

Level Term Assurance

Data Capture Form

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.



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		

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

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

	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		

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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If the Application is assessed and accepted on our normal terms, we will start cover immediately, unless the Applicant(s) have instructed otherwise, or have stated 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	<input type="text"/>	GBP	
Term of Plan	<input type="text"/>	years	
Is Critical Illness and Disability Benefit to be included?	<input type="text"/>	Yes	No
Type of premium rate	<input type="text"/>		
Is Waiver of Premium Benefit to be included?	<input type="text"/>	Yes	No
Who should have this Benefit?	<input type="text"/>		
Premium frequency	<input type="text"/>		

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)	<input type="text"/>	Yes	No	<input type="text"/>	Yes	No
Number of cigarettes per day	<input type="text"/>		<input type="text"/>			
Number of cigars per day	<input type="text"/>		<input type="text"/>			
Grams of tobacco (pipe or other method) per day	<input type="text"/>		<input type="text"/>			
Other for example nicotine patches, nicotine gum - please specify what form and how much per day	<input type="text"/>		<input type="text"/>			
If the Life Assured smokes less than daily, please state what form, how much and frequency	<input type="text"/>		<input type="text"/>			
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	<input type="text"/>		<input type="text"/>			

Alcohol consumption

FIRST (or only) LIFE ASSURED

SECOND LIFE ASSURED

Does the Life Assured drink alcohol?	<input type="text"/>	Yes	No	<input type="text"/>	Yes	No
(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?	<input type="text"/>			<input type="text"/>		
If the Life Assured drinks less than weekly, please state how many units they drink and frequency	<input type="text"/>			<input type="text"/>		
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?	<input type="text"/>	Yes	No	<input type="text"/>	Yes	No
Please provide full details	<input type="text"/>			<input type="text"/>		

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)?	<input type="text"/>	Yes	No	<input type="text"/>	Yes	No
Types of drugs taken	<input type="text"/>			<input type="text"/>		
Dates taken	<input type="text"/>			<input type="text"/>		
Is the Life Assured still taking any non-prescription drugs?	<input type="text"/>	Yes	No	<input type="text"/>	Yes	No

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)	<input type="text"/>	Yes	No	<input type="text"/>	Yes	No
Activity (1)	<input type="text"/>			<input type="text"/>		
Qualifications held or the association the Life Assured belongs to	<input type="text"/>			<input type="text"/>		
How many times a year does the Life Assured engage in this activity?	<input type="text"/>			<input type="text"/>		
Level of participation e.g. heights, depths, categories, classes	<input type="text"/>			<input type="text"/>		
Does the Life Assured engage in this activity outside the UK?	<input type="text"/>	Yes	No	<input type="text"/>	Yes	No
Countries visited	<input type="text"/>			<input type="text"/>		

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 not already listed above?							
		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)				

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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 the 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 number	<input type="text"/>	<input type="text"/>

Height and weight

What is the Life Assured's 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
What is the Life Assured's 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"/>

Occupation details

What is the Life Assured's occupation?	<input type="text"/>	<input type="text"/>
Occupation (if not listed)	<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 <input type="text"/> No	<input type="text"/> Yes <input type="text"/> 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 <input type="text"/> No	<input type="text"/> Yes <input type="text"/> No
Frequency of trips	<input type="text"/>	<input type="text"/>
Length of trips	<input type="text"/>	<input type="text"/>

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Occupation details - continued

FIRST (or only) LIFE ASSURED

SECOND LIFE ASSURED

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 a week	<input type="text"/>	average hours a 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 a year	<input type="text"/>	miles a year	<input type="text"/>	miles a year		
Does the Life Assured's occupation involve any other manual or physical activity such as carrying, lifting, prolonged repetitive activity etc?	<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"/>	%	
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"/>	%	
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"/>	%	

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

Occupation details - continued

	FIRST (or only) LIFE ASSURED		SECOND LIFE ASSURED			
Is the Life Assured currently absent from work for any reason?		Yes	No		Yes	No
Reason for and duration of absence						
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)		Yes	No		Yes	No
Reason						
Amount of time off						
Any other reason?		Yes	No		Yes	No
Reason						
Amount of time off						

Financial details

Will the total amount of insurance the Life Assured is now applying for, added to any existing cover that they already hold with any company result in the total exceeding £1,000,000 for life cover or £600,000 critical illness cover?		Yes	No		Yes	No
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The Life Assured needs to include in their calculations any other life insurance policies that they already hold together with this and 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.

Please provide details of any existing Life and/or Critical Illness cover along with any simultaneous Applications the Life Assured is making that they intend to proceed with

Type of Cover						
Company						
Sum Assured GBP						
Date effected or date to be effected						
Reason for cover						
Any other cover?		Yes	No		Yes	No

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

Financial details - continued

	FIRST (or only) LIFE ASSURED		SECOND LIFE ASSURED			
Type of Cover						
Company						
Sum Assured GBP						
Date effected or date to be effected						
Reason for cover						
Any other cover?		Yes	No		Yes	No
Type of Cover						
Company						
Sum Assured GBP						
Date effected or date to be effected						
Reason for cover						
Any other cover?		Yes	No		Yes	No
Type of Cover						
Company						
Sum Assured GBP						
Date effected or date to be effected						
Reason for cover						

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		

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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?

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

1e. Has the Life Assured ever tested positive for HIV, Hepatitis B or C or are they awaiting the results of such a test?

Note: If the result was 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

1f. Visual disturbance, blurred or double vision, optic or retrobulbar neuritis?

What diagnosis was made?

Date of diagnosis

Are they currently receiving treatment?

If yes, nature of treatment

Have they previously received treatment?

If yes, when did they last receive treatment?

If yes, nature of treatment

Are they still undergoing follow-ups?

If yes, name of doctor/specialist seen and name of hospital/surgery where seen

If no, date of last follow up

If no, results of last follow up

Are they still experiencing symptoms?

If yes, nature of symptoms

If yes, duration of symptoms

If no, date of last symptoms

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

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

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

1g. 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?		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

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

	FIRST (or only) LIFE ASSURED			SECOND LIFE ASSURED		
2b. 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.

2c. 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	
2c. 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.

2d. 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				

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				
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				
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.

2e. 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

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				
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.

2f. Any lump that has appeared or grown in size, or a mole or freckle that has bled, caused pain or changed in appearance?		Yes No		Yes No
What diagnosis was made?				
Date of diagnosis		mm yyyy		mm yyyy
Part of body affected				
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				
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. Asthma or any chest, lung or breathing disorder 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.

2h. 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"/>	<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"/>			
Cause	<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"/>

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		
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		
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.

2i. Any impairment of vision or hearing or any disorder of the eyes or ears?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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	mm yyyy	mm yyyy
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

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

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, 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.

2j. 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

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				
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.

2k. 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
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

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		
7. continued						
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.

8. 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						
Any others?		Yes	No			No

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

Additional information

FIRST (or only) LIFE ASSURED

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

