

# TRAFFORDS LIMITED PROPOSAL FORM FOR LOSS OF LICENCE INSURANCE

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## IMPORTANT ADVICE TO ALL PROPOSERS

*All Sections of the Proposal Form must be fully completed, even if it is for renewal of, or for an additional amount to, an existing insurance. All details of your medical history must be declared and should not be omitted because you have been declared fit or told that results of medical investigations have been satisfactory, or because you think, or have been advised, that they are irrelevant or immaterial. Failure to disclose material information may invalidate the policy.*

## PERSONAL INFORMATION

Surname: \_\_\_\_\_ First Names: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight \_\_\_\_\_  
Weight 12 months ago: \_\_\_\_\_  
Telephone Number : \_\_\_\_\_  
Email Address: \_\_\_\_\_

1. Employer & Flight Category: \_\_\_\_\_

2. Annual Salary; \_\_\_\_\_ Flying Occupation: \_\_\_\_\_  
Any Non-flying Occupation: \_\_\_\_\_

3. Sum to be Insured: \_\_\_\_\_

4. Date you require Insurance Cover (no cover is in force until agreed in writing) : \_\_\_\_\_

## FLYING DETAILS

5. Licences held (*Detail types, numbers and issuing authorities*)  
\_\_\_\_\_  
\_\_\_\_\_

6. Type of Flying (*Last 2 years and in future*)  
\_\_\_\_\_  
\_\_\_\_\_

7. Are you a member of an aircrew association? Yes  No   
*If yes, please give details*

8. Is this proposal for renewal , replacement  or amendment  of an existing insurance?

9. Are you entitled to benefit under any accident or illness insurance arranged by you or your employer?  
*If yes, please give details* Yes  No

## MEDICAL HISTORY

***It is in your interest to declare all your medical history and not to omit any details because you think or your advisers (professional or otherwise) tell you it is irrelevant or immaterial. You should declare all conditions even though you have been declared fit. You should not omit to mention investigations where you have been told that the result is satisfactory. If you have no history to declare state NIL.***

10. Have you or any relative(s) had investigated, diagnosed or been treated for:  
*(If yes, please give full details)*
- a) any Psychiatric or nervous disorder (including Migraine)  
Epilepsy or any other form of convulsion or any loss of consciousness ? Yes  No
- b) any heart, blood pressure, stroke, circulatory  
or respiratory disorder ? Yes  No
- c) any condition involving eyes, ears, nose or throat, alimentary  
tract or genito - urinary system ? Yes  No
- d) any disorder of the blood or lymphatic system ? Yes  No
- e) any condition affecting the bones and/or joints?  
*(Including spinal conditions) ?* Yes  No
- f) any disorder of the skin ? Yes  No
- g) Diabetes ? Yes  No

11. Have you ever suffered from any conditions which necessitated hospital attendance,  
or admission, or diagnosis, or treatment?  
*(If yes, state when and for what reason)* Yes  No

12. Please give dates and full details of any other medical condition, illness or injury which has been diagnosed  
and for which you have had treatment:  
*(Include accidents involving injury)*

13. Do you currently smoke? Yes  No

14. Have you ever been grounded or had your licence invalidated for medical reasons?  
*(If yes, please give dates and full details)* Yes  No

15. Has any limitation ever been endorsed on your licence?  
*(If yes, please give dates and full details)* Yes  No

16. Please give the date of your last electrocardiograph examination approved by the licence issuing authority:  
  
Were you advised of any abnormality revealed by this or any previous examination?  
*(If yes, please give dates and full details)* Yes  No

17. After or during a medical examination have you ever:  
*(If yes, please give dates and full details)*

a) been required to take additional tests ? Yes  No

b) been referred for specialist examination ? Yes  No

c) had the issue or renewal of your medical certificate deferred? Yes  No

d) had to return for examination at less than the normal interview time ? Yes  No

e) been ordered to take drugs or follow any special diet ? Yes  No

18. Are you aware of any deterioration in your general health, eyesight or blood pressure?  
*(If yes, please give dates and full details)* Yes  No

