MAPFRE | MSV Life

Application Form Sections C & N

To be attached to and form part of Application Form dated: ___ / ___ / ___

For: Plan Type:

Applied for by: Policy Owner:

I.D. Card No. / Company Registration No. (if applicable)

Section C – Details of the Person to be Covered

This section is to be completed and attached to the Application Form if the person to be covered is a Third Party
It is not advisable to select more than one person to be covered if the person covered is a child under the age of 18 years and the title to the plan is intended to be transferred to the child after the age of 18 years.

	First Person Covered	Second Person Covered
First Name/s		
Surname / Title		
Maiden Name		
Marital Status / Gender	Male ☐ Female ☐	Male ☐ Female ☐
I.D. Card / Passport No		

Please provide a true authenticated photocopy of your I.D. card / Passport

	First Person Covered	Second Person Covered
Date of Birth / Country of Birth	/ /	/ /
Address	Postcode	Postcode
Telephone (Home)		
Telephone (Mobile)		
Telephone (Work)		
E-mail		
Country of Residence		
Country of Employment		

Section N - Lifestyle and Medical Questionnaire

This section is to be completed and attached to the Application Form if:
(a) the Death Benefit IS NOT the Minimum Sum Insured OR
(b) the Guaranteed Insurability Option IS REQUIRED (where it is available), OR
(c) the application INCLUDES the Waiver of Premium Benefit.

	First Person Covered		Second Person Covered	
1) Occupation (Exact Nature of work/ part time work)				
2) Height	cms	ft inches	cms	ft inches
3) Weight	kgs	lbs oz	kgs	lbs oz
4a) Name & Address of your usual doctor				
	Postcode		Postcode	

4b) Has this doctor been your usual doctor for less than 1 year? YES ☐ NO ☐ YES ☐ NO ☐

*If your answer to question 4b is **YES**, please provide us with details in the space provided below.*

	First Person Covered	Second Person Covered
Name & Address of your previous doctor		
	Postcode	Postcode

5a) Do you smoke or have you done so in the past 2 years? YES ☐ NO ☐ YES ☐ NO ☐
We may ask you to undergo a simple test to confirm your answer to this question.

*If your answer to question 5a is **YES**, please provide us with details in the space provided below.*

Type	Amount	Frequency (Daily/Monthly)	Type	Amount	Frequency (Daily/Monthly)
☐ Cigarettes			☐ Cigarettes		
☐ Cigars			☐ Cigars		
☐ Pipe			☐ Pipe		

5b) Have you ever smoked? YES ☐ NO ☐ YES ☐ NO ☐

*If your answer to question 5b is **YES**, please reply to questions (5bi) and (5bii).*

5b i) How many did you smoke?

	First Person Covered	Second Person Covered
☐ Cigarettes	Less than 20 / day ☐	Less than 20 / day ☐
☐ Cigars	20-40 / day ☐	20-40 / day ☐
☐ Pipe	40+ / day ☐	40+ / day ☐

5b ii) When did you stop smoking?	First Person Covered	Second Person Covered
	6 months to 2 years ago ☐	6 months to 2 years ago ☐
	between 2 and 5 years ago ☐	between 2 and 5 years ago ☐
	more than 5 years ago ☐	more than 5 years ago ☐

6a) Do you drink alcohol? YES ☐ NO ☐ YES ☐ NO ☐

*If your answer to question 6a is **YES**, please provide us with details in the space provided below.*

1 Unit = 1 glass Wine
1 Unit = 1/2 pint Beer
1 Unit = 1 measure Spirits

Type	Amount	Frequency (Daily/Monthly)	Type	Amount	Frequency (Daily/Monthly)
☐ Wine			☐ Wine		
☐ Beer			☐ Beer		
☐ Spirits			☐ Spirits		

6b) Have you ever been advised to reduce or give up drinking alcohol? YES ☐ NO ☐ YES ☐ NO ☐

	First Person Covered		Second Person Covered	
7) Do you, or do you intend to participate in any hazardous occupation, pursuits or hobbies e.g. aviation, motorsports, working at heights above 30 feet, fireworks manufacture, extreme sports or diving?	YES ☐	NO ☐	YES ☐	NO ☐
8) Do you intend to travel or reside outside of the Maltese islands, or have you done so in the past 5 years? (Holidays abroad less than 30 days per year may be ignored)	YES ☐	NO ☐	YES ☐	NO ☐
9) Are you in good health and entirely free from any mental or physical impairments or deformities?	YES ☐	NO ☐	YES ☐	NO ☐
10) Have you received, or are you now receiving any form of medical treatment, pills, drugs (whether prescribed by a doctor or not), medical advice, consultations or tests / investigations in connection with any suspected medical condition, or do you intend to do so?	YES ☐	NO ☐	YES ☐	NO ☐
11) Have you ever been, or are you now a user of non-prescribed drugs e.g. cocaine, heroin, marijuana or narcotics?	YES ☐	NO ☐	YES ☐	NO ☐
12) Have you ever tested positive for HIV, Hepatitis B or C, or are you awaiting the results of such a test OR have you been exposed within the last 5 years to the risk of HIV infection or tested positive OR been treated for any other disease which was transmitted sexually? (HIV can be transmitted through unsafe sex, intravenous drug abuse, or blood transfusions or surgery especially if undertaken outside of the EU)	YES ☐	NO ☐	YES ☐	NO ☐
13) Has any immediate member of your family been diagnosed before the age of 65 with any of the following named conditions: heart disease, stroke, diabetes, cancer or have they suffered from any hereditary disease?	YES ☐	NO ☐	YES ☐	NO ☐
14) Were you ever convicted of a criminal offence / drunk driving offence or are you now facing any criminal court proceedings?	YES ☐	NO ☐	YES ☐	NO ☐
15) Do you have any other previous life insurance policies with MSV Life which you intend to replace with this application? If so, please specify the previous policy number(s) to be cancelled and replaced and the reason why.	YES ☐	NO ☐	YES ☐	NO ☐

	First Person Covered	Second Person Covered
Policy Numbers to be cancelled:		
Reason for cancellation:		

	First Person Covered		Second Person Covered	
16) Have special terms ever been imposed on you by any life insurance company or has any application / policy for life, health or sickness insurance on your life been declined or postponed OR are you applying for or have you applied for any other life insurance within the past 12 months?	YES ☐	NO ☐	YES ☐	NO ☐

If you have EITHER
a) answered NO to question 9 or YES to any of the other questions on this page OR
b) if you wish to provide any additional information which you feel may be material to your application for life insurance please provide full details in the empty space below and if necessary on a separate signed and dated sheet of paper.

Question No.	First Person Covered

Question No.	Second Person Covered

Declaration by the Person Covered

I declare that the information given in this questionnaire is true, accurate and complete and that no material fact has been withheld. I understand that failure to disclose a material fact may result in the contract being declared void and that a claim under the policy may not be paid. A material fact is one which is likely to influence MSV Life in the best assessment and acceptance of this Application Form. If in doubt as to whether a fact is material, then it should be disclosed. I agree to inform MAPRE MSV Life of any material fact which occurs after the completion of this Application Form and before the commencement of the policy.

I authorise MAPFRE MSV Life or the Chief Medical Officer, or his representative, to collect any information deemed necessary by the Company from third parties relevant to the conclusion of this contract or to the settlement of any claim under this contract and the validity thereof. In particular I authorise the attending doctors, hospitals and clinics who I have consulted about my physical or mental health to give to MAPFRE MSV Life or the Chief Medical Officer or his representative all the information necessary and pertinent to the insurance contract. Furthermore I agree to reimburse MAPFRE MSV Life with any costs should such costs arise as a result of the withholding of information and/or the provision of incomplete or incorrect information by me or any person or organisation acting on my behalf.

I acknowledge that MAPFRE MSV Life may process the personal data that I provide in this Form in accordance with the Data Protection Act, 2001 and with the Data Protection Policy of provision of MAPFRE MSV Life (a copy of which is available from our offices, website and Tied Insurance Intermediaries). I acknowledge that I have a right to request access to and rectification of such data as processed by MAPFRE MSV Life. Any such request must be signed by myself as the Person Covered to whom the personal data relates.

I acknowledge that I will have no rights under the policy issued on the basis of this Medical Questionnaire if I am not also the owner of this policy.

Signature (First Person Covered)	Signature (Second Person Covered)	Date:

Intermediary Rubber Stamp / Name

Signature Code:

Declaration by the Intermediary

I declare that the signatures appearing on this form are authentic. I have explained the implications of withholding material facts and to the best of my knowledge and belief no material facts have been withheld.

I confirm that I have ☐ seen ☐ not seen the person covered

I confirm that I am ☐ related ☐ not related to the person covered

Registered Address: MAPFRE MSV Life p.l.c., The Mall, Triq il-Mall, Floriana, FRN 1470, Malta.
Postal Address: P.O. Box 54, Marsa, MRS 1000, Malta. **Registration Number:** C15722
Telephone: (+356) 2590 9000 **Telefax:** (+356) 2122 6429 **Email:** info@msvlife.com **Website:** www.msvlife.com

MMSV020420/1

D8010 21 06

MAPFRE MSV Life p.l.c. (C-15722) is authorised by the Malta Financial Services Authority (MFSA) to carry on long term business under the Insurance Business Act, Cap 403 of the Laws of Malta.
MAPFRE MSV Life p.l.c. is regulated by the MFSA.