

eSelect[®] Protection Life and Critical Illness

Adviser's data capture form

This is not an application form

It is intended simply to help advisers gather information before submitting it on behalf of their customers using the eSelect Protection on-line application process.

This form must not be sent to Friends Provident. It will not be processed and will be returned to you.

Commission

Initial commission	% basic commission to be taken	%
	fixed total initial amount	£
Renewal commission	% premium (maximum 2.5%)	% a year

Basis of sale

Advised sale?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Introduction

Notes

- You should explain to your customer that the information supplied here, together with any other information collected subsequently will form part of the application that you submit electronically to Friends Provident. We ask only relevant questions. Therefore you and the customer should assume that if we ask a question, it is important. The customer must answer all questions accurately and completely to the best of their knowledge. If they do not, Friends Provident will be legally entitled not to pay a claim and to cancel the policy.
- **Please ensure that your customer informs us if anything about their health or circumstances changes before we have assumed risk for all the cover applied for.** We need to know of any changes which would have resulted in different replies to questions asked either:
 - on or resulting from the application 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 in-patient or out-patient or a blood test for any reason. We also need to know immediately if they change their occupation or take up any hazardous sports or pastimes before cover starts.

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

- eSelect Protection does not extend to life of another cases.
- We may ask them to contact their doctor if we are waiting for reports, which we have asked for.

If we ask them 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 their 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. They can get details of general reassurance principles and details of any company we use to assess their application, from our head office.

- Please ensure that you have given your customer a key facts leaflet, an illustration and a Simplified Guide to Critical Illness and Disability Benefit (if applicable).
- You should ensure that when using the eSelect Protection on-line application facility you comply at all times with the terms of business agreed between your firm and Friends Provident.

Medical evidence

- Please remind your customer that if there is nothing disclosed in their personal or family history to require it, we will not usually obtain a report from their general practitioner or need a medical examination unless the sum assured exceeds specific levels based on age.
- Please remind your customer that, even if we do request a report from their doctor, that does not remove their duty to disclose all facts to Friends Provident. It is therefore important that they answer all questions as fully and accurately as possible.

Non smoker discount

- To qualify for 'non-smoker' status rates your customer must not have used any form of tobacco or nicotine products within the last twelve months. We reserve the right to check the accuracy of the reply if your customer has stated that he or she does not use any form of tobacco or nicotine products.

Confidentiality

- Friends Provident has a confidentiality policy in place, which means that your customer's medical information is held securely and access is limited to authorised individuals who need to see it. Your customer is entitled to ask for a copy of our confidentiality policy.

Terms and conditions

- Full details of the terms and conditions of all Friends Provident's plans are available on request (eSelect Protection terms and conditions are available on-line).

Definitions

For the purpose of this document, HIV 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.

Marital/civil partnership status

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

Civil partner - use this status if your customer has registered their civil partnership.

Former civil partner - use this status if your customer was previously part of a registered civil partnership in respect of which a court has made a dissolution or nullity order.

Separated civil partner - use this status if your customer's registered civil partnership has broken down but has not yet been dissolved by court order.

Surviving civil partner - use this status if your customer was part of a registered civil partnership, but your customer's partner has died.

Data protection

Please ensure you obtain your customer(s) agreement that the data you input to eSelect Protection on-line on their behalf can be viewed by Friends Provident and relevant third parties.

1. Friends Provident will use the information from the eSelect Protection application
 - a) for administrative and underwriting purposes
 - b) to assess any claim
 - c) for research and statistical purposes.
2. Friends Provident may share the information with
 - a) third parties acting for Friends Provident in an administrative, underwriting or claims assessment capacity, including medical practitioners, reinsurers and any agency appointed by Friends Provident for these purposes in the UK or any other country (which may not have laws to protect your information). Details of the countries involved in your case will be provided on request. Friends Provident will remain responsible for making sure that the information is held securely.
 - b) the Association of British Insurers (ABI) in order that they can make it available to other insurers (critical illness and waiver benefits only).
 - c) third parties for the prevention or detection of fraud, enabling assets to be rightfully claimed or where required by law or regulation.

Quote details

Package reference (if known)

Agency number (if known)

Cover required

Choose one of the following cover types

- Life Cover - Level
- Life Cover - Decreasing
- Life or Earlier Critical Illness - Level
- Life or Earlier Critical Illness - Decreasing

Amount of cover required

£

OR

Monthly premium

£

OR

Annual premium

£

Cover term

Premium basis (only required for Life or Earlier Critical Illness Cover)

GUARANTEED REVIEWABLE

Is this product to cover a mortgage?

No or not known Yes

Single/joint Cover?

Joint Single

FIRST APPLICANT

Sex

Male Female

Date of birth

- -

Smoker

Yes No

Waiver of premium

Yes No

Occupation

(Needed if waiver or CIC has been selected)

SECOND APPLICANT

Sex

Male Female

Date of birth

- -

Smoker

Yes No

Waiver of premium

Yes No

Occupation

(Needed if waiver or CIC has been selected)

Contact details

	FIRST APPLICANT	SECOND APPLICANT
Title	<input type="text"/>	<input type="text"/>
Forename(s)	<input type="text"/>	<input type="text"/>
Surname	<input type="text"/>	<input type="text"/>
Address	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	Town	Town
	County	County
Postcode	<input type="text"/>	<input type="text"/>
Are the applicant(s) going to change their contact details in the next 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, future address	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	Town	Town
	County	County
Postcode	<input type="text"/>	<input type="text"/>
It may be necessary for one of our underwriters to contact the applicant(s) to discuss the information you have provided. This will help to speed up the underwriting of the application.		
Preferred contact phone number	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>	<input type="text"/>

Personal details – Part 1

Medical history

Please explain the following to your customer(s) and ask them to answer each of the following questions please, putting each of the questions to your customer(s) in full.

You and your customer must give all the information we ask for. All the questions we ask are relevant and important. They must be answered accurately and completely to the best of the customer's knowledge. If they are not, we will have the legal right to cancel any policy issued as a result of the application and to not pay any claim.

The customer must not assume that any information will be obtained from a doctor or any other source that we may write to, or from any other application.

	FIRST APPLICANT	SECOND APPLICANT
Marital/civil partnership status (see Introduction)	<input type="text"/>	<input type="text"/>
Height	<input type="text"/> ft <input type="text"/> in or <input type="text"/> cm	<input type="text"/> ft <input type="text"/> in or <input type="text"/> cm
Weight	<input type="text"/> st <input type="text"/> lbs or <input type="text"/> kg	<input type="text"/> st <input type="text"/> lbs or <input type="text"/> kg
Have the applicant(s) recently lost or gained any weight?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes please provide details	Details <input type="text"/>	Details <input type="text"/>
Have they used any form of tobacco or nicotine products in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of cigarettes a day	<input type="text"/>	<input type="text"/>
Number of cigars a day	<input type="text"/>	<input type="text"/>
Pipe smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other tobacco or nicotine product for example patches, gum	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many units of alcohol do they drink per week? (1 unit = a single measure of spirits or 1 glass of wine or 1/2 pint of beer)	<input type="text"/>	<input type="text"/>

Personal details – Part 1 (continued)

	FIRST APPLICANT		SECOND APPLICANT					
Have they ever been advised to stop or reduce drinking on medical grounds?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Has the applicant(s) ever taken non-prescription drugs? (e.g. ecstasy, cocaine, heroin, anabolic steroids)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Within the last 5 years has the applicant(s) been exposed to the risk of HIV infection?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Details				Details			

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

Personal details – Part 2

Have they ever made a waiver, income protection or critical illness claim against Friends Provident?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Are they applying or about to apply for any other life, critical illness or income protection cover with Friends Provident or have they done so within the last 12 months?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Will the total amount of insurance the applicant(s) are now applying for, added to any existing cover that they already hold with any insurance company, result in the total cover exceeding £600,000 for critical illness or £1,000,000 for life cover?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Note: The applicant(s) need to include in their calculations any other life or critical illness insurance policies that they already hold together with this and any other applications they are currently making that they intend to proceed with. They do 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 the applicant(s) answers 'yes' to the previous question they will be asked to answer all of the following five questions.

Total amount of life cover including the insurance they are now applying for:

Total amount of critical illness cover including the insurance they are now applying for:

If the applicant(s) will be applying for life cover in excess of £800,000, or critical illness in excess of £500,000 they will be asked to answer the following three questions.

Reason for policy:	<input type="text"/>	<input type="text"/>						
Annual taxable earned income:	<input type="text"/>	<input type="text"/>						
Loan details, if applicable (including details of lender, name of borrowers, amount, loan term and interest rate payable):	<input type="text"/>	<input type="text"/>						
Have they ever been turned down or been offered special terms by any company including Friends Provident?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Name and address of their usual doctor* (Please make your customer aware we may not contact their doctor. Even if we do, they must still disclose all facts when completing the application).	<input type="text"/>				<input type="text"/>			
	<input type="text"/>				<input type="text"/>			
	Town				Town			
	County				County			
Postcode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

* You will only be asked to input these details online if further medical evidence is required or if the application is referred to Friends Provident.

Medical history

Please explain the following to your customer(s) and ask them to answer each of the following questions please, putting each of the questions to your customer(s) in full.

You and your customer must give all the information we ask for. All the questions we ask are relevant and important. They must be answered accurately and completely to the best of the customer's knowledge. If they are not, we will have the legal right to cancel any policy issued as a result of the application and to not pay any claim.

The customer must not assume that any information will be obtained from a doctor or any other source that we may write to, or from any other application.

In accordance with the Association of British Insurers' (ABI) policy on genetics and insurance, the applicant(s) do 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 or less for Life Insurance;
- £300,000 or less for Critical Illness.

Above these limits, they 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 applicant(s) think this may apply to them, please ask us for details of the current position. These details are available from the ABI website at www.abi.org.uk/Public/Consumer/Codes/disclosure.asp. However, they must tell us if they either have a family history of, have previously or are currently experiencing symptoms of, or has had or are having treatment for, a medical condition including any genetically inherited condition.

If they wish 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 the premium, providing their clinical geneticist confirms that this test result indicates a reduced risk of developing the inherited disease.

Does the applicant(s) currently have or have they ever had:

	FIRST APPLICANT		SECOND APPLICANT					
1 Cancer, Leukemia, Hodgkin's disease, lymphoma, brain or spinal tumour	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
2 Heart disease (including heart attack, angina, heart defects from birth or heart surgery)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
3 Stroke, brain haemorrhage or brain injury	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
4 Multiple Sclerosis, optic or retrobulbar neuritis, Parkinson's disease, paralysis, epilepsy, Alzheimer's disease, dementia or cerebral palsy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
5 Any other disorder of the central nervous system not already mentioned	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
6 Disease or disorder of the arteries (including disease in the legs or of the aorta)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
7 Diabetes or sugar in the urine	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
8 Mental illness that has required hospital treatment or referral to a psychiatrist	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Recent health

In the last 5 years has the applicant(s) had:

1 A mole or freckle that has bled, caused pain or changed in appearance or any lump or growth	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
2 Chest pain, irregular heartbeat, raised blood pressure or raised cholesterol	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
3 Asthma, bronchitis or any other respiratory disorder	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
4 Numbness, loss of feeling or tingling of the limbs or face, loss of balance or co-ordination	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
5 Seizures, fits, fainting or blackouts	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
6 Any disorder of the eyes or ears, including blurred or double vision, or impaired hearing	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<i>You can ignore sight problems corrected by glasses or contact lenses</i>								
7 Arthritis, back pain, sciatica, neck, knee or wrist pain or any other joint, bone or muscle disorder (including RSI)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Recent health (continued)

	FIRST APPLICANT		SECOND APPLICANT					
8 Any disorder of the digestive system, liver, stomach, pancreas or bowel (including ulcers, hepatitis, colitis or Crohn's disease)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
9 Any blood disorder or anaemia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
10 Any thyroid disorder	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
11 Any disorder of the kidney, bladder or genitourinary system (including urinary tract infections and blood or protein in the urine)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
12 Any treatment or a positive test for any disease which was transmitted sexually	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
13 Depression, anxiety, stress, fatigue or nervous breakdown	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Health consultations

1 Other than consultations specifically mentioned above, in the last 12 months, has the applicant(s) had any medical consultation? (e.g. doctor, consultant, psychiatrist, hospital, clinic, osteopath)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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In answering Question 1 they do not need to give details of occasional consultations with their GP for just colds, flu, and for consultations for oral contraceptive pills, smear tests, well man/woman check ups where the results are known and were normal.

2 Have they had (or been advised to have) any medical investigation, scan, test or attended hospital in the last five years?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
3 Are they awaiting any medical consultation, check up, investigation, scans or tests?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
4 Have they been prescribed any drugs or been given any other treatment in the last 12 months?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
5 Have they 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"/>	Yes	<input type="checkbox"/>	No

Note: *If the result is negative, the fact of having an HIV test will not in itself have any effect on your acceptance terms for insurance*

If the applicant(s) answered 'Yes' to any of the questions, you can use the space below to collect any other information you may find helpful when completing the online application.

To speed up the application please try and record the following medical information:

- **What was/is the condition?**
- **When was it? (dates)**
- **How long did it last for? (days, months, years)**
- **What was/is the treatment? (names of prescription medication if applicable)**
- **Amount of time off work as a result? (days, months, years)**
- **Details of any residual symptoms?**

This may include the details of the illness, treatment, any referral to specialists, results of investigations and tests and time off work.

But please note that you may still need to refer back to the applicant(s) for further details depending upon the precise information needed by our underwriting system.

FIRST APPLICANT	SECOND APPLICANT

Family health

Before the age of 60, did either of the applicant's natural parents or brothers or sisters suffer or die from heart disease, cardiomyopathy, raised cholesterol, stroke, diabetes, cancer, multiple sclerosis, Huntington's disease, polycystic kidney disease, polyposis of the colon, or any other hereditary disorder not listed above?

	FIRST APPLICANT		SECOND APPLICANT					
1 Heart disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
2 Cardiomyopathy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
3 Stroke	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
4 Raised cholesterol	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
5 Cancer - breast	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
6 Cancer - ovarian	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
7 Cancer - bowel or colo-rectal cancer (for example cancer of the bowel or colon or rectum)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
8 Cancer other	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
9 Diabetes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
10 Multiple Sclerosis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
11 Huntington's Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
12 Polycystic kidney disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
13 Polyposis of the colon	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
14 Any other hereditary disorder	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

If the applicant(s) have answered yes to any of the questions above, please give details below.

FIRST APPLICANT			SECOND APPLICANT		
Disease	Family member	Age at onset	Disease	Family member	Age at onset

Pastimes

Does the applicant(s) take part in any hazardous sports or pastimes, or do they intend to start? The following are examples, but you should include any activities that are hazardous.

If the applicant(s) involvement is, or will be, limited to one occasion, for example a race day, a flying lesson, a trip in a hot air balloon or a team building exercise, and they have no intention of pursuing the activity further, you need not disclose it.

	FIRST APPLICANT		SECOND APPLICANT					
Diving	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Flying	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Motor sports	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Mountaineering/rock climbing	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Other	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Occupation details

FIRST APPLICANT

SECOND APPLICANT

Do they intend to live, work or travel abroad, other than for holidays, or have they done so within the past 5 years?

<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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Please ensure the applicant(s) answer the following set of questions if they are applying for life cover with no other benefits

Does the applicant(s) occupation involve any of the following?

Work at heights over 10 feet (3 metres)

<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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Work underground

<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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Work underwater

<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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Work offshore (for example oil, gas industry)

<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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Work with explosives or firearms

<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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Armed forces

<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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Professional sports

<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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Aviation (except as a fare paying passenger)

<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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Please ensure the applicant(s) answer the following set of questions if they are applying for waiver of premium benefit and/or critical illness and disability benefit or if they have answered 'yes' to any of the life cover occupation questions above:

FIRST APPLICANT

SECOND APPLICANT

What is the applicant(s) occupation?

% of time spent on manual work

<input type="text"/>	%
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<input type="text"/>	%
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By manual work we mean those activities such as

- carrying or lifting
- moving goods
- working with tools or machinery
- crawling or kneeling which form part of their normal day to day occupational duties

Business miles a year

Hours worked a week

Are they currently absent from work?

<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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Have they had any time off work in the last 2 years due to illness or injury? (They can ignore minor ailments such as colds or flu if together they total less than 10 days per year)

<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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Do they have a second job?

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

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

What is their second occupation?

% of time spent on manual work in second job

<input type="text"/>	%
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<input type="text"/>	%
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Business miles a year for second job

Hours worked a week on second job

Start date

Please include the start date for the applicants cover start details

Discretionary trust details

The benefits of this plan can be written under trust online using our discretionary trust forms. Alternative trust forms for use post sale are available in the Document Library.

Our contracts are normally written under the Law of England and Wales, but if your client prefers you can request the Law of Scotland. Under the Law of Scotland, trust terms need to be witnessed and so cannot be completed online.

