BRITISH FRIENDLY

It feels good to be covered

APPLICATION FORM

British Airways Benefit Fund (BABF) Century Plan (Adult)

IMPORTANT NOTES: Please read carefully

- All applicants must be aged between 18 and 59 inclusive. For applicants outside these ages, please call us to discuss the available options.
- When completing this form, you must take reasonable care to answer all the questions honestly and to the best of your knowledge. If in the event of a claim, it is found that you have not answered the questions correctly, this may lead to your membership being cancelled or the claim being rejected or not fully paid. If you are unsure whether or not any details are relevant you should disclose them.
- You must notify the Society straight away if there are any changes to your health or other circumstances which happen before your application has been accepted. These include a change in your occupation, country of residence, the taking up of a hazardous sport or pastime, a change in your own health or that of your father, mother, siblings and half-siblings.
- The Society will assess the application based on the information you have provided. You must not assume that we will automatically obtain a medical report or clarify or confirm the information provided.
- The Society may impose any medical exclusions or restrictions on a member's cover and all applications shall be considered and accepted, postponed or rejected.
- A copy of your completed application form is available on request.
- To improve our Customer Service we may monitor and record your telephone calls.

Please answer all questions fully in BLOCK CAPITALS

Your Details

Title (Mr/Mrs/Miss/Ms/Other): _____

Surname: _____

First name(s): _____

Marital Status: _____

Address: _____

_____

Postcode: _____

Are you normally resident in the UK?: Yes ☐ No ☐

Date of birth: _____

Occupation: _____

Are you employed or self-employed?: _____

Home phone number: _____

Work phone number: _____

Mobile number: _____

Email address: _____

Your Income

What is your gross annual income? _____

If you are employed, for what period would you continue to receive any earnings if you are unable to work due to sickness or injury? _____

In the event of sickness or injury, would you receive any other regular income or benefit from any other source? Yes ☐ No ☐

If yes, how much: £ _____ weekly/monthly

Cover required

Number of units required (min 30 to max 1000) _____

Do you want the units to increase automatically by 5% each year? Yes ☐ No ☐

Please pay sick pay once illness has lasted: one day ☐ 4 weeks ☐ 8 weeks ☐ 13 weeks ☐ 26 weeks ☐

The monthly premium will be: £ _____

To work out the premium and benefits, please refer to the tables on page 12 or call us on 0800 975 6565 for a no obligation quote

Previous Insurance

Has any application to this or any other provider for sickness, disability, accident, critical illness or life assurance ever been postponed, withdrawn, declined, offered or accepted on special terms? Yes ☐ No ☐

If 'yes', please give full details about the insurers, type of cover, dates and decisions:

_____

_____

_____

_____

_____

_____

_____

_____

If there is insufficient room, please continue on a separate piece of paper

Current & Future Hazardous Activities

In the last 5 years have you taken part in any of the following sports or pastimes or do you intend to do so?

Aviation	Yes ☐	No ☐		Outdoor rock climbing /mountaineering	Yes ☐	No ☐	
Diving	Yes ☐	No ☐		Parachuting	Yes ☐	No ☐	
Hang gliding	Yes ☐	No ☐		Potholing/Caving	Yes ☐	No ☐	
Horse riding (other than private hacking)	Yes ☐	No ☐		Rugby	Yes ☐	No ☐	
Martial arts	Yes ☐	No ☐		Sailing	Yes ☐	No ☐	
Microlighting	Yes ☐	No ☐		Winter sports (other than on-piste skiing)	Yes ☐	No ☐	
Motor sports	Yes ☐	No ☐		Any other sport which might be considered dangerous	Yes ☐	No ☐	

If you answer 'yes' to any of the above, please provide full details to include the name of the sport/pastime, if this is carried out on an amateur or professional basis and how often you participate in the sport/pastime (i.e. 1 to 2 times per week, once a month etc.)?

