

**SCOTTISH POLICE FEDERATION  
SERVING POLICE OFFICER  
LIFE AND CRITICAL ILLNESS INSURANCE – NOMINATION FORM**

I hereby apply to become a member of the Scheme and I agree to be bound by the rules governing the Scheme as long as I remain a member. I hereby grant authority for the appropriate deductions to be made from my salary or any financial sums agreed by the Scottish Police Federation.

**Part A - Member**

Full Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_

PSI Number: \_\_\_\_\_ Rank: \_\_\_\_\_

Date of appointment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_ Postcode: \_\_\_\_\_

Home No (Landline): \_\_\_\_\_ Mobile No: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Member's Nomination to the Trustees**

I would like the under named to receive the benefit payable on my death:

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ % \_\_\_\_\_

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ % \_\_\_\_\_

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ % \_\_\_\_\_

If further space is required please mark this clearly and continue on a separate sheet

**I understand that in exercising your discretion that you will not be bound by this expression of my wishes, but I request that you bear them in mind.**

Please tick this box to receive News & Information from the Scottish Police Federation

Please visit [www.spf.org.uk](http://www.spf.org.uk) to view our privacy policies on how we process this data

**Member's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PART B - SPOUSE/PARTNER OR CIVIL PARTNER OF MEMBER \***  
**(To be completed only if the benefit is to be provided for Partner)**

**Spouse/Partner Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_

\*Partner means the person the member of the associated policy is married to or, if the member is not married, a person who is openly cohabiting with him/her and who has been so cohabiting for the 6 months' period prior to the date of their inclusion in the policy, and on whom such a member is financially interdependent.

**Spouse / Partner Nomination to the Trustees**

I would like the under named to receive the benefit payable on my death:

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ % \_\_\_\_\_

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ % \_\_\_\_\_

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ % \_\_\_\_\_

If further space is required please mark this clearly and continue on a separate sheet

**I understand that in exercising your discretion that you will not be bound by this expression of my wishes, but I request that you bear them in mind.**

**I hereby apply to join the Group Insurance scheme for Life and Critical Illness cover.**

**Health Declaration (applicable to spouse/partner):**

I confirm I have been actively at work in my usual occupation for a period of 8 consecutive weeks prior to my intended commencement of cover date (normal annual holiday entitlement may be ignored) and that I have not had more than 14 days absence through illness and/or injury during the last 12 months.

Or if you are unemployed:

I have been fully fit and active for a period of 8 weeks prior to my intended commencement of cover date and that I have not suffered from illness or injury for more than 14 days in total in the last 12 months.

I confirm I am in good health and not aware of any condition or symptoms which may give rise to a claim under this insurance and I confirm I am not in receipt of any ongoing treatment or care (including checkups or regular medication) for any accident, illness or medical condition.

I confirm that I am not currently awaiting referral to a medical practitioner or specialist/consultant and I am not awaiting the results of any tests or medical investigation.

I confirm I have not had any application for insurance declined, postponed or subject to an increased premium or other special terms, and that I have not previously made any claim for Critical Illness insurance.

I confirm that I have not previously been refused entry into the group insurance scheme.

I understand that if this declaration is found to be untrue then my insurance will be invalidated and scheme membership cancelled with no return of premiums.

**Spouse / Partner signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please return this form to:**

Scottish Police Federation  
5 Woodside Place  
GLASGOW  
G3 7QF

E-mail: [member.services@spf.org.uk](mailto:member.services@spf.org.uk)

Telephone: 0300 303 0027