

This form is not an application form, but is intended simply to help intermediaries gather information before submitting it on behalf of their client. It should not be sent to Friends Provident.



Important Information - It is essential that you read this part before completing the Application Form.

1. Please check you have received a Key Facts document and an illustration for this Plan. Your Financial Adviser will supply these if you have not got them.

Please read all of this form and contact your Financial Adviser if there are any questions that are unclear.

2. Help us to assess your Application by giving us all the information we ask for. **All the questions we ask are relevant and important. You must answer them accurately and completely to the best of your knowledge. If you do not, we will have the legal right to cancel any policy issued as a result of your Application and to not pay a claim.**

IF ANYTHING ABOUT YOUR HEALTH OR CIRCUMSTANCES CHANGES AFTER YOU HAVE COMPLETED THIS APPLICATION AND BEFORE WE ASSUME RISK FOR THE COVERS APPLIED FOR YOU MUST LET US KNOW IMMEDIATELY.

We need to know of any changes which have resulted in different replies to questions asked either:

- o on or resulting from the Application Form or other questionnaire; or
- o by any doctor or nurse acting on our behalf.

If we are advised of any changes we will confirm in writing whether or not any terms quoted will still apply.

If you would prefer, you may complete the medical questions in private and return the Application Form direct to the Chief Medical Officer. Please indicate on the form if you have done so.

3. If you and another person are applying together for cover on a single life or a joint life basis, we will write to you jointly with details of our offer based on the information you each provide.
4. The Plan will not start until we have assessed and accepted your Application, and the first premium has been paid. In the case of a joint life application the Plan will not start until we have assessed and accepted you both, and the first premium has been paid.

In most instances your payments will be as originally quoted. We may offer you revised terms, but occasionally we may not be able to offer any terms.

5. If we ask you to attend a medical examination, we will need to share the Application information with any company we authorise to conduct such examinations. They will make the arrangements for the examination to take place.

We may need to send your Application and relevant medical reports to our reassurers for their opinion or agreement of the terms offered. Or, we may need to send them at a later stage for purposes relating to managing the policy. You can get details of general reinsurance principles and details of any company we use to assess your Application, from our head office.

We have a confidentiality policy in place which means we hold your medical information securely and access is limited to authorised individuals who need to see it. You can get details of our confidentiality policy and our standard terms and conditions from our Salisbury Office.

Personal details to be completed by the life or lives assured

	FIRST (or only) LIFE ASSURED	SECOND LIFE ASSURED
Title		
Sex		
First name(s)		
Surname		
Date of birth		
Marital/civil partnership status		
Current address		
Postcode		

At least one telephone number must be completed.

Daytime phone number (including STD code)		
Evening phone number (including STD code)		
Mobile phone number		
Email address		

It may be necessary for one of our underwriters to contact your customer by phone to discuss the information you have provided. This will help speed up the underwriting of the Application.

Is the customer happy for us to contact them?		Yes	No		Yes	No
If yes, please confirm the most suitable time(s)	Weekdays am			Weekdays am		
	Weekdays pm			Weekdays pm		
	Saturdays am			Saturdays am		
	Saturdays pm			Saturdays pm		

Applicant(s) details

ONLY COMPLETE THIS SECTION IF THE LIFE OR LIVES TO BE ASSURED ARE NOT TO BE THE INTENDED OWNER(S) OF THE POLICY OR POLICIES

If the Applicant is an individual	FIRST (or only) APPLICANT	SECOND APPLICANT
Title		
Sex		
First name(s)		
Surname		
Date of birth		
Address		
Postcode		
Contact phone number (including STD code)		
Email address		

If the Applicant is a business	FIRST (or only) APPLICANT	SECOND APPLICANT
Business name		
Business contact title		
Business contact first name(s)		
Business contact surname		
Business address		
Postcode		
Contact phone number (including STD code)		
Email address		

Start date

Should anything about the health or other circumstances of the Life/Lives Assured change before all the cover applied for starts, they and the Applicant's must tell us immediately. We will then confirm whether any terms we have quoted will remain available. Failure to notify us of any such change may result in Cover becoming void and the benefits not becoming payable.

Start date	
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Non Loan Related Plans

If the Application is assessed and accepted on our normal terms then, unless the Applicant(s) have stated above a date on which they would like cover to start or have instructed otherwise, we will start the cover immediately.

If the Application is not accepted on our normal terms, the cover will start when we receive written confirmation of the Applicant(s) acceptance of the revised terms.

We also need to have received the first premium payment or a completed Direct Debit instruction.

Loan Related Plans

If the Application is assessed and accepted on our normal terms, we shall assume risk and begin cover when the Applicant(s) instruct us unless the Applicant(s) have stated above a date on which they would like cover to start.

If the Application is not accepted on our normal terms then no cover will start until we receive written confirmation of the Applicant(s) acceptance of the revised terms and their instructions to go on risk.

We also need to have received the first premium payment or a completed Direct Debit Instruction.

Contract details

Amount of Life Cover (GBP)	
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Premium frequency	
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Term of plan		years
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Is Critical Illness and Disability Benefit to be included?		Yes	No
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Is Waiver of Premium Benefit to be included?		Yes	No
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Who should have this Benefit?	
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Recreation and travel to be completed by the life or lives to be assured

Tobacco usage

	FIRST (or only) LIFE ASSURED		SECOND LIFE ASSURED				
Has the Life Assured smoked or used any form of tobacco (for example cigarettes, cigars, pipe tobacco) or nicotine product (for example nicotine patches, nicotine gum) in the last 12 months? (A random test may be required to verify non-smoker status)		Yes	No			Yes	No
Number of cigarettes per day							
Number of cigars per day							
Grams of tobacco (pipe or other method per day)							
Other for example nicotine patches, nicotine gum - please specify what form and how much per day							
If the Life Assured smokes less than daily, please state what form, how much and frequency							

Tobacco usage - continued

FIRST (or only) LIFE ASSURED

SECOND LIFE ASSURED

If the Life Assured has given up in the last 12 months, please state the date they gave up, what form they smoked and how much a day before they gave up

Alcohol consumption

Does the Life Assured drink alcohol?

	Yes	No
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	Yes	No
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(1 unit = single measure of spirits or 1 glass of wine or 1/2 pint of beer)

How many units a week does the Life Assured drink?

If the Life Assured drinks less than weekly, please state how many units they drink and frequency

Has the Life Assured ever been advised by a doctor or any other medical practitioner to reduce or stop their alcohol consumption on medical grounds or have they ever taken part in counselling, therapy or a programme with the aim of reducing or stopping their alcohol consumption?

	Yes	No
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	Yes	No
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Please provide full details

Recreational drugs

In the last 7 years has the Life Assured taken any non-prescription drugs (for example LSD, ecstasy, cocaine, heroin, cannabis, anabolic steroids etc)?

	Yes	No
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	Yes	No
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Types of drugs taken

Dates taken

Is the Life Assured still taking any non-prescription drugs?

	Yes	No
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	Yes	No
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Hazardous sports / pastimes

Does the Life Assured take part in any hazardous sport or pastime or do they intend to start? (Mountaineering, motor sport, sub aqua diving and private flying are examples but they should include any activity that is hazardous. The Life Assured does not need to include sports such as football, rugby, hockey, cricket or racquet sports)

	Yes	No
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	Yes	No
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Activity (1)

Qualifications held or the association the Life Assured belongs to

How many times a year does the Life Assured engage in this activity?

Level of participation e.g. heights, depths, categories, classes

Does the Life Assured engage in this activity outside the UK?

	Yes	No
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	Yes	No
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Countries visited

Hazardous sports / pastimes - continued

	FIRST (or only) LIFE ASSURED		SECOND LIFE ASSURED			
Does the Life Assured take part in any other hazardous sports or pastimes or do they intend to start?		Yes	No		Yes	No
Activity (2)						
Qualifications held or the association the Life Assured belongs to						
How many times a year does the Life Assured engage in this activity?						
Level of participation e.g. heights, depths, categories, classes						
Does the Life Assured engage in this activity outside the UK?		Yes	No		Yes	No
Countries visited						

Travel abroad

In the last 5 years, apart from holidays, has the Life Assured lived, worked or travelled abroad?		Yes	No		Yes	No
Country visited						
Start date of travel						
End date of travel						
Reason for and duration of visit						
Any others?		Yes	No		Yes	No
Country visited						
Start date of travel						
End date of travel						
Reason for and duration of visit						
Any others?		Yes	No		Yes	No
Country visited						
Start date of travel						
End date of travel						
Reason for and duration of visit						

Travel abroad - continued

	FIRST (or only) LIFE ASSURED		SECOND LIFE ASSURED			
Apart from holidays, does the Life Assured intend to live, work or travel abroad?		Yes	No		Yes	No
Intended country						
Start date of travel						
End date of travel						
Reason for and duration of visit						
Any others?		Yes	No		Yes	No
Intended country						
Start date of travel						
End date of travel						
Reason for and duration of visit						
Any others?		Yes	No		Yes	No
Intended country						
Start date of travel						
End date of travel						
Reason for and duration of visit						

Family history

Before the age of 60, have any of the Life Assured's natural parents, brothers or sisters had, or died from heart disease, cardiomyopathy, stroke, diabetes, cancer, Huntington's disease, polycystic kidney disease, polyposis of the colon, multiple sclerosis, Alzheimer's disease, Parkinson's disease, motor neurone disease, muscular dystrophy or any hereditary disorder?		Yes	No		Yes	No
Which family member?						
Current age (if still alive)						
Medical conditions past and present						
Age at onset						
If cancer, which part of the body was affected first?						
Age at death (if applicable)						
Cause of death (if applicable)						

Family history - continued

	FIRST (or only) LIFE ASSURED		SECOND LIFE ASSURED	
Any other family members?		Yes	No	
Which family member?				
Current age (if still alive)				
Medical conditions past and present				
Age at onset				
If cancer, which part of the body was affected first?				
Age at death (if applicable)				
Cause of death (if applicable)				
Any other family members?		Yes	No	
Which family member?				
Current age (if still alive)				
Medical conditions past and present				
Age at onset				
If cancer, which part of the body was affected first?				
Age at death (if applicable)				
Cause of death (if applicable)				
Any other family members?		Yes	No	
Which family member?				
Current age (if still alive)				
Medical conditions past and present				
Age at onset				
If cancer, which part of the body was affected first?				
Age at death (if applicable)				
Cause of death (if applicable)				

FAILURE TO GIVE ACCURATE AND COMPLETE INFORMATION MAY RESULT IN NON PAYMENT OF A CLAIM

Doctors details

Please note we may not contact the Life Assured's doctor. Even if we do, the Life Assured must still give accurate and complete information when completing this Application.

	FIRST (or only) LIFE ASSURED	SECOND LIFE ASSURED
Name of Life Assured's doctor	<input type="text"/>	<input type="text"/>
Address	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
Postcode	<input type="text"/>	<input type="text"/>
Telephone	<input type="text"/>	<input type="text"/>

Height and weight

Height	<input type="text"/> ft <input type="text"/> in <input type="text"/> m	<input type="text"/> ft <input type="text"/> in <input type="text"/> m
Weight	<input type="text"/> st <input type="text"/> lbs <input type="text"/> kg	<input type="text"/> st <input type="text"/> lbs <input type="text"/> kg
Has the Life Assured lost more than 1 stone or 6 kilograms in the last 6 months?	<input type="text"/> Yes <input type="text"/> No	<input type="text"/> Yes <input type="text"/> No
Please give details	<input type="text"/>	<input type="text"/>

Financial details

Reason for policy type and level of cover	<input type="text"/>	<input type="text"/>
Will the total amount of insurance the Life Assured is now applying for, added to any existing cover they already hold with any insurance company including Friends Provident, result in their total cover exceeding 1,000,000 GBP life cover or 600,000 GBP critical illness cover?	<input type="text"/> Yes <input type="text"/> No	<input type="text"/> Yes <input type="text"/> No

The Life Assured needs to include in their calculations any other Life or Critical Illness insurance policies that they already hold together with this any other Applications they are currently making that they intend to proceed with.

The Life Assured does not need to include the following:

- simultaneous Applications made to other companies, providing that only one of the Applications made (which includes the current Application to Friends Provident) will proceed to policy;
- Applications made to other companies which have now been cancelled;
- existing policies which will be cancelled if and when this Application proceeds to policy.

If this Application is for a **Commercial Loan** then please provide details of any existing Life and/or Critical Illness cover along with any simultaneous Applications the Life Assured is making which they intend to proceed with.

Type of Cover	<input type="text"/>	<input type="text"/>
Company	<input type="text"/>	<input type="text"/>
Sum Assured (GBP)	<input type="text"/>	<input type="text"/>
Date effected or to be effected	<input type="text"/>	<input type="text"/>
Reason for cover	<input type="text"/>	<input type="text"/>

Financial details - continued

FIRST (or only) LIFE ASSURED

SECOND LIFE ASSURED

Please use the section 'Additional Information' if there are any others.

What is the Life Assured's annual taxable earned income (GBP)?		
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Please provide the following details about the commercial loan that this application is to protect.

Name of lender		
Name of borrower(s)		
Amount of loan (GBP)		
Term of loan		
	years	years
Interest rate payable		
Repayment method		
Please give details		

If this Application is for a **Key Person, Partnership and Share Purchase or Other** then please provide details of any existing Life and/or Critical Illness cover along with any simultaneous Applications the Life Assured is making which they intend to proceed with.

If Other, what is the reason for the policy type and level of cover?		
Type of Cover		
Company		
Sum Assured (GBP)		
Date effected or to be effected		
Reason for cover		

Please use the section 'Additional Information' if there are any others.

What is the Life Assured's annual taxable earned income (GBP)?		
Are any other Key Person or Partnership and Shareholder Protection Applications being made at this time on this life or other lives?	Yes	No
Type of Cover		
Name		
Sum Assured (GBP)		
Insurance company		

Please use the section 'Additional Information' if there are any others.

Additional information

FIRST (or only) LIFE ASSURED

SECOND LIFE ASSURED

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FAILURE TO GIVE ACCURATE AND COMPLETE INFORMATION MAY RESULT IN NON PAYMENT OF A CLAIM

Occupation details

	FIRST (or only) LIFE ASSURED		SECOND LIFE ASSURED	
Occupation	<input type="text"/>		<input type="text"/>	
Occupation (if not listed)	<input type="text"/>		<input type="text"/>	
Nature of the business the Life Assured is in	<input type="text"/>		<input type="text"/>	
Does the Life Assured's occupation involve working at heights over 10 feet or 3 metres?	<input type="text"/>	Yes No	<input type="text"/>	Yes No
Percentage of time spent at heights	<input type="text"/>	%	<input type="text"/>	%
Average height worked at (m)	<input type="text"/>	m	<input type="text"/>	m
Maximum height worked at (m)	<input type="text"/>	m	<input type="text"/>	m
Does the Life Assured's occupation involve working offshore?	<input type="text"/>	Yes No	<input type="text"/>	Yes No
Frequency of trips	<input type="text"/>		<input type="text"/>	
Lenght of trips	<input type="text"/>		<input type="text"/>	
Does the Life Assured's occupation involve working underground or underwater?	<input type="text"/>	Yes No	<input type="text"/>	Yes No
Details of activity	<input type="text"/>		<input type="text"/>	
Percentage of working time spent on each activity	<input type="text"/>	%	<input type="text"/>	%
Average depth worked at (m)	<input type="text"/>	m	<input type="text"/>	m
Maximum depth worked at (m)	<input type="text"/>	m	<input type="text"/>	m
Any other activities?	<input type="text"/>	Yes No	<input type="text"/>	Yes No
Details of activity	<input type="text"/>		<input type="text"/>	
Percentage of working time spent on each activity	<input type="text"/>	%	<input type="text"/>	%
Average depth worked at (m)	<input type="text"/>	m	<input type="text"/>	m
Maximum depth worked at (m)	<input type="text"/>	m	<input type="text"/>	m

The following questions should be completed if the Life Assured is applying for Critical Illness Cover and/or Waiver of Premium.

On average, how many hours does the Life Assured work each week?	<input type="text"/>	average hours per week	<input type="text"/>	average hours per week
Does the Life Assured's occupation involve business driving? (They do not need to include commuting to and from their normal place of work)	<input type="text"/>	Yes No	<input type="text"/>	Yes No
Average business miles per annum	<input type="text"/>	miles per annum	<input type="text"/>	miles per annum
Does the Life Assured's occupation involve the use of machinery or tools? (They do not need to include use of a computer, photocopier, or fax machine)	<input type="text"/>	Yes No	<input type="text"/>	Yes No
Type	<input type="text"/>		<input type="text"/>	
Percentage of working time spent on each type	<input type="text"/>	%	<input type="text"/>	%

Occupation details - continued

	FIRST (or only) LIFE ASSURED		SECOND LIFE ASSURED			
Any other types?	<input type="text"/>	Yes	No	<input type="text"/>	Yes	No
Type	<input type="text"/>		<input type="text"/>			
Percentage of working time spent on each type	<input type="text"/>	%	<input type="text"/>	%		
Does the Life Assured's occupation involve any other manual or physical activity such as carrying, lifting, prolonged repetitive activity?	<input type="text"/>	Yes	No	<input type="text"/>	Yes	No
Type	<input type="text"/>		<input type="text"/>			
Percentage of working time spent on each activity	<input type="text"/>	%	<input type="text"/>	%		
Any other types?	<input type="text"/>	Yes	No	<input type="text"/>	Yes	No
Type	<input type="text"/>		<input type="text"/>			
Percentage of working time spent on each activity	<input type="text"/>	%	<input type="text"/>	%		
Is the Life Assured currently absent from work for any reason?	<input type="text"/>	Yes	No	<input type="text"/>	Yes	No
Reason for and duration of absence	<input type="text"/>		<input type="text"/>			
In the last 2 years has the Life Assured had any time off work due to illness or injury? (For this question the Life Assured does not need to give details of minor ailments such as colds or flu if together they total less than 10 days per year)	<input type="text"/>	Yes	No	<input type="text"/>	Yes	No
Reason	<input type="text"/>		<input type="text"/>			
Amount of time off	<input type="text"/>		<input type="text"/>			
Any other reason?	<input type="text"/>	Yes	No	<input type="text"/>	Yes	No
Reason	<input type="text"/>		<input type="text"/>			
Amount of time off	<input type="text"/>		<input type="text"/>			

Health details to be completed by the life or lives to be assured

Please note we may not contact the Life Assured's doctor. Even if we do, the Life Assured must still give accurate and complete information when completing this Application.

All the question we ask are relevant and important. The Life Assured must answer them accurately and completely to the best of their knowledge. If they do not, we will have the legal right to cancel any policy issued as a result of the Application and to not pay any claim. If the answer to any question is 'Yes' please give full details disclosing all facts as they can influence the assessment and acceptance of the Application.

In accordance with the Association of British Insurers' (ABI) policy on genetics and insurance, the Life Assured does not need to tell us about any genetic test result they have had if this Application for insurance, taken together with any other insurance policies they already have, for this type of insurance totals:

- * 500,000 GBP or less for Life Insurance;
- * 300,000 GBP or less for Critical Illness.

Above these limits, the Life Assured may need to tell us about certain genetic test results when applying for insurance. We will only be interested in genetic test results where the Government's Genetics and Insurance Committee (GAIC) has approved them for insurers to use. If the Life Assured thinks this may apply, please ask us for details of the current position. These details are also available from the ABI website at www.abi.org.uk/public/consumer/codes/disclosure.asp

However, the Life Assured must tell us if they either have a family history of, have or are experiencing symptoms of, or have had or are having treatment for, a medical condition including any genetically inherited condition.

If the Life Assured wishes to disclose to us a negative genetic test result, which shows us that they have not inherited a genetic disorder, we will take this into account in setting their premium, providing their clinical geneticist confirms that this test result indicates a reduced risk of developing the inherited disease.

Health details - continued

Does the Life Assured currently have or have they ever had any of the following?

	FIRST (or only) LIFE ASSURED		SECOND LIFE ASSURED			
1a. Cancer, leukaemia, Hodgkin's disease, lymphoma or a brain or spinal tumour?	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
What diagnosis was made?	<input type="text"/>		<input type="text"/>			
Date of diagnosis	mm <input type="text"/> yyyy <input type="text"/>		mm <input type="text"/> yyyy <input type="text"/>			
Part of body affected	<input type="text"/>		<input type="text"/>			
Are they currently receiving treatment?	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, nature of treatment	<input type="text"/>		<input type="text"/>			
Have they previously received treatment?	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, when did they last receive treatment?	mm <input type="text"/> yyyy <input type="text"/>		mm <input type="text"/> yyyy <input type="text"/>			
If yes, nature of treatment	<input type="text"/>		<input type="text"/>			
Are they still undergoing follow-ups?	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, name of doctor/specialist seen and name of hospital/surgery where seen	<input type="text"/>		<input type="text"/>			
If no, date of last follow up	mm <input type="text"/> yyyy <input type="text"/>		mm <input type="text"/> yyyy <input type="text"/>			
If no, results of last follow up	<input type="text"/>		<input type="text"/>			
How long were they off work?	<input type="text"/>		<input type="text"/>			
Any others?	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Please use the section 'Additional Information' if there are any others.

1b. Heart disease, angina, a heart attack, heart abnormality or defect, heart valve disorder or an irregular heart beat?	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
What diagnosis was made?	<input type="text"/>		<input type="text"/>			
Date of diagnosis	mm <input type="text"/> yyyy <input type="text"/>		mm <input type="text"/> yyyy <input type="text"/>			
Are they currently receiving treatment?	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, nature of treatment	<input type="text"/>		<input type="text"/>			
Have they previously received treatment?	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, when did they last receive treatment?	mm <input type="text"/> yyyy <input type="text"/>		mm <input type="text"/> yyyy <input type="text"/>			
If yes, nature of treatment	<input type="text"/>		<input type="text"/>			
Are they still undergoing follow-ups?	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, name of doctor/specialist seen and name of hospital/surgery where seen	<input type="text"/>		<input type="text"/>			

Health details - continued

Does the Life Assured currently have or have they ever had any of the following?

	FIRST (or only) LIFE ASSURED	SECOND LIFE ASSURED
1b. continued		
If no, date of last follow up	mm yyyy	mm yyyy
If no, results of last follow up		
Are they still experiencing symptoms?	Yes No	Yes No
If yes, nature of symptoms		
If yes, duration of symptoms		
If no, date of last symptoms	mm yyyy	mm yyyy
If no, nature of last symptoms		
If no, duration of symptoms		
How long were they off work?		
Any others?	Yes No	Yes No

Please use the section 'Additional Information' if there are any others.

1c. A stroke, mini stroke, transient ischaemic attack (TIA) or a brain or subarachnoid haemorrhage?	Yes No	Yes No
What diagnosis was made?		
Date of diagnosis	mm yyyy	mm yyyy
Are they currently receiving treatment?	Yes No	Yes No
If yes, nature of treatment		
Have they previously received treatment?	Yes No	Yes No
If yes, when did they last receive treatment?	mm yyyy	mm yyyy
If yes, nature of treatment		
Are they still undergoing follow-ups?	Yes No	Yes No
If yes, name of doctor/specialist seen and name of hospital/surgery where seen		
If no, date of last follow up	mm yyyy	mm yyyy
If no, results of last follow up		
Are they still experiencing symptoms?	Yes No	Yes No
If yes, nature of symptoms		

Health details - continued

Does the Life Assured currently have or have they ever had any of the following?

	FIRST (or only) LIFE ASSURED			SECOND LIFE ASSURED		
1c. continued						
If yes, duration of symptoms						
If no, date of last symptoms	mm		yyyy	mm		yyyy
If no, nature of last symptoms						
If no, duration of symptoms						
How long were they off work?						
Any others?		Yes	No		Yes	No

Please use the section 'Additional Information' if there are any others.

1d. Multiple sclerosis, Parkinson's disease, Alzheimer's disease, paralysis or paraplegia?		Yes	No		Yes	No
What diagnosis was made?						
Date of diagnosis	mm		yyyy	mm		yyyy
Are they currently receiving treatment?		Yes	No		Yes	No
If yes, nature of treatment						
Have they previously received treatment?		Yes	No		Yes	No
If yes, when did they last receive treatment?	mm		yyyy	mm		yyyy
If yes, nature of treatment						
Are they still undergoing follow-ups?		Yes	No		Yes	No
If yes, name of doctor/specialist seen and name of hospital/surgery where seen						
If no, date of last follow up	mm		yyyy	mm		yyyy
If no, results of last follow up						
Are they still experiencing symptoms?		Yes	No		Yes	No
If yes, nature of symptoms						
If yes, duration of symptoms						
If no, date of last symptoms	mm		yyyy	mm		yyyy
If no, nature of last symptoms						
If no, duration of symptoms						

Health details - continued

Does the Life Assured currently have or have they ever had any of the following?

FIRST (or only) LIFE ASSURED

SECOND LIFE ASSURED

1d. continued				
How long were they off work?				
Any others?		Yes	No	
				Yes No

Please use the section 'Additional Information' if there are any others.

1e. Visual disturbance, blurred or double vision, optic or retrobulbar neuritis?		Yes	No		Yes	No
What diagnosis was made?						
Date of diagnosis	mm	yyyy	mm	yyyy		
Are they currently receiving treatment?		Yes	No		Yes	No
If yes, nature of treatment						
Have they previously received treatment?		Yes	No		Yes	No
If yes, when did they last receive treatment?	mm	yyyy	mm	yyyy		
If yes, nature of treatment						
Are they still undergoing follow-ups?		Yes	No		Yes	No
If yes, name of doctor/specialist seen and name of hospital/surgery where seen						
If no, date of last follow up	mm	yyyy	mm	yyyy		
If no, results of last follow up						
Are they still experiencing symptoms?		Yes	No		Yes	No
If yes, nature of symptoms						
If yes, duration of symptoms						
If no, date of last symptoms	mm	yyyy	mm	yyyy		
If no, nature of last symptoms						
If no, duration of symptoms						
How long were they off work?						
Any others?		Yes	No		Yes	No

Please use the section 'Additional Information' if there are any others.

Health details - continued

Does the Life Assured currently have or have they ever had any of the following?

	FIRST (or only) LIFE ASSURED		SECOND LIFE ASSURED			
1f. Tingling, pins and needles, numbness, a tremor or any loss of feeling, balance or coordination, for which the Life Assured has consulted a doctor or hospital?	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
What diagnosis was made?	<input type="text"/>		<input type="text"/>			
Date of diagnosis	mm <input type="text"/> yyyy <input type="text"/>		mm <input type="text"/> yyyy <input type="text"/>			
Are they currently receiving treatment?	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, nature of treatment	<input type="text"/>		<input type="text"/>			
Have they previously received treatment?	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, when did they last receive treatment?	mm <input type="text"/> yyyy <input type="text"/>		mm <input type="text"/> yyyy <input type="text"/>			
If yes, nature of treatment	<input type="text"/>		<input type="text"/>			
Are they still undergoing follow-ups?	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, name of doctor/specialist seen and name of hospital/surgery where seen	<input type="text"/>		<input type="text"/>			
If no, date of last follow up	mm <input type="text"/> yyyy <input type="text"/>		mm <input type="text"/> yyyy <input type="text"/>			
If no, results of last follow up	<input type="text"/>		<input type="text"/>			
Are they still experiencing symptoms?	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, nature of symptoms	<input type="text"/>		<input type="text"/>			
If yes, duration of symptoms	<input type="text"/>		<input type="text"/>			
If no, date of last symptoms	mm <input type="text"/> yyyy <input type="text"/>		mm <input type="text"/> yyyy <input type="text"/>			
If no, nature of last symptoms	<input type="text"/>		<input type="text"/>			
If no, duration of symptoms	<input type="text"/>		<input type="text"/>			
How long were they off work?	<input type="text"/>		<input type="text"/>			
Any others?	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Please use the section 'Additional Information' if there are any others.

1g. Has the Life Assured ever tested positive for HIV, Hepatitis B or C or are they awaiting the results of such a test?	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Note: If the result is negative, the fact of having an HIV test will not in itself have any effect on the Life Assured's acceptance terms for insurance.

Details	<input type="text"/>	<input type="text"/>
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Health details - continued

In the last 5 years has the Life Assured had any of the following:

	FIRST (or only) LIFE ASSURED		SECOND LIFE ASSURED			
2a. Any lump that has appeared or grown in size, or a mole or freckle that has bled, caused pain or changed in appearance?	<input type="checkbox"/>	Yes	No	<input type="checkbox"/>	Yes	No
What diagnosis was made?	<input type="text"/>		<input type="text"/>			
Date of diagnosis	mm yyyy		mm yyyy			
Part of body affected	<input type="text"/>		<input type="text"/>			
Are they currently receiving treatment?	<input type="checkbox"/>	Yes	No	<input type="checkbox"/>	Yes	No
If yes, nature of treatment	<input type="text"/>		<input type="text"/>			
Have they previously received treatment?	<input type="checkbox"/>	Yes	No	<input type="checkbox"/>	Yes	No
If yes, when did they last receive treatment?	mm yyyy		mm yyyy			
If yes, nature of treatment	<input type="text"/>		<input type="text"/>			
Are they still undergoing follow-ups?	<input type="checkbox"/>	Yes	No	<input type="checkbox"/>	Yes	No
If yes, name of doctor/specialist seen and name of hospital/surgery where seen	<input type="text"/>		<input type="text"/>			
If no, date of last follow up	mm yyyy		mm yyyy			
If no, results of last follow up	<input type="text"/>		<input type="text"/>			
How long were they off work?	<input type="text"/>		<input type="text"/>			
Any others?	<input type="checkbox"/>	Yes	No	<input type="checkbox"/>	Yes	No

Please use the section 'Additional Information' if there are any others.

2b. Raised blood pressure or raised cholesterol for which treatment, further readings or a change in diet were advised?	<input type="checkbox"/>	Yes	No	<input type="checkbox"/>	Yes	No
What diagnosis was made?	<input type="text"/>		<input type="text"/>			
Date of diagnosis	mm yyyy		mm yyyy			
Are they currently receiving treatment?	<input type="checkbox"/>	Yes	No	<input type="checkbox"/>	Yes	No
If yes, nature of treatment	<input type="text"/>		<input type="text"/>			
Have they previously received treatment?	<input type="checkbox"/>	Yes	No	<input type="checkbox"/>	Yes	No
If yes, when did they last receive treatment?	mm yyyy		mm yyyy			
If yes, nature of treatment	<input type="text"/>		<input type="text"/>			
Are they still undergoing follow-ups?	<input type="checkbox"/>	Yes	No	<input type="checkbox"/>	Yes	No
If yes, name of doctor/specialist seen and name of hospital/surgery where seen	<input type="text"/>		<input type="text"/>			

Health details - continued

In the last 5 years has the Life Assured had any of the following:

	FIRST (or only) LIFE ASSURED	SECOND LIFE ASSURED
2b. continued		
If no, date of last follow up	mm yyyy	mm yyyy
If no, results of last follow up		
Are they still experiencing symptoms?	Yes No	Yes No
If yes, nature of symptoms		
If yes, duration of symptoms		
If no, date of last symptoms	mm yyyy	mm yyyy
If no, nature of last symptoms		
If no, duration of symptoms		
How long were they off work?		
Any others?	Yes No	Yes No

Please use the section 'Additional Information' if there are any others.

2c. Asthma or any chest, lung or breathing disorder for which the Life Assured has consulted a doctor or hospital?	Yes No	Yes No
What diagnosis was made?		
Date of diagnosis	mm yyyy	mm yyyy
Are they currently receiving treatment?	Yes No	Yes No
If yes, nature of treatment		
Have they previously received treatment?	Yes No	Yes No
If yes, when did they last receive treatment?	mm yyyy	mm yyyy
If yes, nature of treatment		
Are they still undergoing follow-ups?	Yes No	Yes No
If yes, name of doctor/specialist seen and name of hospital/surgery where seen		
If no, date of last follow up	mm yyyy	mm yyyy
If no, results of last follow up		
Are they still experiencing symptoms?	Yes No	Yes No
If yes, nature of symptoms		

Health details - continued

In the last 5 years has the Life Assured had any of the following:

	FIRST (or only) LIFE ASSURED	SECOND LIFE ASSURED
2c. continued		
If yes, duration of symptoms		
If no, date of last symptoms	mm yyyy	mm yyyy
If no, nature of last symptoms		
If no, duration of symptoms		
How long were they off work?		
Any others?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please use the section 'Additional Information' if there are any others.

2d. Recurrent headache for which the Life Assured has consulted a doctor or any epilepsy, seizure, fit or blackout?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
What diagnosis was made?		
Date of diagnosis	mm yyyy	mm yyyy
Cause		
Are they currently receiving treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, nature of treatment		
Have they previously received treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, when did they last receive treatment?	mm yyyy	mm yyyy
If yes, nature of treatment		
Are they still undergoing follow-ups?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, name of doctor/specialist seen and name of hospital/surgery where seen		
If no, date of last follow up	mm yyyy	mm yyyy
If no, results of last follow up		
Are they still experiencing symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, nature of symptoms		
If yes, duration of symptoms		
If no, date of last symptoms	mm yyyy	mm yyyy
If no, nature of last symptoms		

Health details - continued

In the last 5 years has the Life Assured had any of the following:

FIRST (or only) LIFE ASSURED

SECOND LIFE ASSURED

2d. continued

If no, duration of symptoms

How long were they off work?

Any others?

<input type="text"/>	Yes	No
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<input type="text"/>	Yes	No
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Please use the section 'Additional Information' if there are any others.

2e. Any impairment of vision or hearing or any disorder of the eyes or ears?

<input type="text"/>	Yes	No
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<input type="text"/>	Yes	No
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The Life Assured may ignore sight problems corrected by glasses or contact lenses but they must tell us about all hearing problems, even if corrected by hearing aid(s).

Does this problem affect both eyes/ears or only one eye/ear? (If only one, tell us whether left or right)

What diagnosis was made?

Date of diagnosis

<input type="text"/>	mm	<input type="text"/>	yyyy
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<input type="text"/>	mm	<input type="text"/>	yyyy
----------------------	----	----------------------	------

Are they currently receiving treatment?

<input type="text"/>	Yes	No
----------------------	-----	----

<input type="text"/>	Yes	No
----------------------	-----	----

If yes, nature of treatment

Have they previously received treatment?

<input type="text"/>	Yes	No
----------------------	-----	----

<input type="text"/>	Yes	No
----------------------	-----	----

If yes, when did they last receive treatment?

<input type="text"/>	mm	<input type="text"/>	yyyy
----------------------	----	----------------------	------

<input type="text"/>	mm	<input type="text"/>	yyyy
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If yes, nature of treatment

Are they still undergoing follow-ups?

<input type="text"/>	Yes	No
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<input type="text"/>	Yes	No
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If yes, name of doctor/specialist seen and name of hospital/surgery where seen

If no, date of last follow up

<input type="text"/>	mm	<input type="text"/>	yyyy
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<input type="text"/>	mm	<input type="text"/>	yyyy
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If no, results of last follow up

Are they still experiencing symptoms?

<input type="text"/>	Yes	No
----------------------	-----	----

<input type="text"/>	Yes	No
----------------------	-----	----

If yes, nature of symptoms

If yes, duration of symptoms

If no, date of last symptoms

<input type="text"/>	mm	<input type="text"/>	yyyy
----------------------	----	----------------------	------

<input type="text"/>	mm	<input type="text"/>	yyyy
----------------------	----	----------------------	------

If no, nature of last symptoms

If no, duration of symptoms

How long were they off work?

Health details - continued

In the last 5 years has the Life Assured had any of the following:

	FIRST (or only) LIFE ASSURED		SECOND LIFE ASSURED	
2e. continued				
Any others?		Yes No		Yes No

Please use the section 'Additional Information' if there are any others.

2f. Back pain, neck pain, sciatica, joint pain, arthritis, repetitive strain injury or any other disorder of the muscles, bones or limbs for which the Life Assured has consulted a doctor, hospital, physiotherapist, osteopath, chiropractor or any other type of medical practitioner or for which they have taken time off work?		Yes No		Yes No
What diagnosis was made? (Where applicable please include whether right, left or both wrist(s) etc, were effected)				
Date of diagnosis	mm	yyyy	mm	yyyy
Are they currently receiving treatment?		Yes No		Yes No
If yes, nature of treatment				
Have they previously received treatment?		Yes No		Yes No
If yes, when did they last receive treatment?	mm	yyyy	mm	yyyy
If yes, nature of treatment				
Are they still undergoing follow-ups?		Yes No		Yes No
If yes, name of doctor/specialist seen and name of hospital/surgery where seen				
If no, date of last follow up	mm	yyyy	mm	yyyy
If no, results of last follow up				
Are they still experiencing symptoms?		Yes No		Yes No
If yes, nature of symptoms				
If yes, duration of symptoms				
If no, date of last symptoms	mm	yyyy	mm	yyyy
If no, nature of last symptoms				
If no, duration of symptoms				
How long were they off work?				
Any others?		Yes No		Yes No

Please use the section 'Additional Information' if there are any others.

Health details - continued

In the last 5 years has the Life Assured had any of the following:

	FIRST (or only) LIFE ASSURED			SECOND LIFE ASSURED		
2g. Diabetes, Crohn's disease or colitis?		Yes	No		Yes	No
What diagnosis was made?						
Date of diagnosis	mm		yyyy	mm		yyyy
Are they currently receiving treatment?		Yes	No		Yes	No
If yes, nature of treatment						
Have they previously received treatment?		Yes	No		Yes	No
If yes, when did they last receive treatment?	mm		yyyy	mm		yyyy
If yes, nature of treatment						
Are they still undergoing follow-ups?		Yes	No		Yes	No
If yes, name of doctor/specialist seen and name of hospital/surgery where seen						
If no, date of last follow up	mm		yyyy	mm		yyyy
If no, results of last follow up						
Are they still experiencing symptoms?		Yes	No		Yes	No
If yes, nature of symptoms						
If yes, duration of symptoms						
If no, date of last symptoms	mm		yyyy	mm		yyyy
If no, nature of last symptoms						
If no, duration of symptoms						
How long were they off work?						
Any others?		Yes	No		Yes	No

Please use the section 'Additional Information' if there are any others.

2h. Any disorder of the kidneys?		Yes	No		Yes	No
What diagnosis was made?						
Date of diagnosis	mm		yyyy	mm		yyyy
Are they currently receiving treatment?		Yes	No		Yes	No
If yes, nature of treatment						

Health details - continued

In the last 5 years has the Life Assured had any of the following:

	FIRST (or only) LIFE ASSURED		SECOND LIFE ASSURED	
2h. continued				
Have they previously received treatment?		Yes No		Yes No
If yes, when did they last receive treatment?	mm yyyy		mm yyyy	
If yes, nature of treatment				
Are they still undergoing follow-ups?		Yes No		Yes No
If yes, name of doctor/specialist seen and name of hospital/surgery where seen				
If no, date of last follow up	mm yyyy		mm yyyy	
If no, results of last follow up				
Are they still experiencing symptoms?		Yes No		Yes No
If yes, nature of symptoms				
If yes, duration of symptoms				
If no, date of last symptoms	mm yyyy		mm yyyy	
If no, nature of last symptoms				
If no, duration of symptoms				
How long were they off work?				
Any others?		Yes No		Yes No

Please use the section 'Additional Information' if there are any others.

2i. Treatment or a positive test for any disease which was transmitted sexually?		Yes No		Yes No
What diagnosis was made?				
Date of diagnosis	mm yyyy		mm yyyy	
Are they currently receiving treatment?		Yes No		Yes No
If yes, nature of treatment				
Have they previously received treatment?		Yes No		Yes No
If yes, when did they last receive treatment?	mm yyyy		mm yyyy	
If yes, nature of treatment				
Are they still undergoing follow-ups?		Yes No		Yes No

Health details - continued

In the last 5 years has the Life Assured had any of the following:

	FIRST (or only) LIFE ASSURED	SECOND LIFE ASSURED
2i. continued		
If yes, name of doctor/specialist seen and name of hospital/surgery where seen		
If no, date of last follow up	mm yyyy	mm yyyy
If no, results of last follow up		
Are they still experiencing symptoms?	Yes No	Yes No
If yes, nature of symptoms		
If yes, duration of symptoms		
If no, date of last symptoms	mm yyyy	mm yyyy
If no, nature of last symptoms		
If no, duration of symptoms		
How long were they off work?		
Any others?	Yes No	Yes No

Please use the section 'Additional Information' if there are any others.

2j. Any mental illness or eating disorder or has the Life Assured attempted self-harm or taken an overdose?	Yes No	Yes No
What diagnosis was made?		
Date of diagnosis	mm yyyy	mm yyyy
Cause		
Are they currently receiving treatment?	Yes No	Yes No
If yes, nature of treatment		
Have they previously received treatment?	Yes No	Yes No
If yes, when did they last receive treatment?	mm yyyy	mm yyyy
If yes, nature of treatment		
Are they still undergoing follow-ups?	Yes No	Yes No
Name of doctor/specialist seen and name of hospital/surgery where seen		
If no, date of last follow up	mm yyyy	mm yyyy
If no, results of last follow up		

Health details - continued

In the last 5 years has the Life Assured had any of the following:

	FIRST (or only) LIFE ASSURED		SECOND LIFE ASSURED	
2j. continued				
Are they still experiencing symptoms?		Yes No		Yes No
If yes, nature of symptoms				
If yes, duration of symptoms				
If no, date of last symptoms		mm yyyy		mm yyyy
If no, nature of last symptoms				
If no, duration of symptoms				
How long were they off work?				
Any others?		Yes No		Yes No

Please use the section 'Additional Information' if there are any others.

2k. Any other feeling of depression, anxiety, stress or fatigue that the Life Assured has reported to a doctor, hospital, nurse, psychologist or psychiatrist or any other type of medical practitioner?		Yes No		Yes No
Type of symptom and diagnosis				
Date of diagnosis		mm yyyy		mm yyyy
Cause				
Are they currently receiving treatment?		Yes No		Yes No
If yes, nature of treatment				
Have they previously received treatment?		Yes No		Yes No
If yes, when did they last receive treatment?		mm yyyy		mm yyyy
If yes, nature of treatment				
Are they still undergoing follow-ups?		Yes No		Yes No
If yes, name of doctor/specialist seen and name of hospital/surgery where seen				
If no, date of last follow up		mm yyyy		mm yyyy
If no, results of last follow up				
Are they still experiencing symptoms?		Yes No		Yes No
If yes, nature of symptoms				

Health details - continued

In the last 5 years has the Life Assured had any of the following:

	FIRST (or only) LIFE ASSURED		SECOND LIFE ASSURED	
2k. continued				
If yes, duration of symptoms				
If no, date of last symptoms	mm	yyyy	mm	yyyy
If no, nature of last symptoms				
If no, duration of symptoms				
How long were they off work?				
Any others?		Yes	No	
		Yes	No	

Please use the section 'Additional Information' if there are any others.

3. In the last 5 years has the Life Assured been exposed to the risk of HIV infection?		Yes	No		Yes	No
---	--	-----	----	--	-----	----

Note: HIV can be caught through unsafe sex, intravenous drug abuse, blood transfusions or surgery undertaken outside the European Union.

Details						
4. In the last 2 years, other than for those conditions the Life Assured has already mentioned:		Yes	No		Yes	No
a. Has the Life Assured had any medical consultation (for example with a doctor, consultant, psychiatrist, clinic, physiotherapist or any other type of medical practitioner) or attendance at a hospital as an inpatient or outpatient?						

The Life Assured does not need to give details of occasional consultations with their GP for colds, flu or consultations for oral contraceptive pills, smear tests, wellman/woman check ups where the results are known and were normal.

Reason						
Date consulted/recommended	mm	yyyy	mm	yyyy		
Name of doctor/specialist seen and name of hospital/surgery where seen						
Are they currently receiving treatment?		Yes	No		Yes	No
If yes, nature of treatment						
Have they previously received treatment?		Yes	No		Yes	No
If yes, when did they last receive treatment?	mm	yyyy	mm	yyyy		
If yes, nature of treatment						
Are they still undergoing follow-ups?		Yes	No		Yes	No
If yes, name of doctor/specialist seen and name of hospital/surgery where seen						
If no, date of last follow up	mm	yyyy	mm	yyyy		

Health details - continued

	FIRST (or only) LIFE ASSURED		SECOND LIFE ASSURED	
4a. continued				
If no, results of last follow up				
Are they still experiencing symptoms?		Yes No		Yes No
If yes, nature of symptoms				
If yes, duration of symptoms				
If no, date of last symptoms		mm yyyy		mm yyyy
If no, nature of last symptoms				
If no, duration of symptoms				
Any others?		Yes No		Yes No

Please use the section 'Additional Information' if there are any others.

4. In the last 2 years, other than for those conditions the Life Assured has already mentioned:		Yes No		Yes No
b. Has the Life Assured had, or been advised to have, any medical investigation, x-ray, scan or test?				

The Life Assured does not need to give details of consultations for oral or contraceptive pills, smear tests, well man/woman check-ups where the results are known and were normal.

Type of medical investigation, x-ray, scan or test				
Reason				
Date consulted/recommended		mm yyyy		mm yyyy
Name of doctor/specialist seen and name of hospital/surgery where seen				
Are they currently receiving treatment?		Yes No		Yes No
If yes, nature of treatment				
Have they previously received treatment?		Yes No		Yes No
If yes, when did they last receive treatment?		mm yyyy		mm yyyy
If yes, nature of treatment				
Are they still undergoing follow-ups?		Yes No		Yes No
If yes, name of doctor/specialist seen and name of hospital/surgery where seen				
If no, date of last follow up		mm yyyy		mm yyyy
If no, results of last follow up				

Health details - continued

	FIRST (or only) LIFE ASSURED		SECOND LIFE ASSURED	
4b. continued				
Are they still experiencing symptoms?		Yes No		Yes No
If yes, nature of symptoms				
If yes, duration of symptoms				
If no, date of last symptoms	mm	yyyy	mm	yyyy
If no, nature of last symptoms				
If no, duration of symptoms				
Any others?		Yes No		Yes No

Please use the section 'Additional Information' if there are any others.

5. In the last 12 months has the Life Assured been prescribed any drug, medicine or tablet or have they had any other form of medical treatment (for example physiotherapy, psychotherapy)?		Yes No		Yes No
Name of drug, medicine or tablet or type of medical treatment				
Reason				
Date consulted/recommended	mm	yyyy	mm	yyyy
Name of doctor/specialist seen and name of hospital/surgery where seen				
Are they still undergoing follow-ups?		Yes No		Yes No
If yes, name of doctor/specialist seen and name of hospital/surgery where seen				
If no, date of last follow up	mm	yyyy	mm	yyyy
If no, results of last follow up				
Are they still experiencing symptoms?		Yes No		Yes No
If yes, nature of symptoms				
If yes, duration of symptoms				
If no, date of last symptoms	mm	yyyy	mm	yyyy
If no, nature of last symptoms				
If no, duration of symptoms				
Any others?		Yes No		Yes No

Please use the section 'Additional Information' if there are any others.

Health details - continued

FIRST (or only) LIFE ASSURED

SECOND LIFE ASSURED

6. In the last 6 months has the Life Assured had any medical symptom, change in their physical or mental health or change in their physical or mental ability for which they have not consulted a doctor, hospital or medical practitioner?

	Yes	No
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	Yes	No
--	-----	----

The Life Assured does not need to give details of colds and flu which have lasted less than 2 weeks in total.

Type

Date started

mm yyyy

mm yyyy

Are they still experiencing symptoms?

	Yes	No
--	-----	----

	Yes	No
--	-----	----

If yes, nature of symptoms

If yes, duration of symptoms

If no, date of last symptoms

mm yyyy

mm yyyy

If no, nature of last symptoms

If no, duration of symptoms

How long were they off work?

Any others?

	Yes	No
--	-----	----

	Yes	No
--	-----	----

Please use the section 'Additional Information' if there are any others.

7. In the next 12 months is the Life Assured due to have any consultation or check-up in connection with any medical symptom or condition, or are they waiting for the result of any medical investigation?

	Yes	No
--	-----	----

	Yes	No
--	-----	----

Type

Reason and symptoms or condition

Date of check-up or expected result

mm yyyy

mm yyyy

Name of doctor/specialist seen and name of hospital/surgery where seen

Are they still experiencing symptoms?

	Yes	No
--	-----	----

	Yes	No
--	-----	----

If yes, nature of symptoms

If yes, duration of symptoms

If no, date of last symptoms

mm yyyy

mm yyyy

If no, nature of last symptoms

If no, duration of symptoms

Health details - continued

FIRST (or only) LIFE ASSURED

SECOND LIFE ASSURED

7. continued

Any others?

	Yes	No
--	-----	----

	Yes	No
--	-----	----

Please use the section 'Additional Information' if there are any others.

8. Other than the information the Life Assured has already provided, have they ever had an illness or medical condition that has lasted more than 3 months and which affected their ability to study or perform normal daily activities or for which they took more than 2 weeks off work?

	Yes	No
--	-----	----

	Yes	No
--	-----	----

Type of illness/condition

--

--

Date symptoms started

mm	yyyy
----	------

mm	yyyy
----	------

Are they still experiencing symptoms?

	Yes	No
--	-----	----

	Yes	No
--	-----	----

If yes, nature of symptoms

--

--

If yes, duration of symptoms

--

--

If no, date of last symptoms

mm	yyyy
----	------

mm	yyyy
----	------

If no, nature of last symptoms

--

--

If no, duration of symptoms

--

--

Are they currently receiving treatment?

	Yes	No
--	-----	----

	Yes	No
--	-----	----

If yes, nature of treatment

--

--

Have they previously received treatment?

	Yes	No
--	-----	----

	Yes	No
--	-----	----

If yes, when did they last receive treatment?

mm	yyyy
----	------

mm	yyyy
----	------

If yes, nature of treatment

--

--

How long were they off work?

--

--

Any others?

	Yes	No
--	-----	----

	Yes	No
--	-----	----

Please use the section 'Additional Information' if there are any others.

Additional information

FIRST (or only) LIFE ASSURED

SECOND LIFE ASSURED

Empty box for providing information for the first (or only) life assured.

Empty box for providing information for the second life assured.

Important notes

Critical Illness and Disability - Permanent and Total Disability Definition.

We are normally able to offer this benefit to provide Cover related to a person's normal occupation. However, for certain occupations and for those not normally working for at least 16 hours per week on a regular basis, we are only able to offer this benefit with the following alternative definition of 'permanently disabled'.

'Permanently disabled' means that the Life Assured, before the earlier of the expiry date of the policy and Policy Anniversary following their 60th birthday, is

a) totally and permanently unable, throughout the remainder of their lifetime, irrespective of when the cover ends or the Life Assured retires, because of illness or accidental injury to perform three of the following five tests without the help of another person but with the use of appropriate assistive or corrective aids or appliances:

1 Walking

Able to walk 200 metres on the flat without having to stop or suffering from severe discomfort

2 Bending

Able to get into or out of a standard saloon car and able to bend or kneel to pick up something from the floor and straighten up

3 Communicating

Able to answer the telephone and take a message

4 Reading

Having the eyesight required to be able to read a daily newspaper

5 Writing

Having the physical ability to write legibly using a pen or pencil

OR

b) shown to be suffering a psychotic or well defined mental illness which is surgically and medically uncontrollable despite treatment by a Consultant Psychiatrist and which has no prospect whatsoever of improving at any time during their lifetime, irrespective of when the cover ends or the Life Assured retires.

Definitions

For the purpose of this document, HIV and AIDS will have the following definitions:

HIV: Human Immunodeficiency Virus

This is a viral infection caused by the human immunodeficiency virus that gradually destroys the immune system.

AIDS: Acquired Immune Deficiency Syndrome

This is the most serious stage of HIV infection characterised by symptoms of severe immune deficiency.

Marital/Civil Partnership Status

The Civil Partnership Act came into force in December 2005. Should this apply to you, we have provided the following guide to help you complete this section of the Application Form;

Civil Partner - use this status if you have registered your civil partnership.

Former Civil Partner - use this status if you were previously part of a civil partnership in respect of which a court has made a dissolution or nullity order.

Separated Civil Partner - use this status if your registered civil partnership has broken down but has not yet been dissolved by court order.

Surviving Civil Partner - use this status if you were part of a registered civil partnership, but your partner has died.





FRIENDS PROVIDENT

Instruction to your Bank or Building Society to pay Direct Debits



**FRIENDS PROVIDENT
PO BOX 1550
MILFORD
SALISBURY
WILTSHIRE
SP1 2TW
Tel: 0870 607 1352**

Originator's identification Number

99 04 57

Branch sort code

Account number

Instruction to your Bank or Building Society

Please pay Friends Provident Direct Debits from the account detailed on this Instruction subject to the safeguards assured by The Direct Debit Guarantee. I understand that this Instruction may remain with Friends Provident and if so, details will be passed electronically to my Bank/Building Society.

Name and full postal address of your Bank or Building Society

To: The Manager Bank or Building Society

Address

Postcode

Account holder(s) name

This guarantee should be detached and retained by the Payer.

The direct debit guarantee

- This guarantee is offered by all Banks and Building Societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by the Applicant's own Bank or Building Society.
- If the amounts to be paid or the payment dates change Friends Provident will notify the Applicant 10 days in advance of collection or as otherwise agreed.
- If an error is made by Friends Provident or the Applicant's Bank or Building Society, they are guaranteed a full and immediate refund from their branch of the amount paid.
- The Applicant can cancel a Direct Debit at any time by writing to their Bank or Building Society. They should also send a copy of the letter to Friends Provident.



Access to Medical Reports

Case Ref No.

Please note we may not contact your doctor. Even if we do, you must still disclose all facts when completing this Application.

We may need to get medical reports to support this Application. Before we can ask any doctor that you have consulted to fill in a report, we need your permission under the Access to Medical Reports Act 1988. Your rights under the act are as follows:

You do not need to give permission, but if you do not, we may not be able to go ahead with your Application. This does not prevent you from applying to other companies for insurance.

You can ask to see the report before the doctor returns it to us; if this is the case, we will tell the doctor to keep the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.

If you choose not to see the report at this stage, you may ask the doctor for a copy within six months of it being sent to us. We can send a copy of the report to your doctor if you ask to see it at a later date.

If you think that any part of the report is not factually correct or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him or her to attach a statement outlining your views, which will then accompany the report.

Your doctor can withhold from you access to the report if he or she feels that it would cause physical or mental harm to you or others.

The medical report your doctor fills in asks about the following:

- Your current health
 - Any care, medication or treatment you are currently receiving.
 - The results of referrals or tests you are waiting for.
- Any time off work in the last three years.
- Your past health
 - Details of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your GP or any other medical adviser, therapist or counsellor, in particular whether you have a history of:
 - Malignancy (cancer), cardiovascular (heart) disease, diabetes, and degenerative (gradually worsening) diseases;
 - Musculoskeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles;
 - Anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue;
 - Suicidal thoughts or attempts at suicide; or
 - Conditions related to drug or alcohol misuse or smoking or chewing tobacco
 - Details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations
 - Any blood pressure readings in the last three years
- Any history of disease among your parents or brothers or sisters that you have told your doctor about.

We ask your doctor not to reveal information about:

- Negative tests for HIV, hepatitis B or C;
- Any sexually-transmitted diseases unless there could be long-term effects on their health; or
- Predictive genetic test results unless there is a favourable test result which shows that you have not inherited a condition your family suffers from or the total sum insured is over the limit detailed under 'Genetic Tests'.

The information you and your doctor provide about your health may result in us:

- Refusing to provide insurance;
- Increasing premiums above standard rates; or
- Applying an exclusion to the cover; or
- Setting premiums at standard rates.

If you have any question about your rights under the Act or questions relating to the process of getting, assessing or storing medical information, you should write to: The Chief Medical Officer, Friends Provident Life Assurance Ltd, PO Box 1550, Milford, Salisbury SP1 2TW

I agree to you asking any doctor I have consulted about my physical or mental health to provide medical information so you may assess this application. You may gather relevant information from other insurers about other applications for life, critical illness, sickness, disability, accident or private medical insurance on my life that I have applied for. I authorise those asked to provide medical information when they see a copy of this consent form, including after my death to support any claim made on the plan proceeds. This information can also be used to maintain management information for business analysis.

Signature to Declaration and Consent

Life 1

- I do **not** want to see the report before it is sent to the company
- I **do** want to see the report before it is sent to the company

Life 2

- I do **not** want to see the report before it is sent to the company
- I **do** want to see the report before it is sent to the company

Full Name (Block capitals)

Signature

Date



THE BUSINESS TRUST FOR PARTNERS AND SHAREHOLDERS (BT)

This form is suitable for use with our range of life assurance products **other than those applied for online**. It is not suitable for pension contracts or for life assurance contracts approved under pensions legislation.

It is important that an additional trustee is appointed at outset.

You can include yourself as a potential beneficiary by ticking the box in section (c) of Part E of the trust Schedule. Your inclusion as a potential beneficiary of this trust would enable the policy to be assigned to you in the future, if you leave the business. However, before you decide to be included, you should be aware that, as a consequence, the trust arrangement would fall under the pre-owned assets tax (POAT) regime.

Under that regime a percentage of the policy value (currently 5%) would be treated as your income each year for tax purposes. Term assurance and critical illness benefit have no significant value while you remain in good health and would not therefore trigger an income tax charge. But should you be in poor health on any 6th April, the policy might have a much higher taxable value for the ensuing tax year and an income tax charge might result.

If you are in any doubt as to the suitability of this form we recommend that you obtain independent professional advice.



THE BUSINESS TRUST (BT)

Explanatory Notes

It is important to read these notes before completing this Trust Form

The advantages of writing life assurance in trust

Trust form BT enables the proceeds of the policy(ies) in the trust to be paid to the remaining partners or shareholders in the business so that they can purchase your business share. Details of who may benefit are set out in Section E of the Trust Schedule.

The policy proceeds should not be included in your estate for the purposes of inheritance tax (IHT). Premiums should be exempt from inheritance tax and from the gift with reservation provisions if the setting up of the policy and trust are part of a fully commercial arrangement between the partners or shareholders (but see opposite).

When will this trust form be used?

It is important to note that members of your family who are not partners or shareholders in the business cannot be included as potential beneficiaries if the trust is to form part of a commercial arrangement between partners or shareholders.

Although you can include yourself as a potential beneficiary by ticking the box in Part E, section (c), you should be aware that, as a consequence, the arrangement would fall under the POAT regime.

The trust form can be used anywhere in the United Kingdom. It is not suitable for pension contracts or for life assurance contracts approved under pensions legislation.

Who are the Trustees?

You are automatically appointed as the first trustee. You should (and in Scotland must) appoint one or more additional trustees.

The other partner(s)/shareholder(s) in the arrangement would normally be the other trustee(s) unless there are so many as to make the arrangement unwieldy. In these cases, the Company Secretary or legal adviser of the business may be an appropriate choice of trustee.

Provided there is at least one surviving trustee, then in the event of a death claim against the policy, we can pay the trustees as soon as proof is received. If no additional trustees are appointed, payment cannot be made until probate, letters of administration or confirmation have been granted and new trustees have been appointed.

Warning: Law and HM Revenue & Customs practice may change at any time. These notes are based on our understanding of both as at March 2007. Friends Provident cannot take responsibility for or guarantee the legal effectiveness of any amendments.

What are the Inheritance Tax (IHT) consequences of using this Trust Form?

(a) *On payment of premiums*

Provided HM Revenue & Customs accept that this trust is declared as part of a commercial arrangement, the premiums will not be regarded as gifts for IHT purposes[†].

(b) *On your death*

Again, provided HM Revenue & Customs accept that this trust is declared as part of a commercial arrangement, the trust fund will not form part of your estate for IHT purposes[†].

(c) *On a change in the composition of the partnership or company*

There are no IHT consequences if a partner or co-shareholder leaves the business, or when a new member joins.

This also applies where the share(s) of an existing partner or shareholder is increased or decreased.

(d) *Ongoing tax charges*

It is possible that there may be a tax charge on each tenth anniversary of the trust, and when a payment is made from the trust. However, there is unlikely to be a tax charge when a protection policy is the only asset of the trust*.

We recommend that you discuss the effect of using this trust with your financial adviser.

[†]If the arrangement is not commercial, appropriate advice should be sought.

*Term assurances normally have little value unless the life assured is in poor health.

Select Protection Plans

A Select Protection Plan can potentially consist of several different policies, some of which cannot be placed in trust e.g. income protection. Each separate policy should be placed in its own trust (if required) according to the benefits it provides.

Alterations

If you make a mistake when completing this form, please cross through the error, insert the correction and sign against it. The Additional Trustees do not need to sign the alterations. Please do not use correction fluid.

Declaration of Trust – Business Trust (BT)

1. Definitions and Interpretation

1.1 In this trust form (except where the context otherwise requires) the following words shall have the following meanings:

“Additional Trustees” means the person or persons specified in Part C of the Schedule;

“the Applicant” means the person specified in Part A of the Schedule;

“the Initial Beneficiaries” has the meaning given in part D of the Schedule;

“the Policy” means the policy specified in Part B of the Schedule;

“the Potential Beneficiaries” has the meaning given in part E of the Schedule;

“the Relevant Date” shall mean the earlier of the date of death of the Applicant or the date on which liability is admitted in respect of any claim in respect of any illness or disability covered by the policy(ies) proposed or by any subsequent policy including illness or disability benefits which is subject to the provisions of this trust;

“the Schedule” means the Schedule hereto;

“the Trustees” means the Applicant and the Additional Trustees or such person or persons who may hereafter be appointed as a trustee or trustees hereunder;

“the Trust Fund” means the Policy, all monies to become payable thereunder (including bonuses) and monies received on the sale or surrender thereof, all property at any time added thereto by way of further settlement, accumulation of income, capital accretion or otherwise and all property from time to time representing the foregoing respectively;

“the Trust Period” means the period commencing on the date hereof and ending on the second anniversary of the death of the Applicant (which period shall be the perpetuity period for the purposes of this trust).

1.2 The Schedule forms part of this trust form.

1.3 The clause headings are included for convenience only and shall not affect the interpretation of this trust form.

1.4 In this trust form (except where the context otherwise requires):

1.4.1 Use of the singular includes the plural and vice versa.

1.4.2 Use of any gender includes the other genders.

1.4.3 Any reference to an English legal term for any action, remedy, method of judicial proceeding, legal document, legal status, court, official or any legal concept or thing shall, in respect of any jurisdiction other than England, be deemed to include a reference to what most nearly approximates in that jurisdiction to the English legal term.

2. Declaration of Trust

The Applicant HEREBY DECLARES that the Trust Fund shall be held upon the trusts with and subject to the powers and provisions hereinafter declared and contained.

3. Discretionary Power of Appointment

3.1 The Trustees shall hold the income and capital of the Trust Fund upon trust for or for the benefit of such one or more of the Potential Beneficiaries at such ages and in such shares, upon such trusts and in such manner at any time or times before the expiry of the Trust Period by any deed or deeds revocable or irrevocable as the Trustees (being at least two in number) shall in their absolute discretion appoint.

3.2 The Trustees may at any time or times by deed or deeds extinguish (or restrict the future exercise of) the discretionary power of appointment in this Clause.

3.3 No power or discretion by this trust form or by law conferred on the Trustees or any of them or any other person shall (notwithstanding anything to the contrary herein expressed or implied) be exercised so as to cause or permit any part of the capital or income of the Trust Fund to become in any way payable to or applicable for the benefit of the Applicant unless the Applicant is included as a potential beneficiary under Part E, section (c) of the Schedule.

4. Trusts in Default of Appointment

Until and subject to and in default of any appointment under Clause 3, the Trustees shall hold the capital and income of the Trust Fund in trust for the Initial Beneficiaries in the same proportions as the share in the profits of such partnership to which each such person is entitled (or the number of ordinary shares in such company held by such persons) then bears to the aggregate share in such profits to which all such persons are entitled (or the aggregate number of such ordinary shares held by all such persons).

5. Payment of income

Subject to the terms of any appointment under Clause 3, all **income** of the Trust Fund shall be paid to or applied for the benefit of the person(s) entitled, whether by appointment or in default of appointment at the time the income arises and in the shares in which they are so entitled.

6. Law

This Trust shall be subject to, and shall be construed in accordance with, the Law as indicated in section F of the schedule.

7. Irrevocability

This Declaration of Trust shall be irrevocable.

POWERS

8. Powers of investment

The Trustees may apply any money to be invested in the purchase or acquisition (either alone or jointly with others) of such property, of whatever nature and wherever situate and whether of a wasting nature, involving liabilities or producing income or not, or in making such loans with or without security, as they think fit so that they shall have the same powers to apply money to be invested as if they were an absolute beneficial owner provided that any option, right of surrender or other right under any policy of assurance forming part of the Trust Fund must be exercised by all the Trustees acting together.

9. Power to borrow

The Trustees may borrow and raise money on the security of the whole or any part of the Trust Fund and to use such money to pay the premiums on any policy of assurance or for acquiring investments to be held as part of the Trust Fund or for any other purpose for which the Trust Fund may be used.

10. Power to appoint new trustees

10.1 The power of appointing new trustees shall be vested in the Trustees jointly.

10.2 The Applicant hereby appoints the Additional Trustees to be trustees to act with the Applicant in the trusts of this trust form, which office the Additional Trustees acknowledge has been accepted on execution of this trust form.

11. Receipts

The receipt of the Trustees shall be a good and sufficient discharge to any person for all monies payable by such person under any policy forming part of the Trust Fund.

12. Power to Charge

12.1 A Trustee (other than the Applicant) being a person engaged in any profession or business shall be entitled to charge and be paid all usual professional and other charges for business done, services rendered or time spent by such Trustee personally or by such Trustee's firm in the administration of these trusts including acts which a Trustee not being in any profession or business could have done personally.

12.2 A Trustee (other than the Applicant) shall be entitled to retain any commission which may be received personally or by such Trustee's firm in respect of any transaction carried out in relation to the Trust Fund for which such Trustee or Trustee's firm is, in the normal course of business, allowed commission, notwithstanding that the receipt of such commission was procured by an exercise by such trustee or the Trustees of powers over the Trust Fund.

12.3 If any corporate body shall act as a Trustee hereof it shall be entitled to charge in accordance with its published terms for trust business in force from time to time and in the absence of published terms in accordance with such terms as may from time to time be agreed between the Trustee and the Applicant.

13. Power of Appropriation

The Trustees may appropriate any part of the Trust Fund in or towards satisfaction of the interest of any beneficiary and may for such purpose place such value on any property as they think fit.

14. Power to Vary Administrative Provisions

The Trustees may by deed amend or add to the administrative provisions of this trust.

Schedule - Business Trust (BT)

In part A insert your full name and address.	A	Applicant: _____ Address: _____
In Part B insert the class of policy for which you are applying, the sum assured and the date of your application for it.	B	Class of Policy: _____ Date of Application: _____ Sum Assured: £ _____
In Part C insert the full names of the persons who are to be Additional Trustees. At least one additional trustee must be appointed, if this is not done the trust may not be valid. Note: the trust fund may be subject to tax in any territory where a trustee is resident. Friends Provident cannot advise on non-UK tax issues.	C	Additional Trustees: (1) Full Name: _____ Address: _____ (2) Full Name: _____ Address: _____ (3) Full Name: _____ Address: _____
Please complete either (a) or (b) in this section with the name of the firm or company.	D	The "Initial Beneficiaries" shall mean: (a) such persons (other than the Applicant) as shall immediately before the Relevant Date be carrying on business in the firm of (Name of Firm) _____ or that firm's successors in business (b) such persons (other than the Applicant) as shall immediately before the Relevant Date hold ordinary shares in (Name of Company) _____ or that company's successors in business
These are the classes of persons whom the Trustees may appoint at a later date to receive benefit. You may add yourself as a potential beneficiary by ticking the box in section (c). However, such action would result in the trust arrangement falling under the pre-owned assets tax (POAT) regime.	E	The "Potential Beneficiaries" shall mean any one or more of: (a) any person who is at any time in partnership with the Applicant; (b) any person who is at any time a co-shareholder in any private limited company with the Applicant; (c) the Applicant but only if this box is ticked <input type="checkbox"/> (Please tick this box if you wish to add yourself (the Applicant) to the class of potential beneficiaries.)
Please indicate which law is required by ticking the relevant box.	F	Law <input type="checkbox"/> English <input type="checkbox"/> Scottish

IN WITNESS WHEREOF these presents consisting of this and the two preceding pages are executed by the Applicant and the Additional Trustees in acceptance of their appointment on the date shown in Part B and if executed in Scotland before the witnesses hereto subscribing.

The trust form should then be signed by you and the Additional Trustees. If the trust is declared in Scotland, each should sign in the presence of an independent witness whose signature and details should be included where indicated. * If the trust is declared in England, Wales or Northern Ireland, witnesses are not required	G	SIGNED: Signature of Applicant: _____ *Witness: Signature _____ Full Name: _____ Address: _____
		SIGNED: Signature of First Additional Trustee: _____ *Witness: Signature _____ Full Name: _____ Address: _____
		SIGNED: Signature of Second Additional Trustee: _____ *Witness: Signature _____ Full Name: _____ Address: _____
		SIGNED: Signature of Third Additional Trustee: _____ *Witness: Signature _____ Full Name: _____ Address: _____

Free Accidental Death Cover (FADC)

How much is the FADC benefit?

The Sum Assured is limited to the least of 500,000 GBP and the requested amount of Life Cover if a claim arises through Accidental Death.

What do we mean by Accidental Death?

Accidental Death means death as a result of an accident caused by violent, visible and external means. Accidental drowning is also included.

When does FADC start?

Upon receipt by Friends Provident of a fully completed Application Form including an acceptable method of payment.

Terms and conditions

The FADC benefit can only be paid once per application.

The FADC benefit will not be paid if Friends Provident finds out that any of the information given by any Life Assured or any Applicant or anyone acting on behalf of a Life Assured or Applicant, was not true, not accurate, or not complete and, if Friends Provident had had all the information, would have meant that they would not have accepted the application for Life Cover

The FADC benefit will continue until the earliest of:

- the death of the Life Assured, or either of the Lives Assured in a joint life application, by accident as defined above
- the 60th day after FADC starts
- the date you become eligible for any Interim Life Cover
- the date risk assumed under the Life Cover applied for
- The twenty-first day after the date Friends Provident issues any letter giving special terms for the acceptance of the Life Cover
- the date on which Friends Provident issues any letter postponing or declining any Life Cover in the application
- the date on which the Applicant writes to or verbally informs their Financial Adviser or Friends Provident of their decision to cancel the application

The FADC benefit will not be paid if death is caused directly or indirectly by any of the following:

- bodily or mental infirmity or illness or disease of any kind, or from medical treatment for this
- acting against the advice of a registered medical practitioner
- suicide or self inflicted injury or disease, while sane or insane
- any form of war, whether declared or not
- committing, provoking or taking part in a criminal act
- engaging in any form of motor-sport, mountaineering or rock-climbing, potholing, underwater diving, caving, horse-riding, parachuting or any form of aviation or aerial flight except as a fare paying passenger in a commercially licensed passenger aircraft
- alcohol or drug abuse. This means the inappropriate use of alcohol or drugs, including but not limited to the following: consuming too much alcohol; taking an overdose of drugs, whether lawfully prescribed or otherwise; taking Controlled Drugs (as defined by the Misuse of Drugs Act 1971) otherwise than in accordance with a lawful prescription

Claiming under FADC benefit:

Any claim payment made under FADC will be paid to the Applicant(s) specified on the application form, their executors, administrators or assigns and is subject to the claims notification and provision of supporting evidence conditions as specified in the policy documentation applicable to the policy being applied for.

The cover is not assignable in full or part thereof.



Interim Life or Critical Illness Cover

This statement details the basis of Interim Life or Critical Illness Cover relating to an Application for Business Protection submitted electronically.

When does it start?

Within five working days of Friends Provident receiving a fully completed Application Form if all of the following conditions are met. If they are not met within this time we will not be able to offer Interim Life or Critical Illness Cover at any other time during the application process:

- Friends Provident has received a fully completed Application Form including an acceptable method of payment
- Friends Provident has received any required Financial Underwriting Questionnaire and any evidence requested within that questionnaire within five working days of Friends Provident having received the Application Form and, whether a Financial Underwriting Questionnaire or financial evidence is required or not, is satisfied that the application is acceptable financially and that there is a clearly identifiable need for cover
- No application is being made to Friends Provident or any other insurance company for similar cover
- This application is not replacement cover for cover that is currently in force with Friends Provident or any other insurance company
- Where appropriate a completed business trust form has been received by Friends Provident within five working days of Friends Provident receiving a fully completed Application Form
- The application, in respect of all Lives Assured, would be acceptable on Friends Provident's standard terms and conditions and at our standard rate of premium on the basis of the Application Form alone, and the only reason Friends Provident is not able to issue standard acceptance terms or the policy document is because further medical evidence is required due to the level of cover applied for
- All Lives Assured are under age 55 attained
- All Lives Assured are UK residents

If you are eligible for Interim Life or Critical Illness Cover Friends Provident will always write to tell you that it applies to your application and the date on which it starts.

How much is it?

The Sum Assured under Interim Cover is limited to the least of:

- For Life Cover - 2,000,000 GBP and the amount of Cover requested on the Application Form, reduced where applicable to the amount of Cover that Friends Provident is prepared to offer after its consideration of the financial evidence
- For Critical Illness Cover - 500,000 GBP and the amount of Cover requested on the Application Form, reduced where applicable to the amount of Cover that Friends Provident is prepared to offer after its consideration of the financial evidence

How long does it last?

The Interim Life or Critical Illness Cover will continue until the earliest of:

- The thirtieth day after Interim Cover started
- The date risk assumed of the cover applied for
- The thirtieth day after Friends Provident requests a medical examination if the medical examination report hasn't been received
- The fourteenth day from the issue by Friends Provident of a letter offering terms for the acceptance of the application

- The date on which Friends Provident issues any letter postponing or declining the application
- The date that the Applicant(s) write or verbally inform their Financial Adviser or Friends Provident of their decision to cancel the application
- The date on which an insured event arises

What will stop it paying out?

- Friends Provident will not pay any claim under Interim Cover if it finds out that any of the information given by any Life Assured or any Applicant or anyone acting on behalf of a Life Assured or Applicant, was not true, not accurate, or not complete
- Friends Provident will not pay any claim under Interim Cover if the claim is caused directly or indirectly by suicide or self inflicted injury or disease, while sane or insane
- Friends Provident will not pay any claim under Interim Cover if the cause is one we exclude within the policy conditions applicable to the policy being applied for

Additional Notes

- Our Critical Illness definitions are those specified in the policy conditions applicable to the policy being applied for
- Any Interim Life or Critical Illness Cover can only be paid once per application
- Friends Provident may withdraw Interim Life or Critical Illness Cover if the Life/Lives Assured inform Friends Provident that information contained within the Confirmation Schedule sent to them was not true, not accurate, or not complete. Friends Provident will only do this if any new information supplied meant that we would not be able to accept the Application on our standard terms and conditions and at our standard rate of premium

Claiming under Interim Life or Critical Illness Cover

- Any claim payment made under Interim Life or Critical Illness Cover will be paid to the Applicant(s) specified on the application form, their executors, administrators or assigns and is subject to the claims notification and provision of supporting evidence conditions as specified in the policy documentation applicable to the policy being applied for

The cover is not assignable in full or part thereof.

CHANGE IN HEALTH OR OTHER CIRCUMSTANCES

The Life/Lives Assured and the Applicant(s) must inform Friends Provident immediately of any changes in the health or circumstances of the Life/Lives Assured after the application questions have been completed and before the policy to which this interim cover applies commences.

THIS IS MOST IMPORTANT. If Friends Provident are not notified of these changes, we will be unable to pay a claim. We need to know of any changes which would result in different replies to questions asked either:

On or resulting from the application form or other questionnaire; or by any doctor or nurse acting on our behalf.

Changes would include having or expecting to have doctor, hospital or clinic consultations, treatment as an inpatient or a blood test for any reason. They would also include changes in occupation or occupational duties or taking up any hazardous sports or pastimes before Friends Provident assumes risk for the Cover applied for.

If we are advised of any changes we will confirm in writing whether or not any Interim Cover applying to the Application at the time still applies or whether any terms quoted still apply.



Interim Life Cover

This statement details the basis of Interim Life Cover relating to an Application for Business Protection submitted electronically.

When does it start?

Within five working days of Friends Provident receiving a fully completed Application Form if all of the following conditions are met. If they are not met within this time we will not be able to offer Interim Life Cover at any other time during the application process:

- Friends Provident has received a fully completed Application Form including an acceptable method of payment
- Friends Provident has received any required Financial Underwriting Questionnaire and any evidence requested within that questionnaire within five working days of Friends Provident having received the Application Form and, whether a Financial Underwriting Questionnaire or financial evidence is required or not, is satisfied that the application is acceptable financially and that there is a clearly identifiable need for cover
- No application is being made to Friends Provident or any other insurance company for similar cover
- This application is not replacement cover for cover that is currently in force with Friends Provident or any other insurance company
- Where appropriate a completed business trust form has been received by Friends Provident within five working days of Friends Provident receiving a fully completed Application Form
- The application, in respect of all Lives Assured, would be acceptable on Friends Provident's standard terms and conditions and at our standard rate of premium on the basis of the Application Form alone, and the only reason Friends Provident is not able to issue standard acceptance terms or the policy document is because further medical evidence is required due to the level of cover applied for
- All Lives Assured are under age 55 attained
- All Lives Assured are UK residents

If you are eligible for Interim Life Cover Friends Provident will always write to tell you that it applies to your application and the date on which it starts.

How much is it?

The Sum Assured under Interim Cover is limited to the least of:

- 2,000,000 GBP and the amount of Cover requested on the Application Form, reduced where applicable to the amount of Cover that Friends Provident is prepared to offer after its consideration of the financial evidence

How long does it last?

The Interim Life Cover will continue until the earliest of:

- The thirtieth day after Interim Cover started
- The date risk assumed of the cover applied for
- The thirtieth day after Friends Provident requests a medical examination if the medical examination report hasn't been received
- The fourteenth day from the issue by Friends Provident of a letter offering terms for the acceptance of the application
- The date on which Friends Provident issues any letter postponing or declining the application
- The date that the Applicant(s) write or verbally inform their Financial Adviser or Friends Provident of their decision to cancel the application
- The date on which the insured event arises

What will stop it paying out?

- Friends Provident will not pay any claim under Interim Cover if it finds out that any of the information given by any Life Assured or any Applicant or anyone acting on behalf of a Life Assured or Applicant, was not true, not accurate, or not complete
- Friends Provident will not pay any claim under Interim Cover if the claim is caused directly or indirectly by suicide or self inflicted injury or disease, while sane or insane

Additional Notes

- Any Interim Life Cover can only be paid once per application
- Friends Provident may withdraw Interim Life Cover if the Life/Lives Assured inform Friends Provident that information contained within the Confirmation Schedule sent to them was not true, not accurate, or not complete. Friends Provident will only do this if any new information supplied meant that we would not be able to accept the Application on our standard terms and conditions and at our standard rate of premium

Claiming under Interim Life Cover

- Any claim payment made under Interim Life Cover will be paid to the Applicant(s) specified on the application form, their executors, administrators or assigns and is subject to the claims notification and provision of supporting evidence conditions as specified in the policy documentation applicable to the policy being applied for

The cover is not assignable in full or part thereof.

CHANGE IN HEALTH OR OTHER CIRCUMSTANCES

The Life/Lives Assured and the Applicant(s) must inform Friends Provident immediately of any changes in the health or circumstances of the Life/Lives Assured after the application questions have been completed and before the policy to which this interim cover applies commences.

THIS IS MOST IMPORTANT. If Friends Provident are not notified of these changes, we will be unable to pay a claim. We need to know of any changes which would result in different replies to questions asked either:

On or resulting from the application form or other questionnaire; or by any doctor or nurse acting on our behalf.

Changes would include having or expecting to have doctor, hospital or clinic consultations, treatment as an inpatient or a blood test for any reason. They would also include changes in occupation or occupational duties or taking up any hazardous sports or pastimes before Friends Provident assumes risk for the Cover applied for.

If we are advised of any changes we will confirm in writing whether or not any Interim Cover applying to the Application at the time still applies or whether any terms quoted still apply.



Financial evidence is required to support Life and Critical Illness applications for large sums assured. This is so the underwriter can assess whether the type and amount of cover applied for is appropriate. For this purpose the definition of a large sum assured is where the life to be assured or the applicant is applying for a sum assured in excess of £800,000 Life cover or £500,000 Critical Illness cover. Under these sums assured financial evidence will generally not be requested unless total cover in the market exceeds £1,000,000 Life cover or £600,000 Critical Illness cover.

Full details of our minimum requirements can be found on Page 1 of this questionnaire.

Where the policy is to be owned by a company or business, the questionnaire should be completed and signed by an authorised official of the company other than the life to be assured (eg a Director or the Company Secretary).

If you need more space to write your answers, please use the section headed Additional Information on the back page of this questionnaire.



Financial evidence requirements

- These are Friends Provident's minimum requirements and we reserve the right to ask for additional information if deemed necessary
- The sums assured below relate to total cover in the market
- For sole applications up to £800,000 Life cover and £500,000 Critical Illness cover, financial evidence will generally not be requested unless total cover in the market exceeds £1,000,000 Life cover or £600,000 Critical Illness cover
- For keyperson cover, the sums assured below relate to total keyperson cover in the market on all key employees
- For partnership & shareholder protection cover, the sums assured below relate to total partnership & shareholder protection cover in the market on all shareholders

KEYPERSON

Life cover	Critical Illness cover	Evidence requirements
£800,001 to £1,000,000		<ul style="list-style-type: none"> • Annual taxable income • Details of existing cover
£1,000,001 to £2,000,000	£500,001 to £800,000	<ul style="list-style-type: none"> • Financial Underwriting Questionnaire (Sections A, B and C)
Over £2,000,000	£800,001 to £1,000,000	<ul style="list-style-type: none"> • Financial Underwriting Questionnaire (Sections A, B and C) • Copy of the last 2 years' reports and accounts • In the case of a new business, copy of the business plan to include projections • Copy of the life to be assured's CV • Copy of the life to be assured's service agreement
	Over £1,000,000	<ul style="list-style-type: none"> • Cover of this level is rarely justified. Individual consideration

COMMERCIAL LOAN

Life cover	Critical Illness cover	Evidence requirements
£800,001 to £1,000,000	£350,001 to £800,000	<ul style="list-style-type: none"> • Annual taxable income • Details of existing cover • Loan details
£1,000,001 to £2,000,000*		<ul style="list-style-type: none"> • Financial Underwriting Questionnaire (Sections A, B and D)
Over £2,000,000	£800,001 to £1,000,000*	<ul style="list-style-type: none"> • Financial Underwriting Questionnaire (Sections A, B and D) • Copy of the last 2 years' reports and accounts • In the case of a new business, copy of the business plan to include projections • Copy of the loan offer
	Over £1,000,000	<ul style="list-style-type: none"> • Cover of this level is rarely justified. Individual consideration

*A copy of the loan offer letter will waive the need for a Financial Underwriting Questionnaire and reports and accounts etc up to £2,000,000 Life cover and £1,000,000 Critical Illness cover

PARTNERSHIP & SHAREHOLDER PROTECTION

Life cover	Critical Illness cover	Evidence requirements
£800,001 to £1,000,000		<ul style="list-style-type: none"> • Annual taxable income • Details of existing cover
£1,000,001 to £2,000,000	£500,001 to £800,000	<ul style="list-style-type: none"> • Financial Underwriting Questionnaire (Sections A, B and E)
Over £2,000,000	£800,001 to £1,000,000	<ul style="list-style-type: none"> • Financial Underwriting Questionnaire (Sections A, B and E) • Copy of the last 2 years' reports and accounts • In the case of a new business, copy of the business plan to include projections • Copy of the share purchase agreement
	Over £1,000,000	<ul style="list-style-type: none"> • Cover of this level is rarely justified. Individual consideration

Where the policy is to be owned by a company or business, the questionnaire should be completed and signed by an authorised official of the company other than the life to be assured (eg a Director or the Company Secretary)

If you need more space to write your answers, please use the section headed Additional Information on the back page of this questionnaire

Please complete Sections A and B and then Section C, D or E as appropriate

Section A (to be completed in all cases)

1 Application number (if known)

2 Name of life to be assured

3 Date of birth of life to be assured

4 Name of company or business

5 Nature of business

6 Number of employees

7 Date business established

8 Date life to be assured joined the business

9 Position held by life to be assured

	Year	Turnover	Gross profit	Net profit before tax
10 Please provide details of turnover, gross profit and net profit before tax for the last 3 years. If the business is only recently established, please provide projections		£	£	£
		£	£	£
		£	£	£

11 If a gross or net loss has been reported in the last 3 years, please provide a brief explanation for this

12 a) Where the total sum assured for Life cover exceeds £2,000,000 or Critical Illness cover exceeds £800,000 or there has been a gross or net loss reported in the last 3 years, we will request a copy of the last 2 years' reports and accounts from the Registrar of Companies. Will these be available (ie have the accounts been submitted for the last two years' trading)?

Yes
 No
 Not applicable

- b) If No and the above limits have been exceeded or a loss has been reported in the last 3 years, please provide:
- **A copy of the last 2 years' reports and accounts or in the case of a new business, a copy of the business plan to include projections**

Section B (to be completed in all cases unless you have already provided this information on the Application Form in which case please move on to the next applicable section)

1 What is the reason for the policy type and level of cover chosen?

2 Please provide details of any existing Life and/or Critical Illness cover the life to be assured has in force along with any simultaneous applications which are currently being made and which the life to be assured intends to proceed with

Company	Type of cover (Life or Critical Illness)	Sum assured	Date effected or date to be effected	Reason for cover

3 What is the annual taxable earned income of the life to be assured? £

Section C: Keyperson (to be completed for all keyperson cover applications)

1 What special knowledge or qualities does the life to be assured have, and why is the company so dependent on them?

2 Does the company have any existing keyperson insurance in force either on the life to be assured or any other key personnel or does it intend to effect any such policies? Yes No

If Yes, please provide details

Employee's name	Employee's position in the company	Type of cover (Life or Critical Illness)	Sum assured	Reason for cover

3 Where the total sum assured for keyperson Life cover exceeds £2,000,000 or Critical Illness cover exceeds £800,000, please provide:

- **A copy of the life to be assured's CV**
- **A copy of the life to be assured's service agreement**

Section D: Commercial Loan (to be completed for all loan cover applications)

Please provide details of the lender, name(s) of the borrower(s), amount and term of the loan, interest rate payable and repayment method (If you have already provided this information on the Application Form, please move onto question 2)

- 1 a) The lender
- b) The name(s) of the borrower(s)
- c) The amount of the loan
- d) The term of the loan (If the term of the policy differs from the term of the loan, please give reason)
- e) The interest rate payable
- f) The method of repayment (eg interest only, capital & interest)
- 2 What is the reason for the loan?
- 3 What is the reason for the choice of the life to be assured to be covered under this policy?
- 4 Is the loan conditional upon the issue of this policy? Yes No
- 5 Are any other loans in existence? Yes No
- If Yes, please provide details
- 6 Where the total sum assured for Life cover exceeds £2,000,000 or Critical Illness cover exceeds £800,000, please provide:
- **A copy of the loan offer**

Section E: Partnership & Shareholder Protection (to be completed for all partnership & shareholder protection cover applications)

- 1 What share of the business/partnership is held by the life to be assured? %
- 2 What is the current value of the business/partnership?
- 3 Who performed this valuation and what is the valuation based upon?
- 4 How many partners/shareholders are there in the business/partnership?
- 5 Are policies being effected on the lives of other partners/shareholders? Yes No
- If Yes, please provide details. If No, please provide reason
- 6 Is there a 'double option' agreement in place or is it intended to complete such an agreement? Yes No
- If No, please give details of any obligation which exists which gives rise to the need for this policy
- 7 Where the total sum assured for partnership & shareholder protection Life cover exceeds £2,000,000 or Critical Illness cover exceeds £800,000, please provide:
- **A copy of the share purchase agreement**

Additional Information

Declaration

I declare that the answers I have given are, to the best of my knowledge and belief, true and I have not withheld any fact.

I agree that this questionnaire will form part of my application for insurance to Friends Provident and that failure to disclose a fact or the giving of false information may invalidate any future claim.

I agree Friends Provident will use the information I give for administration, underwriting, claims, research and statistical purposes. I agree Friends Provident may pass information to reinsurers and any agency appointed by Friends Provident for these purposes. (These agencies may be located in countries outside the UK that do not have laws to protect your information. Details of the companies and countries involved in your case will be provided on request. Friends Provident will remain responsible for making sure that the information is held securely.)

I also agree Friends Provident may pass the information to third parties for the prevention of crime or detection of fraud, enabling assets to be rightfully claimed or where required by law or regulation.

Signature

Date

**Status in the company or business
(where applicable)**

Friends Provident Life Assurance Limited

Salisbury Office: United Kingdom House, Castle Street, Salisbury, Wiltshire SP1 3SH

Registered and Head Office: Pixham End, Dorking, Surrey RH4 1QA

Incorporated company limited by shares and registered in England number 782698

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