



TO BE COMPLETED BY ALL ADVISERS:

Non-advised sale

If not ticked we will assume advice was given.

Part 1 – Important information - It is essential that you read this part before completing the application form.

- 1 Please check you have received a key facts leaflet 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 all questions accurately and completely to the best of your knowledge. If you do not, we have the legal right to cancel any policy issued as a result of your application and to not pay any claim.**

IF ANYTHING ABOUT YOUR HEALTH OR CIRCUMSTANCES CHANGES AFTER YOU HAVE COMPLETED THIS APPLICATION AND BEFORE WE ASSUME RISK FOR ALL THE COVERS APPLIED FOR YOU MUST LET US KNOW IMMEDIATELY. We need to know of any changes which would have resulted in different replies to questions asked either:

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

Changes would include having or expecting to have doctor, hospital or clinic consultations, treatment as an in-patient or out-patient or a blood test for any reason or having a symptom of any type that you have been asked about in the application form. We also need to know immediately if you change your occupation, take up any hazardous sport or pastime, work or travel abroad or change your country of residence before cover starts.

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 this form if you have done so.

- 3 If you and another person are applying together for cover on 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 premiums 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 Salisbury 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.

Please use BLOCK CAPITALS throughout and tick the boxes where appropriate. If you make a mistake please cross it out, correct it and initial the correction. If you need more space to write your answers, please use the section headed Additional information on page 12.

Part 2 – Personal details to be completed by the life or lives to be assured

FIRST (or only) LIFE ASSURED

SECOND LIFE ASSURED

1 Title	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Miss <input type="checkbox"/>	Ms <input type="checkbox"/>	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Miss <input type="checkbox"/>	Ms <input type="checkbox"/>
	Other (please specify) <input type="text"/>				Other (please specify) <input type="text"/>			
2 Surname	<input type="text"/>				<input type="text"/>			
3 First name(s)	<input type="text"/>				<input type="text"/>			
4 Current address	<input type="text"/>				<input type="text"/>			
	<input type="text"/>				<input type="text"/>			
	Town <input type="text"/>				Town <input type="text"/>			
	County <input type="text"/>				County <input type="text"/>			
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"/>

It may be necessary for us to contact you to discuss the information you have provided. This will help to speed up the assessment of your application.

Please confirm that you are happy for us to contact you	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes, please confirm the most suitable times	<input type="text"/>		<input type="text"/>	
	Weekdays <input type="checkbox"/>	Saturdays <input type="checkbox"/>	Weekdays <input type="checkbox"/>	Saturdays <input type="checkbox"/>

Please provide telephone numbers below and use the tick box provided to indicate your preferred contact number.

		Tick box		Tick box
5 Daytime telephone number (including STD code)	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
6 Home telephone number (including STD code)	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
7 Mobile telephone number	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
8 E-mail address	<input type="text"/>		<input type="text"/>	
9 Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
10 Marital/civil partnership status (see Important notes on page 17)	<input type="text"/>		<input type="text"/>	
11 What is your height?	<input type="text"/> ft	<input type="text"/> in	or	<input type="text"/> cm
12 a) What is your weight?	<input type="text"/> st	<input type="text"/> lbs	or	<input type="text"/> kg
b) Have you lost more than 1 stone or 6 kilograms in the last 6 months?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes, please provide details	Details <input type="text"/>		Details <input type="text"/>	
13 Name and address of your doctor	<input type="text"/>		<input type="text"/>	
	<input type="text"/>		<input type="text"/>	
Please note we may not contact your doctor. Even if we do, you must still give accurate and complete information when completing this application	Town <input type="text"/>	County <input type="text"/>	Postcode <input type="text"/>	
	Telephone <input type="text"/>		Telephone <input type="text"/>	

Part 3 – Plan details

1. Level Term Assurance Homebuyer Protection Plan
2. Amount of Life Cover
3. Amount of premium payable

Annually	<input type="checkbox"/>
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- All monthly premiums must be paid by direct debit. Annual premiums may be paid by direct debit or cheque.
Please complete the attached direct debit instruction if required.
4. Is this plan to be used in connection with your mortgage?

Yes	<input type="checkbox"/>
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No	<input type="checkbox"/>
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5. Term of plan in years
6. Please tick this box if the plan is to be written under trust. (If this box is not ticked we will assume it is not to be written under trust.)

Part 4 – Optional cover

Please complete this section *only* if you would like waiver of premium benefit or critical illness and disability benefit.

Waiver of premium benefit

If you require waiver of premium benefit, please tick which basis it will be required on:

First life only <input type="checkbox"/>	Second life only <input type="checkbox"/>	Joint life <input type="checkbox"/>
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Critical illness and disability benefit

If you require critical illness and disability benefit, please tick which premium basis it will be required on:

Guaranteed <input type="checkbox"/>	Reviewable <input type="checkbox"/>
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Part 5 – Recreation and travel details to be completed by the life or lives to be assured

- | | FIRST (or only) LIFE ASSURED | SECOND LIFE ASSURED | | | | | | | | |
|---|--|---------------------|--------------------------|----|--------------------------|--|-----|--------------------------|----|--------------------------|
| 1. Have you 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) | <table border="1" style="display: inline-table;"><tr><td>Yes</td><td><input type="checkbox"/></td></tr></table> <table border="1" style="display: inline-table;"><tr><td>No</td><td><input type="checkbox"/></td></tr></table> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | <table border="1" style="display: inline-table;"><tr><td>Yes</td><td><input type="checkbox"/></td></tr></table> <table border="1" style="display: inline-table;"><tr><td>No</td><td><input type="checkbox"/></td></tr></table> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Yes | <input type="checkbox"/> | | | | | | | | | |
| No | <input type="checkbox"/> | | | | | | | | | |
| Yes | <input type="checkbox"/> | | | | | | | | | |
| No | <input type="checkbox"/> | | | | | | | | | |
| If Yes, please state what form and how much a day. If you smoke less than daily, please state what form, how much you smoke and frequency. If you have given up in the last 12 months, please state date, what form and how much a day before you gave up | Details | Details | | | | | | | | |
| 2. Do you drink alcohol? | <table border="1" style="display: inline-table;"><tr><td>Yes</td><td><input type="checkbox"/></td></tr></table> <table border="1" style="display: inline-table;"><tr><td>No</td><td><input type="checkbox"/></td></tr></table> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | <table border="1" style="display: inline-table;"><tr><td>Yes</td><td><input type="checkbox"/></td></tr></table> <table border="1" style="display: inline-table;"><tr><td>No</td><td><input type="checkbox"/></td></tr></table> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Yes | <input type="checkbox"/> | | | | | | | | | |
| No | <input type="checkbox"/> | | | | | | | | | |
| Yes | <input type="checkbox"/> | | | | | | | | | |
| No | <input type="checkbox"/> | | | | | | | | | |
| If Yes, please state how many units you drink a week. If you drink less than weekly, please state how many units you drink and frequency

1 unit = a single measure of spirits or 1 glass of wine or 1/2 pint of beer | Details | Details | | | | | | | | |

Part 5 – Recreation and travel - continued

FIRST (or only) LIFE ASSURED

SECOND LIFE ASSURED

3 Have you ever been advised by a doctor or any other medical practitioner to reduce or stop your alcohol consumption on medical grounds or have you ever taken part in counselling, therapy or a programme with the aim of reducing or stopping your alcohol consumption?

Yes No

Yes No

Details

Details

If Yes, please provide full details

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

Yes No

Yes No

Details

Details

If Yes, please provide full details

5 Do you take part in any hazardous sport or pastime or do you intend to start? (Mountaineering, motor sport, sub-aqua diving, horse riding and private flying are examples but you should include any activity that is hazardous. You do not need to include sports such as football, rugby, hockey, cricket or racquet sports)

Yes No

Yes No

Details

Details

If Yes, please provide full details

6 a) In the last 5 years, apart from holidays, have you lived, worked or travelled abroad?

Yes No

Yes No

If Yes, please provide details to include reason for visit(s), countries visited, dates and duration of visit(s)

Details

Details

b) Apart from holidays, do you intend to live, work or travel abroad?

Yes No

Yes No

If Yes, please provide details to include reason for visit(s), intended countries, dates and duration of visit(s)

Details

Details

Part 6 – Family history details to be completed by the life or lives to be assured

Before the age of 60, have any of your 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 listed above?

FIRST (or only) LIFE ASSURED Yes No

SECOND LIFE ASSURED Yes No

If Yes, please complete the relevant section(s) below with details of any of the conditions listed above. Please state the **age at onset of the medical condition** and in the case of cancer, which part of the body was **first affected**.

FIRST (or only) LIFE ASSURED

	Living family member(s)		Deceased family member(s)	
	Current age	Past and present medical conditions (to include age at onset)	Past medical conditions (to include age at onset) and cause of death	Age at death
Father				
Mother				
Brother(s)				
Sister(s)				

SECOND LIFE ASSURED

	Living family member(s)		Deceased family member(s)	
	Current age	Past and present medical conditions (to include age at onset)	Past medical conditions (to include age at onset) and cause of death	Age at death
Father				
Mother				
Brother(s)				
Sister(s)				

Part 7 – Occupation details to be completed by the life or lives to be assured

If you are applying for life cover only please complete questions 1a to 1e.

