



## Kingfisher Pension Scheme Money Purchase Section Additional Benefits Form

You must complete both sides of this form and sign over the page.

### PERSONAL INFORMATION you must complete this section

Full Name

Date of Birth  National Insurance number

Company  Employee number

Address

Postcode

### ADDITIONAL BENEFITS

- I would like to apply for additional Life Assurance and agree that 0.25% of Salary will be deducted from my Core Contribution.
- I would like to apply for additional Incapacity Cover and agree that 0.25% of Salary will be deducted from my Core Contribution.

### MEDICAL INFORMATION

Height:  ft  ins or  metres

Weight:  st  lbs or  kgs

1 Have you at any time had, or been advised to have, any medical consultations, advice, operation, treatment or been absent from work for any one of the following:

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| a) Chest pain, palpitations, heart murmur, high blood pressure, stroke, heart attack or any disease or abnormality of your heart, arteries or veins | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Back, neck, joint, muscle pain, arthritis, sciatica  | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Anxiety, depression, mental illness, nervous breakdown, stress, chronic fatigue or tiredness?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Any form of cancer, tumours, growths or malignant cysts?   | <input type="checkbox"/> | <input type="checkbox"/> |

2 Have you, within the last three years, attended any doctor, hospital or clinic for any form of advice, opinion, operation, treatment or test? (Treatment for common cold, influenza, pregnancy advice and hay fever may be ignored)

Yes  No

Continued over the page

If you have answered "yes" to either question 1 or 2, please provide full details in the boxes below.

Condition	Date of last Symptoms	Treatment	Time off Work

Your personal data is kept secure and only used for purposes relating to the KPS-MP. Information may be disclosed for those purposes to the Company, the Trustee's advisers, the administrators of KPS-MP or insurance companies.

**DECLARATION**

I consent to the medical and health information provided on this form being used by the Trustee to decide the terms for providing life assurance and/or incapacity benefits. I therefore consent to the Trustee passing this information to any third party contracted to assess my qualification for such a benefit(s). I declare that all the information provided by me in this form is true and complete.

Signed

Date

Please return to Prudential, Stirling, FK9 4UE. If you need any help please ring the Prudential Helpline on **0845 300 2634** (Monday to Friday, 9am – 5pm).



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