Have you suffered any accident or injury as a result of participating in any of the above sports/pastimes? Yes ☐ No ☐

If yes, please include the nature of the accident or injury, dates, treatment received and number of days off work:

Lifestyle

What is your height and weight? Height: ft: _____ inches: _____ or Metric Height _____ cm

Weight: st: _____ lbs: _____ or Metric Weight _____ kg

Females: What is your dress size? _____

Males: What is your waist size? _____ (at umbilicus/navel)

Have you smoked or used any tobacco or nicotine products in the last 12 months? Yes ☐ No ☐

If yes, please state your typical consumption per day: Cigarettes: _____ Cigars: _____

Rolled tobacco: _____ grams: _____ or ounces: _____

Type of nicotine replacement product _____

Have you ever been advised to reduce or stop smoking for medical or health reasons? Yes ☐ No ☐

If yes, please give full details:

Do you drink alcohol? Yes ☐ No ☐

If yes, how many units do you typically consume per week? Units: _____ 1 glass of wine (175 ml) = 2 units, 1 pint of lager/beer = 2 units, 1 measure spirits = 1 unit

Have you ever been advised to reduce or stop drinking alcohol for medical or health reasons? Yes ☐ No ☐

If yes, please give full details:

Have you ever taken or injected any drugs that have not been prescribed by a doctor? (e.g. ecstasy, cocaine, heroin, cannabis, anabolic steroids etc.)? Yes ☐ No ☐

If yes, please give the following information for each type of drug used:

- Name of drug
- In what form you have taken this
- The date you first started using this drug
- How long you took it for
- Details of any current use
- Date last used:

If there is insufficient room, please continue on a separate piece of paper

Medical History

You must take reasonable care to answer all the questions honestly and to the best of your knowledge. If you do not answer the questions correctly, your membership may be cancelled, or your claim rejected or not fully paid. If you are unsure whether or not any details are relevant you should disclose them.

Please provide full details regardless of whether or not you have seen your Doctor or required treatment.

1. How much time off work or studies have you had in the last **3** years due to illness or injury? _____ Weeks _____ Days

2. Do you currently have, or have you ever had, any of the following:

• Any disease or disorder of your heart, veins or arteries including angina, heart attack, heart defects from birth or heart surgery?	Yes ☐	No ☐
• Stroke, transient ischaemic attack (TIA), brain haemorrhage or brain injury?	Yes ☐	No ☐
• Cancer, Hodgkin's disease, leukaemia, lymphoma, brain or spinal tumours?	Yes ☐	No ☐
• Diabetes or sugar in your urine?	Yes ☐	No ☐
• Multiple sclerosis (MS), optic neuritis, Parkinson's disease, cerebral palsy, paralysis or any other disease or disorder of the neurological system?	Yes ☐	No ☐
• Epilepsy?	Yes ☐	No ☐
• Mental illness, including anxiety, stress, depression, severe fatigue, tiredness or low mood which has required specialist consultations either as an inpatient or outpatient?	Yes ☐	No ☐

3. In the last **5** years have you had any of the following:

• Back, neck or shoulder pain, or any other symptoms, disease or disorder affecting your back, neck or shoulders including arthritis, slipped disc, sciatica or whiplash?	Yes ☐	No ☐
• Rheumatism, arthritis, gout or muscular complaints including joint pains, bone fractures or repetitive strain injury?	Yes ☐	No ☐
• Nervous or mental disorders such as anxiety, depression, stress, fatigue, eating disorders or insomnia?	Yes ☐	No ☐
• Chronic fatigue syndrome, persistent or recurrent fatigue, tiredness, ME or fibromyalgia?	Yes ☐	No ☐
• High blood pressure?	Yes ☐	No ☐
• High cholesterol?	Yes ☐	No ☐
• Low blood pressure, poor circulation, chest pain, irregular heartbeat, palpitations, deep vein thrombosis (DVT), thrombophlebitis or varicose veins?	Yes ☐	No ☐
• Any disease, disorder or abnormality of the blood including anaemia?	Yes ☐	No ☐
• Any fainting, dizziness, balance problems, recurrent headaches or migraines, seizures, fits or blackouts?	Yes ☐	No ☐
• Any disease or disorder of the thyroid gland?	Yes ☐	No ☐
• Any numbness, change in skin sensation, tingling, loss of feeling, tremor, weakness or spasm in any part of your body or difficulty with co-ordination or walking?	Yes ☐	No ☐
• Any eye problems or impaired vision not totally corrected by glasses or lenses?	Yes ☐	No ☐
• Any ear or hearing problems, including recurrent infections, tinnitus, Meniere's disease or labyrinthitis?	Yes ☐	No ☐
• Any disease or disorder of the digestive system, liver, stomach, pancreas or bowel, including hernia, gastric or duodenal ulcer, hepatitis, colitis or Crohn's disease?	Yes ☐	No ☐
• Any disease or disorder of the kidneys, bladder, prostate (including raised PSA) or genito-urinary system, including blood or protein in the urine or urinary tract infections?	Yes ☐	No ☐
• Asthma, bronchitis or any other respiratory, chest or lung disorders?	Yes ☐	No ☐
• Any disease or disorder of the skin such as eczema, psoriasis or dermatitis?	Yes ☐	No ☐
• Lump, growth or cyst of any kind, or any mole or freckle that has bled, become painful, changed colour or increased in size?	Yes ☐	No ☐
• Any sexually transmitted disease?	Yes ☐	No ☐
• Female only - Any gynaecological disorder, abnormal smear or fertility treatment?	Yes ☐	No ☐
• Female only - Any breast problems such as lumps, cysts, bleeding, nipple discharge, abnormal mammogram or any other abnormalities?	Yes ☐	No ☐

If you have answered 'yes' to any of the conditions listed above in questions 2 and 3, please give us full details on page 6:

Medical History (continued)

Nature of symptoms/diagnosis (If applicable, please include which part of body was affected e.g. lower back, left knee, right foot etc.)	Date(s) of consultation	Treatment received	Date of last treatment/symptoms	Any future treatment/advice planned

If there is insufficient room, please continue on a separate piece of paper

Medical History (continued)

4. Have you ever tested positive for HIV or Hepatitis B or C or are you awaiting the results of such a test? Yes ☐ No ☐

If 'yes' please give full details:

5. In the last 5 years have you been prescribed or advised to take any treatment (including herbal or alternative medicine) which has lasted more than 2 weeks that you have not already mentioned? Yes ☐ No ☐

If 'yes' please provide details to include what treatment you received, when this commenced and the date you last received this treatment:

6. In the last 5 years have you been referred by any medical professional for any test(s) or investigation(s) which you have not already mentioned? Yes ☐ No ☐

If 'yes' please give full details to include the date(s), nature of the test(s) or investigation(s), reason(s) why this/these were carried out and the results:

Medical History (continued)

7. Are you waiting for any surgery or are you due to have an appointment, test or investigation with your GP or a Specialist at a hospital or clinic which you have not already mentioned? Yes ☐ No ☐

If 'yes' please advise what this is and when it is planned for:

8. Are you currently experiencing any symptoms which you have not already mentioned for which you might seek medical attention? Yes ☐ No ☐

If 'yes' please give full details to include the nature of the symptoms and the date this started:

If there is insufficient room, please continue on a separate piece of paper

Family History

Has your natural mother or father or any siblings (including half-siblings) died or suffered from any of the following conditions before the age of 66: Diabetes, heart disease, cardiomyopathy, high cholesterol, stroke, polycystic kidney disease, cancer, multiple sclerosis, Huntington's disease, Parkinson's disease, Alzheimer's, motor neurone disease, polyposis coli (polyps in the colon) or any other hereditary condition?

Yes ☐ No ☐

If 'yes' please give details to include which relative(s) has/had the condition(s), the nature of the condition(s) and the age(s) of diagnosis:

Doctor's Details

Doctor's full name: _____

Doctor's full address: _____

_____

_____ Postcode: _____

Doctor's telephone number: _____

Important Information to all Applicants

ACCESS TO MEDICAL REPORTS ACT 1988 & THE ACCESS TO PERSONAL FILES AND MEDICAL REPORTS (NORTHERN IRELAND) ORDER 1991

The main points of the Act are as follows:

a) If you indicate that you do not wish to see the report we will notify you that we have applied for one but you do not need to take any action. However, if before such report is sent to us you write to your doctor requesting to see it, you will have 21 days to contact your doctor about arrangements to see the report.

b) If you indicate that you wish to see the report we will write to you at the same time as we contact your doctor. We will indicate that you have asked to see the report and that you have 21 days in which to contact the doctor to ask to see the report. When you have seen the report the doctor may not send it to us until you have given your consent to do so. If you do not contact your doctor within 21 days the report will be sent to us.

c) You can ask your doctor if he/she will amend any part of the report which you consider to be incorrect or misleading. If your doctor is not in agreement, you may attach your comments.

d) During the six months after we have received your report you may ask your doctor to see a copy. Should you ask for a personal copy of the report the doctor can charge you a reasonable fee to cover the cost.

e) In some circumstances, the doctor may decide, in the interest of your health, or to respect the interest of other persons, that you should not see all or part of the report. The doctor will notify you of this and you will have the right to see any remaining part of the report. If it is the whole of the report which is affected, this will not be given to us without your consent.

f) You can withhold your consent (in which case we will be unable to proceed with this application).

GENETIC TESTING

We will not ask for the results of a genetic test irrespective of the amount of cover applied for. You must however give information if you have a family history of a genetic condition. It may be to your benefit to disclose if you have had a negative genetic test for such a condition.

DATA PROTECTION ACT

The Society uses personal information held on its database in accordance with applicable data protection law. The information you provide on this form will be used by us for underwriting and administering your membership.

If your application does not proceed, we may hold a record of your application for a limited period of time, not exceeding two years. Your information may be disclosed on a confidential basis, and in accordance with the Data Protection Act 1998, to medical or other service providers for the purposes of processing this application, underwriting and administering your membership, reinsurance, fraud prevention and credit control. Any information relating to your health or lifestyle will be used for underwriting and claims purposes only and may be defined as 'sensitive data' under the Data Protection Act 1998. In each case your information will be held securely and access limited to those who need to see it.

Your details may be used so that we can inform you of any products or services which may be of interest to you. Your details will not be shared with any third parties for marketing purposes.

Please complete:

Please keep me informed: By email: ☐ By post: ☐ Please do not send me any information: ☐

Declaration and Consent

Before signing this application form, you should carefully read:

- The Important Information for all Applicants within this application form; and
- The full Policy Terms and Conditions as this will form the basis of the contract between yourself and British Friendly Society Ltd.

These documents form part of our standard Member agreement upon which we intend to rely. If you do not understand any points raised in these materials, please ask for further information.

- I have read and understood the Important Notes at the front of this application form.
- I accept full responsibility for the accuracy of the answers and statements given, and confirm that they are true and complete to the best of my knowledge and belief. I further agree that if I have knowingly made any incorrect statement in this application, the rules of the Society will be strictly applied and my entitlement to all benefits will cease.
- I understand that the Society will underwrite this application based on the information I have provided on this form, and will not assume that the Society will automatically obtain a medical report or confirm or clarify the information provided.
- I shall advise the Society of any changes in my health or other circumstances which happen before my application has been accepted.
- I have read the explanation of my rights under the Access to Medicals Reports Act 1988 or Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 and consent to the Society being provided with my medical information, including copies of my medical records, from any doctor who has at any time attended me concerning anything which affects my physical or mental health.

I wish to see the report before it is sent to the Society: ☐

The Society MUST be notified of any changes to the information that you have given to the Society in connection with this application, until you receive confirmation from us that the application has been accepted.

British Friendly Society Ltd
45 Bromham Road
Bedford
MK40 2AA

Tel: 01234 358344 (mainline)
Tel: 0800 975 6565
Fax: 01234 327879
Email: enquiries@britishfriendly.com
Website: www.britishfriendly.com

Signed: _____ **Date:** _____

To be completed by the introducer (if applicable)

Introducer's name: _____

Introducer's Membership number: _____

Introducer's address: _____

_____

Postcode: _____

Introducer's telephone number: _____

Monthly Premium Table

For applicants who have not yet attained age 60

The table below gives examples of the premiums payable for the Century Plan, which increases in age bands. Such increases become effective in January i.e. not on your birthday.

Select the appropriate cost per unit and choose the number of units you want from between 30 and 1000. Then refer to the table showing discounts for deferring sick pay and decide when you would like the sickness benefit to start.

To calculate your monthly premium, please multiply the number of units you need by the cost per unit shown below: (Age as at next 31st December).

Age	Cost per Unit
18 to 36	17p
37 to 42	18p
43 to 47	19p
48 to 49	20p
50 to 52	21p
53	22p
54 to 55	23p
56	24p
57 to 58	25p
59	26p
60	27p

The amount of sickness benefit paid depends on the selected number of units. Members between the ages of 18 and 60 are entitled to sickness benefit according to the following table. Initially each unit is worth 60p per week in sickness benefit and you can choose how much you need.

Examples of Weekly Sickness Benefit				
Sick Pay Scale	**100 Units**	**300 Units**	**600 Units**	**1000 Units**
Full Pay*	£60.00	£180.00	£360.00	£600.00
Half Pay**	£30.00	£90.00	£180.00	£300.00
Reduced Pay***	£18.00	£54.00	£108.00	£180.00

*Paid for the first six months **Paid for the next six months ***Paid until recovery, or age 60, whichever comes first

Discounts for Deferring Sick Pay

If you do not require sick pay from day one, please select an alternative then apply a discount to the premium rate, as per the table below:

Discounts for Deferring Sick Pay				
Day One Cover	**4 Weeks Deferral**	**8 Weeks Deferral**	**13 Weeks Deferral**	**26 Weeks Deferral**
0%	15%	20%	22%	25%

If you have any questions relating to this form, please telephone British Friendly Society on **0800 975 6565** or e-mail us at **enquiries@britishfriendly.com**

Reference Information - office use only

Notes:

BRITISH FRIENDLY

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DIRECT DEBIT MANDATE

Direct Debit Mandate

Please fill in the whole form using a ball point pen and send it to:

British Friendly Society Ltd,
45 Bromham Road Bedford,
MK40 2AA
Tel: 01234 358344
Fax: 01234 327879

Name and full postal address of your Bank or Building Society

To: The Manager

Bank/Building Society

Address:

Postcode

Names(s) of account holder(s)

Bank/Building Society account number

Branch sortcode

Instruction to your Bank or Building Society to pay by Direct Debit

Service user number

6	9	8	0	1	4

Reference

FOR THE BRITISH FRIENDLY SOCIETY LTD OFFICIAL USE ONLY
This is not part of the instruction to your bank or building society

Instruction to your Bank or Building Society

Please pay British Friendly Society Ltd Direct Debits from the account detailed in this instruction, subject to the safeguards assured by the Direct Debit Guarantee. I understand that this instruction may remain with British Friendly Society Ltd and if so, will be passed electronically to my Bank/Building Society.

Signature(s)

Date

This Guarantee should be detached and retained by the payer.

The Direct Debit Guarantee

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits.
- If there are any changes to the amount, date or frequency of your Direct Debit the British Friendly Society Ltd will notify you three working days in advance of your account being debited or as otherwise agreed. If you request the British Friendly Society Ltd to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your Direct Debit, by the British Friendly Society Ltd or your bank or building society you are entitled to a full and immediate refund of the amount paid from your bank or building society.
- If you receive a refund you are not entitled to, you must pay it back when the British Friendly Society Ltd asks you to.
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.

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45 Bromham Road, Bedford MK40 2AA

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01234 358344

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