If you are applying for critical illness cover and/or waiver of premium benefit please complete questions 1 to 4.

	FIRST (or only) LIFE ASSURED	SECOND LIFE ASSURED
1 a) What is your occupation? (If you have more than one occupation, please provide full details of each one)	<div style="border: 1px solid black; height: 100px;"></div>	<div style="border: 1px solid black; height: 100px;"></div>
b) What is the nature of the business you are in?	<div style="border: 1px solid black; height: 50px;"></div>	<div style="border: 1px solid black; height: 50px;"></div>
c) Does your occupation involve working at heights over 10 feet or 3 metres? If Yes, please provide details to include percentage of working time spent at heights and average and maximum heights worked at	Yes <input type="checkbox"/> No <input type="checkbox"/> <div style="border: 1px solid black; height: 100px;"></div>	Yes <input type="checkbox"/> No <input type="checkbox"/> <div style="border: 1px solid black; height: 100px;"></div>
d) Does your occupation involve working offshore? If Yes, please provide details to include frequency and length of trips	Yes <input type="checkbox"/> No <input type="checkbox"/> <div style="border: 1px solid black; height: 100px;"></div>	Yes <input type="checkbox"/> No <input type="checkbox"/> <div style="border: 1px solid black; height: 100px;"></div>
e) Does your occupation involve working underground or underwater? If Yes, please provide details to include percentage of working time spent on each activity and average and maximum depths worked at	Yes <input type="checkbox"/> No <input type="checkbox"/> <div style="border: 1px solid black; height: 100px;"></div>	Yes <input type="checkbox"/> No <input type="checkbox"/> <div style="border: 1px solid black; height: 100px;"></div>
2 a) On average, how many hours do you work each week?	Average hours worked a week <input type="text"/>	Average hours worked a week <input type="text"/>
b) Does your occupation involve any business driving? (You do not need to include commuting to and from your normal place of work)	Yes <input type="checkbox"/> No <input type="checkbox"/> Average business miles a year <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Average business miles a year <input type="text"/>
c) Does your occupation involve the use of machinery or tools? (You do not need to include use of a computer, photocopier or fax machine) If Yes, please provide details to include percentage of working time spent on each activity	Yes <input type="checkbox"/> No <input type="checkbox"/> <div style="border: 1px solid black; height: 100px;"></div>	Yes <input type="checkbox"/> No <input type="checkbox"/> <div style="border: 1px solid black; height: 100px;"></div>

Part 7 – Occupation - continued

FIRST (or only) LIFE ASSURED

SECOND LIFE ASSURED

d) Does your occupation involve any other manual or physical activity such as carrying, lifting, prolonged repetitive activity etc?

Yes No

Yes No

If Yes, please provide details to include percentage of working time spent on each activity

3 Are you currently absent from work for any reason?

Yes No

Yes No

If Yes, please provide details to include duration and reason for absence

4 In the last 2 years have you had any time off work due to illness or injury? (For this question you do not need to give details of minor ailments such as colds or flu if together they total less than 10 days a year)

Yes No

Yes No

If Yes, please provide details to include reason(s), date(s) and time off work

Part 8 – Financial details to be completed by the life or lives to be assured (with the intended owner(s) of the policy if different)

1 Will the total amount of insurance you are now applying for, added to any existing cover that you already hold with any insurance company including Friends Provident, result in your total cover exceeding £1,000,000 life cover or £600,000 critical illness cover? (You need to include any other life or critical illness cover that you already hold together with this and any other application you are currently making and intend to proceed with.)

FIRST (or only) LIFE ASSURED Yes No **SECOND LIFE ASSURED** Yes No

If the answer to question 1 is Yes and/or you are applying for life cover over £800,000 or critical illness cover over £500,000 please complete questions 2a to 2e. (If there are other keyperson or shareholder protection applications being made on other lives and the total cover for all lives exceeds £800,000 life cover or £500,000 critical illness cover, please also complete questions 2a to 2e.)

2 a) Please provide details of any existing life and/or critical illness cover along with any simultaneous applications you are making which you intend to proceed with

FIRST (or only) LIFE ASSURED

Company	Sum assured	Type of cover (life or critical illness)	Date effected or date to be effected	Reason for cover

SECOND LIFE ASSURED

Company	Sum assured	Type of cover (life or critical illness)	Date effected or date to be effected	Reason for cover

If you need more space to write your answers, please use the section headed Additional information on page 12.

FIRST (or only) LIFE ASSURED

SECOND LIFE ASSURED

b) What is your annual taxable earned income? £ £

c) What is the reason for the policy type and level of cover chosen? (For example personal protection, loan or mortgage cover on your principal residence, buy to let mortgage cover, commercial loan cover, keyperson cover, shareholder protection etc)?

d) If the policy is to protect a loan or mortgage, please provide details of the lender, name of borrower(s), amount and term of the loan, interest rate payable and repayment method

Lender	
Name of borrower(s)	
Amount of loan	
Term of loan	
Interest rate payable	
Repayment method (for example interest only, capital and interest)	

e) If the policy is for keyperson or shareholder protection, please provide details of any other keyperson or shareholder protection applications being made at this time

Name(s)	
Sum(s) assured	
Insurance company	

Part 9 – Health details to be completed by the life or lives to be assured

Please note we may not contact your doctor. Even if we do, you must still give accurate and complete information when completing this application.

Please answer each of the following questions ticking boxes where appropriate.

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 this 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, you do not need to tell us about any genetic test result you have had if this application for insurance, taken together with any other insurance policies you already have for this type of insurance, totals to:

* £500,000 or less for life insurance

* £300,000 or less for critical illness insurance

Above these limits, you 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 you think this may apply to you, please ask us for details of the current position. These details are also available from the ABI website at www.abi.org.uk

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

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

FIRST (or only) LIFE ASSURED

SECOND LIFE ASSURED

1 Do you currently have or have you ever had any of the following:

- | | | | | |
|---|------------------------------|-----------------------------|------------------------------|-----------------------------|
| a) Cancer, leukaemia, Hodgkin's disease, lymphoma, a brain tumour or spinal tumour? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b) Heart disease, angina, a heart attack, heart abnormality or defect, heart valve disorder or an irregular heart beat? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c) A stroke, mini stroke, transient ischaemic attack (TIA) or a brain or subarachnoid haemorrhage? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d) Multiple sclerosis, Parkinson's disease, Alzheimer's disease, paralysis or paraplegia? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e) Visual disturbance, blurred or double vision, optic or retrobulbar neuritis? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| f) Tingling, pins and needles, numbness, a tremor or any loss of feeling, balance or coordination, for which you consulted a doctor or hospital? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| g) Have you ever tested positive for HIV, Hepatitis B or C or are you awaiting the results of such a test? (If the result was negative, the fact of having an HIV test will not in itself have any effect on your acceptance terms for insurance) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If you answered Yes to any of question 1, please give details below to include condition(s), date(s), duration, treatment, results of investigations and tests and time off work.

If you need more space to write your answers, please use the section headed Additional information on page 12.

FIRST (or only) LIFE ASSURED

SECOND LIFE ASSURED

Condition(s)

Condition(s)

Part 9 – Health - continued

FIRST (or only) LIFE ASSURED

SECOND LIFE ASSURED

Date(s) and duration

Date(s) and duration

Treatment

Treatment

Results of investigations and tests

Results of investigations and tests

Time off work including date(s)

Time off work including date(s)

2 In the last 5 years have you had any of the following:

- | | | | | |
|--|------------------------------|-----------------------------|------------------------------|-----------------------------|
| a) Any lump that has appeared or grown in size, or a mole or freckle that has bled, caused pain or changed in appearance? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b) Raised blood pressure or raised cholesterol for which treatment, further readings or a change in diet were advised? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c) Asthma or any chest, lung or breathing disorder for which you have consulted a doctor or hospital? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d) Recurrent headache for which you have consulted a doctor or any epilepsy, seizure, fit or blackout? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e) Any impairment of vision or hearing or any disorder of the eyes or ears? (You may ignore sight problems corrected by glasses or contact lenses but you must tell us about all hearing problems, even if corrected by hearing aid(s)) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| f) Back pain, neck pain, sciatica, joint pain, arthritis, repetitive strain injury or any other disorder of the muscles, bones or limbs for which you have consulted a doctor, hospital, physiotherapist, osteopath, chiropractor or any other type of medical practitioner or for which you have taken time off work? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| g) Diabetes, Crohn's disease or colitis? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| h) Any disorder of the kidneys? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| i) Treatment or a positive test for any disease which was transmitted sexually? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| j) Any mental illness or eating disorder or have you attempted self-harm or taken an overdose? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| k) Any other feeling of depression, anxiety, stress or fatigue that you have reported to a doctor, hospital, nurse, psychologist or psychiatrist or any other type of medical practitioner? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If you answered Yes to any of question 2, please give details below to include condition(s), date(s), duration, treatment, results of investigations and tests and time off work.