Is a trust required?	No	<input type="checkbox"/>
	Yes - from inception - Law of England and Wales	<input type="checkbox"/>
	Yes - once policy has gone live - Law of England and Wales	<input type="checkbox"/>
	Yes - once policy has gone live - Law of Scotland	<input type="checkbox"/>

Please complete the trustee details below only if you wish to write the policy under trust from inception under the Law of England and Wales.

Trustee details

Trustee 1

Forename	
Surname	
Address	
Postcode	

Trustee 2

Forename	
Surname	
Address	
Postcode	

Trustee 3

Forename	
Surname	
Address	
Postcode	

Important note

Please note that completion of these details does not constitute a trust. The trust will be written on the basis of the information completed online and a copy of the trust provisions will be issued with the policy documents once the policy has been placed on risk.

Please capture your customer's bank or building society details to pay Direct Debit

Instruction to your customer's Bank or building society to pay Direct Debits



Name(s) of Account Holder(s)

Branch sort code — —

Bank/building society account no.

Name and full postal address of your Bank or building society


Bank/building society

Postcode:

Please pay Friends Provident Direct Debits from the account detailed in this Instruction subject to the safeguards assured by the Direct Debit Guarantee.
The applicant(s) understand that this Instruction may remain with Friends Provident and if so, details will be passed electronically to their Bank/building society.
Banks and building societies may not accept Direct Debit Instructions for some types of account.

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 accept instructions to pay Direct Debits.**
- **If there are any changes to the amount, date or frequency of your Direct Debit Friends Provident will notify you 5 working days in advance of your account being debited or as otherwise agreed. If you request Friends Provident to collect a payment, confirmation of the amount and date will be given to you at the time of the request.**
- **If an error is made in the payment of your Direct Debit, by Friends Provident or your bank or building society, you are entitled to a full and immediate refund of the amount paid from your bank or building society**
 - **If you receive a refund you are not entitled to, you must pay it back when Friends Provident asks you to.**
- **You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.**

After submitting details on eSelect Protection on-line you will be informed if Friends Provident requires a General Practitioner's Report. If we do, you should print that report off eSelect Protection on-line and forward it, together with the applicant(s) signed consent, to their doctor direct.

Whilst it is not known at this stage if a report will be needed, in order potentially to save time later, you may wish to ask the applicant(s) to consider and complete the appropriate consent now. This consent is set out below.

Please note Friends Provident may not contact the customer's doctor. Even if Friends Provident does, the customer must still disclose all facts when completing the application.

Access to medical reports

Please note Friends Provident may not contact your doctor. Even if Friends Provident does, you must still disclose all facts when completing the 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 your 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 may ask about any of 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 your 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 in the medical history section.

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, please write to:

The Chief Medical Officer, Friends Provident Life Assurance Limited, PO Box 1550, Milford, Salisbury SP1 2TW

Declaration

I agree to Friends Provident asking any doctor I have consulted about my physical or mental health to provide medical information so that Friends Provident may assess the application. Friends Provident may gather relevant information from other insurers about any 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.

I have read and understood the section above relating to Access to Medical Reports.

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

First Applicant

Second Applicant

Signature
Date

Signature
Date

Declaration for data capture form

Optional declaration which advisers might want to use with their customers but for which Friends Provident accept no liability.

I understand that all the questions within this data capture form are relevant.

I declare that the answers given in this data capture form are true and accurate to the best of my knowledge and belief and that no fact has been withheld.

I authorise my adviser to obtain insurance cover for me from Friends Provident based on these details.

I understand that this data capture form will not be sent to Friends Provident but that my adviser will use the answers I have provided within the form, together with any changes or additional information that I give my adviser before I am covered by my policy, to apply for insurance using Friends Provident's on-line system. All that information will be shown on the confirmation schedule that Friends Provident will send me once my adviser has accepted terms and applied for insurance on my behalf.

I confirm my adviser has explained the purpose of the confirmation schedule and I understand and accept that I must still check my confirmation schedule for accuracy and completeness as soon as I receive it from Friends Provident.

I understand and accept that I must let my adviser know about any changes in my health and circumstances that occur right up until the date that I am covered by my policy.

First applicant

Signature
Date

Second applicant

Signature
Date

This is not an application form.

This form must not be sent to Friends Provident. It will not be processed and will be returned to you.