19. Has any insurance company or underwriter ?  
*(If yes, please give dates and full details)*

a) declined or deferred a proposal from you ? Yes  No

b) charged or quoted more than standard rates ? Yes  No

c) cancelled or declined to renew your insurance ? Yes  No

## EXCEPTIONAL DANGERS

20. Do you wish to be covered for the following risks ? <i>(If yes, completion of the supplementary questionnaire attached is required)</i>	
a) Skin diving	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Rock climbing or mountaineering normally involving the use of ropes or guides ?	Yes <input type="checkbox"/> No <input type="checkbox"/>
c) Potholing ?	Yes <input type="checkbox"/> No <input type="checkbox"/>
d) Hang-gliding or parachuting ?	Yes <input type="checkbox"/> No <input type="checkbox"/>
e) Driving or riding in any kind of race or competition ?	Yes <input type="checkbox"/> No <input type="checkbox"/>
f) Any other occupations, sports, pastimes or activities which are likely to involve extra risks ?	Yes <input type="checkbox"/> No <input type="checkbox"/>

21. Do you have a military licence / permit to fly? <i>(If yes, please give full details of licence and type and frequency of flying involved).</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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The information provided on this form, together with medical and any other information obtained from you or from other parties about you in connection with this policy, will be used by the Insurer for the purposes of determining your application, the operation of insurance (which includes the process of underwriting, administration, claims management, rehabilitation and customer concerns handling) and fraud protection and detection.

Information will be transferred to the UK and may be transferred outside the EEA for these purposes.

Information may be shared by the Insurer for these purposes with group companies and third party insurers, reinsurers, insurance intermediaries and service providers. Such parties may become data controllers in respect of your personal data.

By completing and submitting this form, you consent to the processing of any personal data about you, including sensitive personal data, the transfer of such personal data about you overseas for these purposes as set out in this notice by the Insurer and any other data controllers to which the personal data are transferred or disclosed for these purposes.

Your personal data will be processed fairly and securely in accordance with the Data Protection Act 1998. Your personal data will only be available to those who need to see it. For example, sensitive data, such as medical records will be used for the purposes of underwriting or claim management and rehabilitation only.

You are entitled to a copy of all your personal data upon receipt of a written request to the following address: Traffords Ltd, 7 Doolittle Yard, Froghall Road, Ampthill, Bedford MK45 2NW, United Kingdom

## DECLARATION:

<b>I hereby declare that to the best of my knowledge and belief, the particulars and answers herein are true and correct, and that I have not knowingly withheld any information which would influence the decision of the underwriters in regard to this proposal.</b>
<b>It is understood and agreed that this proposal shall form the basis of the contract should a policy be issued.</b>

Signature:	Print Name :	Date:
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## NOTICE OF STATUTORY RIGHTS UNDER THE ACCESS TO MEDICAL REPORTS ACT 1988

### Your Rights

- You can withhold your consent to the application of a medical report but without it, your cover may be restricted or your proposal for cover refused.
- If you do give your consent you can indicate in the Declaration whether or not you wish to see the report before the doctor sends it to the Insurer.
- If you wish to see any report the Insurer must tell you if they apply for one and notify the doctor of your wishes.
- You will have 21 days to arrange with the doctor to see the report before it is sent to the Insurer.
- You have the right to ask the doctor, in writing, to amend any part of the report which you consider incorrect or misleading and you can ask him to attach a statement of your views on any part he refused to amend.

### Exemptions

- The doctor does not have to let you see any part of a report that he considers would be likely to cause serious harm to the physical or mental health of yourself or others, or that would indicate his intentions towards you. He also does not have to let you see any part that would be likely to disclose information about, or the identity of, another person who has supplied information about you, unless that person has consented or the information relates to, or has been supplied by, a health professional caring for you. If the doctor does not let you see any part of the report, he must notify you of that fact.

### Time Limit

- Once the report has been supplied, the doctor must keep a copy of it for 6 months and you are entitled to inspect it or receive a copy of it during that time.

### Procedures

- If you indicate in the Declaration that you do not wish to see any report, the doctor can send it to the Insurer immediately.
- If at any time within the 6 months time limit you change your mind, you should notify the doctor that you wish to see the report and arrange with him to do so or to supply you with a copy. If you indicate in the Declaration that you do not wish to see any report the Insurer will notify you if they apply for one and you will then have 21 days to arrange with the doctor to see the report before he sends it to them. This could, of course, delay the processing of medical information. The doctor is entitled to charge you a fee for any copy report supplied to you.

### Declaration

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

If you do **not** wish to see the report before it is sent to the Insurer, please tick this box.

If you **do** wish to see the report before it is sent to the Insurer, please tick this box.

Name:

Signature:  Date: