Friends First
Part of the EUREKO Group
Looking forward to your future

GRA INCOME PROTECTION PLAN
APPLICATION FORM

Income Protection Plan for members of the GRA

SECTION 1 PERSONAL DETAILS

Mr. Mrs. Ms. Male Female

First Name:

Surname:

Home Address:

Marital Status:

Date of birth:

Registration Number:

Station:

Contact Tel. Number:

Email Address:

Date attested:

SECTION 2 CONFIRMATION OF ELIGIBILITY FOR MEMBERSHIP

Important Information
You should obtain a copy of the plan booklet and understand the conditions before joining. Please carefully read each question below and the declaration overleaf before completion. If you do not disclose all material facts in answering the questions below your cover will be void and no claim will be paid. A material fact is one which an Insurer would regard as likely to influence the assessment and acceptance of your proposal for insurance. If you are in any doubt as to whether certain facts are material, such facts should be disclosed.

I confirm that:

I am a member of the GRA

I am actively at work or capable of being actively at work on the date below.

I have read and understood the conditions of membership and I am eligible to join the scheme.

SECTION 3 BASIC MEDICAL DETAILS

Please note: In answering the questions in either this section or in section 5, if required, you do not need to disclose details relating to the following ailments: Acne, Anal fissure (single episode only), Hayfever (without asthma), Ganglion, Minor allergies, Thrush/ Candidiasis, Chickenpox, Colds/Influenza, Food poisoning, Measles, Heat stroke/Sunburn/Sunstroke, Laryngitis, Lockjaw (provided full recovery has been made), Mumps, Pharyngitis, Stomach bug (including gastroenteritis once fully recovered), Glandular fever (provided fully recovered), IGTN, Haemorrhoids/piles, Verucca, Childhood bronchitis, Pregnancy (assuming no complications), Miscarriage (assuming no complications), Sinusitis/Nasal Polyps, Tonsillitis/Quinsy

	Yes	No
1. Have you been absent from work due to illness or injury for more than 5 consecutive working days in the last 2 years?		
2. Are you currently taking any prescribed drugs or medication or receiving any treatment, or have you done so in the last 6 months?		
3. Have you attended, or been advised by your GP to attend, any doctor, specialist, consultant, counsellor, hospital or clinic for any medical check-up, blood, saliva or urine test, treatment, investigation or operation in the last 4 years?		
4. Have you ever suffered from or had treatment for:		
(a) Stress, post-natal depression, anxiety, depression, Nervous breakdown or mental disorder?		
(b) Slipped disc, whiplash or other neck or back problem?		
5. Has any application for life, critical illness or salary protection cover (disability benefit) on your life to any insurer ever been declined, postponed, accepted at an increased premium or with an exclusion imposed?		

If you answered Yes to any of the above questions, please complete Section 4 – Health Details (overleaf).
If you answered No to all of the above questions, you need not complete Section 4. You must still complete the declarations contained in Section 5.

SECTION 4 HEALTH DETAILS (Only to be completed if you answered "Yes" to any question in Section 3)

You are not required to disclose any genetic test results 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 test) in answer to the health questions including full details about your family history as required in the health details section.

Name and address of doctor:

	Yes	No
1. Are you due to have any check-up in the next 12 months in connection with any medical condition or symptoms, or are you waiting for the result of any medical investigation? If yes, please provide details below.		
2. Are you taking any prescribed drugs or medication or are you experiencing any signs of ill health or disability for which you have not yet consulted a doctor? If yes, please provide details.		
3. Have you in the last five years lived or worked abroad, are you currently doing so or do you intend to in the future? (Holidays, travel to, or residence in the EU, North America, Switzerland, Scandinavia, Australia or New Zealand can be ignored). If yes, please tell us where and for how long.		
4. Have you ever tested positive for HIV/AIDS, Hepatitis B or C or have you been tested/treated for any other sexually transmitted disease, or are you awaiting the results of any such tests? If yes, please provide details or, if you prefer, details may be sent to our *Chief Medical Officer at Friends First House, Cherrywood Business Park, Loughlinstown, Dublin 18.*		
5. Has any application for life, critical illness or salary protection cover (disability benefit) on your life to any insurer ever been declined, postponed, accepted at an increased premium or with an exclusion imposed? If yes, please give details below.		
6. Have either of your parents, or any brothers or sisters, died or suffered from heart disease, cardiomyopathy, a stroke, diabetes, high blood pressure, kidney disease, cancer, multiple sclerosis, nervous disorder, motor neurone disease, polycystic kidneys, polyposis of the colon or any hereditary disease such as Huntington's disease before age 65? If yes - please give full details i.e. which family member and age at diagnosis. If cancer, please advise site of same (e.g. colon, breast etc).		
7. Please tell us your height (without shoes) in feet/inches. ft ins		
8. Have you smoked any cigarettes, cigars, pipes or tobacco in the last 12 months? If yes, how many per day?		
9. Please tell us your weight (in indoor clothes) in stone/lbs. st lbs		
10. How many units of alcohol do you consume weekly? (1 unit = 1/2 pint of beer or a glass of wine or standard spirit measure)		
11. Have you ever been treated for alcohol abuse, or been advised by a doctor to cease or reduce your alcohol consumption, or taken drugs such as cannabis, cocaine, heroin or any non-prescribed drugs?		
12. Do you, or do you intend to, engage in hazardous or extreme sports or pastimes of any kind e.g. mountaineering, motor sports, diving, equestrianism or aviation (other then as a fare paying passenger)? If yes, please provide details.		

	Yes	No
13. Are any of the following an important part of your occupation or working environment? If yes, please provide details, including your occupation title. • Manual or physical activity or working at heights or depths • Working in extreme temperatures • Working with machinery or tools or with explosives or chemicals • Working in the armed forces • Working at sea/offshore		
14. Have you ever had, or been suspected of having, or consulted anyone, for example doctors, specialists, hospitals, clinics, counsellors, osteopaths or physiotherapists, about any of the following, listed a - q? If you answered "Yes" to any of the questions, please give relevant details below, e.g. description of condition, medication being taken, doctors/counsellors etc. consulted, and current status of condition.		
a) Cancer or any other growth be it malignant or benign (innocent), leukaemia, lymphoma, Hodgkin's disease, brain or spinal tumour, lumps, bumps, tumours or moles, including any mole or freckle that has bled, become painful, changed colour or increased in size, whether seen by a doctor or not?		
b) Any disease or disorder of the heart or circulatory system, irregular heart beat, or raised cholesterol, fainting, palpitations, undue shortness of breath, chest pain, rheumatic fever or raised blood pressure?		
c) Stroke or a Transient Ischamemic Attack (TIA), brain haemorrhage or permanent brain injury?		
d) Diabetes?		
e) Asthma, bronchitis, pneumonia, pleurisy, tuberculosis, sarcoidosis or any other respiratory disorder?		
f) Any problems or abnormalities with your kidneys or bladder, or any abnormality of your urine e.g. the presence of sugar, albumin or blood, or recurrent infections?		
g) Crohn's disease, ulcerative colitis, ulcer, gallstones, or any disease of your stomach, pancreas, bowels or liver?		
h) Multiple sclerosis, tremor, Parkinson's disease, paralysis, Alzheimer's disease, dementia or cerebral palsy, numbness, loss of power or tingling in any of your limbs or face, or any other disorder of the central nervous system?		
i) Epilepsy, fits, seizures, blackouts or migraine?		
j) Any problem with your eyes or vision (not wholly corrected by spectacles) including blurred or double vision and optic neuritis?		
k) Any problem with your ears, hearing or balance?		
l) Depression, stress, anxiety, chronic fatigue, ME, exhaustion or other nervous or mental disorder?		
m) Anaemia or any blood disorder?		
n) Back pain, disc problem, lumbago, sciatica, arthritis, neck pain, gout or any other muscular, rheumatic, bony or other joint problem?		
o) Psoriasis, eczema , dermatitis, or any other skin problem?		
p) A CT scan, MRI scan or any other X-ray examination within the last 5 years?		
q) A blood test, special investigation or any surgical operation* within the last 5 years?		

*Note: The following operations can be ignored Tonsillectomy, Appendectomy, Vasectomy, Adenoidectomy, Wisdom teeth extraction, Traumatic orchidectomy, Caesarean Section (assuming not currently pregnant), Cosmetic surgery (unless reconstructive after illness), Corrective laser surgery for myopia, IGTN.

SECTION 4 HEALTH DETAILS continued

Additional Details

If you answered "Yes" to any of the above questions, please provide details. Please use a separate sheet if you do not have enough room below.

SECTION 5 DECLARATIONS

Membership Declaration

I hereby apply to join the plan and confirm that I have read, and agree to be bound by, the rules of the plan.
I understand that continued membership of the plan is contingent on continuous and simultaneous membership of the GRA.
I have read over the replies to all questions in this application and declare that to the best of my knowledge and belief, all information given is true and includes all material facts and I understand that failure to disclose all relevant facts, including, where required, full disclosure of my medical details and history, may delay or prevent the acceptance of this policy and/or may invalidate future claims. If you are in any doubt as to whether a fact is a material fact you should disclose it I consent to Friends First, verbally or otherwise, seeking and receiving additional information from me or my agents where this information has not been provided on the application or where further information is required in order to process the application and such information will be deemed to be incorporated into this application. I understand that in the interest of customer service and to ensure the accuracy of records, telephone conversations between Friends First and me may be recorded.

Signature of life to be assured: X

Date: X

Please sign and date.

PLEASE ENSURE YOU READ AND SIGN THE DATA PROTECTION DECLARATION & SALARY DEDUCTION MANDATE OVERLEAF.

Data Protection Declaration

Please note that Paragraphs 3, 4 & 5 below are incorporated into this Declaration only if you were required to complete Section 4 of this Application Form. If you were not required to complete Section 4, they do not form part of your Declaration and you are not providing consent as described.

1. Friends First Life Assurance Company Limited ("Friends First") or PenPro may hold, use, disclose and process any information provided by me, which shall include the information held within this application and any subsequent information, provided verbally or otherwise, during the course of our relationship, in order to:
   a) process, manage and administer my policy
   b) communicate with me by post, telephone or e-mail
   c) comply with legal and regulatory requirements
   d) disclose data to any policyholder, life assured, beneficiary, trustee, assignee, successors, company within the Eureko/Friends First group or to any agent acting on my behalf, or to other disclosees as notified to the Data Protection Commissioner's Office and maintained on the Public Register available from that office.
2. I am aware that I have the right of access to my personal data and the right to rectify my data if it is inaccurate or has been processed unfairly.
3. I consent to Friends First collecting and processing sensitive data relating to my mental and physical health.
4. I consent to Friends First seeking medical information from any doctor or other medical professional who has at any time attended me concerning anything which affects my physical or mental health. I agree that this authority shall remain in force after my death as well as prior thereto. I further understand that in the event of me being medically examined the answers given by me to the medical examiner acting on behalf of Friends First shall be deemed to be incorporated into this application.
5. I am aware that if my proposal for insurance is declined or if I am offered insurance on special terms, then this fact will be noted on a central registry, administered by the Irish Insurance Federation, and may be shared with other insurance companies against non-disclosure of material facts. I acknowledge that Friends First may verify information provided by me against this central database and information may also be sought from other insurance companies who hold policy or other relevant information relating to me.
6. I note that failure to consent to the above will prevent Friends First from processing my application further. Furthermore, failure to answer any question contained herein may result in Friends First refusing to accept my application or denying a claim.
7. Your personal data may also be used to send you details about other similar services available from Friends First or PenPro. If you do not wish to avail of this service, please tick this box. ☐

Please sign and date.

Signature of life to be assured: ✗ **Date:** ✗

SECTION 6 – GRA INCOME PROTECTION PLAN SALARY DEDUCTION MANDATE

I hereby agree to have the premium, as set out below, and any future increases in premium to the GRA Income Protection Plan deducted each week from my salary. Such premiums will be paid to the insurer of the GRA Income Protection Plan (as directed by the GRA) on the appropriate dates. I also agree that deductions shall continue to be made unless otherwise notified by the GRA and that the rate of deductions may be changed from time to time by the GRA. I recognise that, beyond making remittance to the insurer equivalent to the amount deducted, the State accepts no further responsibility in the matter. I also recognise that the ultimate responsibility for ensuring that the deductions have been made rests with me.

Registration Number:

First Name: Surname:

Please sign. ✗ Date:

GRA Income Protection Code: 6 1 6 5 Premium: €4.90 per week

Start Date: (For Office Use Only)

PLEASE SIGN BOTH SECTIONS AND RETURN COMPLETED FORM TO:

PenPro Ltd
14 Priory Hall
Stillorgan, Co Dublin
Tel: 01 200 0100 Email: info@penpro.ie

PENPRO PENSION & PROTECTION CONSULTANTS

in association with Friends First
Part of the EUREKO Group
Looking forward to your future

Friends First Life Assurance Company Limited is regulated by the Central Bank of Ireland.
PenPro Ltd is regulated by the Central Bank of Ireland.
In the interest of customer service and to ensure the accuracy of our records calls will be recorded and monitored.