INTERNATIONAL INDIVIDUAL PROPOSAL FORM FOR STUDENT PILOTS DISABILITY INSURANCE

PART 1 - INSTRUCTIONS AND UNDERTAKINGS:

1. All sections of this proposal form **MUST** be completed in full in **ENGLISH**.

2. The Insurer relies on the proposal form containing all material information about you and that the information is true and complete. Material information is **anything** that may influence the Insurers decision to issue a policy or not or to decide on what terms a policy will be offered to you. If you are unsure if something is material, you **must** disclose it.

3. If there is any change in the information declared after the date you sign this proposal form and before any cover offered by the Insurer commences, you must advise the Insurer immediately. The Insurer may alter the terms quoted to you in such circumstances.

4. If you do not make a true and complete disclosure of material information, the Insurer may at their election cancel your policy or modify the terms on which it was issued. It will also prejudice your ability to claim under the policy.

DATA PROTECTION

Accept Försäkringsaktiebolag ("the Insurer")

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 may be transferred overseas 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 such third parties and any other data controllers to which the personal data are transferred or disclosed for these purposes.

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: Accept Försäkringsaktiebolag, Box 2068 , SE-174 02 SUNDBYBERG, Sweden.

PART 2 - PERSONAL INFORMATION:

1. Surname:

2. First name(s):

3. Rank:

4. Address: (in full)

   Post/Zip Code:

5. Telephone:

6. Email:

7. Date of birth: (dd/mm/yyyy)

8. Name of course organiser:

9. Date cover to commence: (dd/mmm/yyyy)

10. Annual Allowance from course organiser: (ccy)

11. Any other earned income from flying: (ccy)

12. During a period of disability, does your course organiser provide contractual sick pay?
    If **YES**, how much and for how long: Yes ☐ No ☐

13. During a period of disability are you entitled to benefit from any other loss of licence, disablement or accident insurance policy which pays a temporary benefit?
    If **YES**, how much and for how long: Yes ☐ No ☐

14. During a period of disability will you receive any other regular income?
If **YES**, how much and for how long:

Yes ☐ No ☐

15. Are you entitled to benefit from any other loss of licence, disablement or accident insurance policy which pays a lump sum benefit only?
If **YES,** please give name of insurer(s), policy number(s) and benefit payable.

Yes ☐ No ☐

16. Type of aircraft flown: (please tick all which apply):

Fixed Wing	
Rotor Wing (On Shore)	
Rotor Wing (Off Shore)	

17. All current licences held: (Please specify type, number, country of issue and whether any limitations apply or have applied previously)

Type	**Number**	**Country of Issue**	**Limitations (yes or no)**

Please give details of any licence limitations in **PART 6 – SUPPLEMENTARY INFORMATION**

PART 3 - BASIS OF COVER:

18. Sum to be insured: (ccy)

19. Is the training course to be financed by: (Please tick which applies)

Bank Loan ☐
Yourself ☐
Other ☐

If 'Other', please give details:

20. In the event of a claim, please state to whom the sum insured should be paid (including if payable to Yourself):

21. Are monthly benefits required with a waiting period of less than 365 days?

Yes ☐ No ☐

If **YES**, please tick which applies: 90 days ☐ 180 days ☐

Failure to disclose relevant information may result in the non-payment of a claim and all cover under the policy being cancelled

22. Please state if this Proposal is: (Please tick which applies)

a) your first proposal to the Insurer ☐

or

b) an additional amount to an existing insurance ☐
(if b) state existing Policy No. and amount insured and insurer)

PART 4 - MEDICAL INFORMATION:

23. Do you hold a current valid medical certificate? Yes ☐ No ☐

24. What is your height: (cm) ☐ What is your current weight: (kg) ☐

25. Has there been any significant change in weight in the last year? (± 6.5kg) Yes ☐ No ☐
If **YES**, please give details:

26. Date of last aircrew medical examination: (dd/mmm/yyyy) ☐

Were you advised of any abnormality, referred for additional tests, specialist examination or asked to follow any treatment or diet plan? Yes ☐ No ☐
If **YES**, please give details:

27. Date of last electrocardiograph taken as required by the Licensing Authority:(dd/mmm/yyyy) ☐

Were you advised of any abnormality, referred for additional tests, specialist examination or asked to follow any treatment or diet plan? Yes ☐ No ☐
If **YES**, please give details:

28. Have you been investigated, diagnosed or treated for any of the following:

a) Cancer, leukaemia, Hodgkin's disease, lymphoma, brain or spinal tumour? Yes ☐ No ☐

b) A mole or freckle that has bled, caused pain or changed in appearance or any lump or growth? Yes ☐ No ☐

Failure to disclose relevant information may result in the non-payment of a claim and all cover under the policy being cancelled

ACCEPT Försäkringar

c)	Heart disease (including heart attack, angina, valve defect, heart defects from birth or heart surgery)?	Yes ☐	No ☐
d)	Chest pain, irregular heart beat, raised blood pressure or raised cholesterol?	Yes ☐	No ☐
e)	Any other lung or chest complaint?	Yes ☐	No ☐
f)	Disease or disorder of the arteries (including disease in the legs or of the aorta)?	Yes ☐	No ☐
g)	Stroke, brain haemorrhage or brain injury?	Yes ☐	No ☐
h)	Asthma, bronchitis or any other respiratory disorder?	Yes ☐	No ☐
i)	Multiple Sclerosis, optic or retrobulbar neuritis, Parkinson's disease, paralysis, epilepsy, Alzheimer's Disease, dementia, bell's palsy or cerebral palsy?	Yes ☐	No ☐
j)	Any other disorder of the central nervous system not already mentioned?	Yes ☐	No ☐
k)	Numbness, loss of feeling or tingling of the limbs or face, loss of balance or coordination?	Yes ☐	No ☐
l)	Seizures, fits, fainting or blackouts?	Yes ☐	No ☐
m)	Mental illness that has required any kind of medical attention, time off work, hospital treatment or referral to a psychiatrist?	Yes ☐	No ☐
n)	Depression, anxiety, stress, insomnia, fatigue (including chronic fatigue syndrome / myalgic encephalopathy) or nervous breakdown?	Yes ☐	No ☐
o)	Any disorder of the eyes or ears including blurred or double vision, or impaired hearing?	Yes ☐	No ☐
p)	Gout, arthritis, back pain, sciatica, neck, knee or wrist pain?	Yes ☐	No ☐
q)	Any other disorder of the joints, bones or muscles (including repetitive strain injury)?	Yes ☐	No ☐
r)	Diabetes, abnormal glucose tolerance or sugar in the urine?	Yes ☐	No ☐
s)	Disorder of the kidneys, bladder, or the genitourinary system (including blood or protein in the urine and urinary tract infections)?	Yes ☐	No ☐
t)	Any disorder of the digestive system, gall bladder, liver, stomach, spleen, pancreas, bowel (including ulcers, hepatitis, colitis or Crohn's disease or any other form of bowel disease)?	Yes ☐	No ☐
u)	Any blood disorder or anaemia?	Yes ☐	No ☐
v)	Thyroid disorder?	Yes ☐	No ☐
w)	Any gynaecological, menstrual or breast problems (eg breast lumps)? (female applicants only)	Yes ☐	No ☐
x)	Any prostate problems or problems relating to the breast tissue? (male applicants only)	Yes ☐	No ☐
y)	Have you ever tested positive for HIV, Hepatitis B or C or are you awaiting the results of such a test?	Yes ☐	No ☐
z)	Any disease which was transmitted sexually?	Yes ☐	No ☐

Failure to disclose relevant information may result in the non-payment of a claim and all cover under the policy being cancelled

aa) Are you currently taking any form of medication, prescribed or otherwise or following any special diet or treatment or have you taken any form of medication for longer than 21 days? Yes ☐ No ☐

bb) Do you have any further disclosures to make with regard to any medical investigation, test or consultation, advice, counselling, operation, medication or treatment that you have had or been advised to have or are currently having, but have not already mentioned? Yes ☐ No ☐

If you have answered **YES** to any of the above, please provide further information regarding the condition, including treatment (whether proposed or received), medication (whether proposed or received) and prognosis in **PART 6 – SUPPLEMENTARY INFORMATION**

29. During the last 5 years have you been off work, unable to carry out your normal duties due to sickness or injury for more than 21 days at any one time, other than previously stated? Yes ☐ No ☐
If **YES,** please give details:

30. Are you aware of any symptoms or complaints for which you have not consulted a doctor or received treatment? Yes ☐ No ☐
If **YES,** please give details:

31. Have you ever been advised by your doctor or another medical practitioner to drink less alcohol? Yes ☐ No ☐
If **YES,** please give details:

32. Have you used any form of tobacco or nicotine products in the last 12 months? Yes ☐ No ☐
If **YES,** please give details of quantity per week:

33. Have your parents, brothers or sisters, before the age of 65, died or suffered from, or had any investigations for heart disease, stroke, polycystic kidney disease, cancer or tumour or diabetes, Multiple Sclerosis or Polyposis of the colon? Yes ☐ No ☐
If **YES**, please give details:

34. Have you ever had an application for loss of licence, life, critical illness or income protection insurance postponed, declined, accepted with an increased premium or on special terms?
If YES, please give details: Yes ☐ No ☐

35. The Insurer may require additional medical information. If you have completed any section declaring medical history, please complete the following:

Usual Doctor or General Practitioner's name and contact address:

Consultant's name and contact address:

PART 5 - DECLARATION:

I hereby declare:

- that I have read the answers to the questions in this application form and, to the best of my knowledge and belief, the answers, whether in my own handwriting or not, are true and complete.
- that I have not withheld any material information which might influence the decision of the Insurer with regard to this proposal.

I agree that this proposal and declaration shall be the basis of the Contract between me and the Insurer if a policy is issued. I also consent to any information the Insurer may have about me being processed by them for the purposes of providing insurance and claims handling which may necessitate them providing such information to third parties.

Signed Dated

(dd/mmm/yyyy)

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

PART 6 – SUPPLEMENTARY INFORMATION:

Which question does this information relate to?

Date of occurrence (if more than one episode, please give all dates):

Diagnosis (suspected or confirmed):

Details of any treatment/medication received:

Periods off work (if no time off work, the duration of the problem):

If you had time off work, were the Licencing Authorities advised of your condition? **YES**/**NO** (please delete as applicable). If **YES,** please give details of all formal groundings and any licence limitations imposed:

Is any further problem or treatment anticipated? **YES**/**NO** (please delete as applicable). If **YES** please give further details:

If no further problem or treatment anticipated, has a full recovery been made? **YES**/**NO** (please delete as applicable). If **NO** please give further details:

Which question does this information relate to?

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FREE TEXT AREA BELOW FOR ANY ADDITIONAL INFORMATION TO BE DECLARED: