarettes, cigars or a pipe in the last 12 months?

YES NO

If YES state average daily quantity _____

P. Has either of your parents or brothers or sisters had diabetes, heart disease, high blood pressure or a mental or nervous disease?

YES NO

If YES please give full details, including approximate age at onset

Q. Has any Insurance Company or Underwriter:

- (i) declined or deferred a Proposal from you ?
- (ii) charged or quoted more than standard rates ?
- (iii) cancelled or declined to renew your insurance ?

YES NO

If YES give details _____

R. Access to Medical Reports Act, 1988 (Applies to UK residents only) (Please see over for further details).

I do / do not wish to see the report before it is sent to the Insurers*
 *Delete as applicable.

I have been informed of my rights under the Access to Medical Reports Act 1988 and I hereby consent to the Insurers obtaining medical reports in connection with this application.

S. Preferred Payment Option: (If applicable)

- Direct Debit (UK only)
- Continuous Credit Card Authority (Sign authority attached)
 (Visa/MasterCard/Euro card/Access)
- Cheque / Eurocheque (Annual payments only)
- Switch (Annual payments only)
- Switch issue number
- Other, please specify _____ (Annual payments only)

Preferred payment frequency:

Monthly Annually Quarterly

I hereby declare that to the best of my knowledge and belief the answers to the foregoing questions whether in my own handwriting or not are true and complete and that I have not withheld any information, which might influence the decision of the Insurers with regard to this proposal. I agree that this proposal and declaration shall be the basis of the Contract between me and the Insurers if a policy is issued.

SIGNED _____

DATE : _____

The Company reserves the right to impose special conditions or refuse to accept a proposal for insurance.