If you need more space to write your answers, please use the section headed Additional information on page 12.

Part 9 – Health - continued

FIRST (or only) LIFE ASSURED

SECOND LIFE ASSURED

Condition(s)	Condition(s)
Date(s) and duration	Date(s) and duration
Treatment	Treatment
Results of investigations and tests	Results of investigations and tests
Time off work including date(s)	Time off work including date(s)

FIRST (or only) LIFE ASSURED

SECOND LIFE ASSURED

3 In the last 5 years have you been exposed to the risk of HIV infection?

Yes

No

Yes

No

If Yes, please provide details (HIV can be caught through unsafe sex, intravenous drug abuse, or blood transfusions or surgery undertaken outside the European Union)

Details

Details

If you need more space to write your answers, please use the section headed **Additional information on page 12.**

4 In the last 2 years, other than for those conditions you have already mentioned:

a) Have you had any medical consultation (for example with a doctor, consultant, psychiatrist, clinic, physiotherapist or any other type of medical practitioner) or attendance at a hospital as an inpatient or outpatient?

Yes No

If Yes, please provide details (For this question, you do not need to give details of occasional consultations with your GP for colds, flu, or consultations for oral contraceptive pills, smear tests, well man/woman check-ups where the results are known and were normal)

Details to include date(s)

Yes No

Details to include date(s)

b) Have you had, or been advised to have, any medical investigation, x-ray, scan or test?

Yes No

If Yes, please provide details (For this question, you do not need to give details of consultations for oral contraceptive pills, smear tests, well man/woman check-ups where the results are known and were normal)

Details to include date(s)

Yes No

Details to include date(s)

Part 9 – Health - continued

	FIRST (or only) LIFE ASSURED	SECOND LIFE ASSURED
<p>5 In the last 12 months have you been prescribed any drug, medicine or tablet, or have you had any other form of medical treatment (for example physiotherapy, psychotherapy)?</p> <p>If Yes, please provide details</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Details to include date(s)</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Details to include date(s)</p>
<p>6 In the last 6 months have you had any medical symptom, change in your physical or mental health or change in your physical or mental ability for which you have not consulted a doctor, hospital or medical practitioner?</p> <p>If Yes, please provide details (For this question, you do not need to give details of colds and flu which have lasted less than 2 weeks in total)</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Details to include date(s)</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Details to include date(s)</p>
<p>7 In the next 12 months are you due to have any consultation or check-up in connection with any medical symptom or condition, or are you waiting for the result of any medical investigation?</p> <p>If Yes, please provide details</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Details to include date(s)</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Details to include date(s)</p>
<p>8 Other than the information you have already provided have you ever had an illness or medical condition that has lasted more than 3 months and which affected your ability to study or perform normal daily activities or for which you took more than 2 weeks off work?</p> <p>If Yes, please provide details</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Details to include date(s), duration and any time off work</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Details to include date(s), duration and any time off work</p>

Part 10 – Additional information

FIRST (or only) LIFE ASSURED	SECOND LIFE ASSURED

Part 11 – Applicant(s) details

ONLY COMPLETE THIS SECTION IF THE LIFE OR LIVES TO BE ASSURED NAMED ON PAGE 2 ARE NOT TO BE THE INTENDED OWNER(S) OF THE POLICY OR POLICIES.

An applicant can be an individual or a company. Please complete either section A or B below as appropriate, followed by sections C and D.

A - If applicant is an individual

FIRST (or only) LIFE APPLICANT

SECOND LIFE APPLICANT

1	Title	<input type="text" value="Mr"/> <input type="text" value="Mrs"/> <input type="text" value="Miss"/> <input type="text" value="Ms"/>	<input type="text" value="Mr"/> <input type="text" value="Mrs"/> <input type="text" value="Miss"/> <input type="text" value="Ms"/>
		<input type="text" value="Other (please specify)"/>	<input type="text" value="Other (please specify)"/>
2	Surname	<input type="text"/>	<input type="text"/>
3	First name(s)	<input type="text"/>	<input type="text"/>

B - If applicant is a company

1	Company name	<input type="text"/>
2	Contact name	<input type="text"/>

C

1	What is your relationship or interest in the life or lives to be assured named on page 2?	<input type="text"/>	<input type="text"/>
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D

1	Address of individual or company as appropriate	<input type="text"/> <input type="text"/> <input type="text" value="Town"/> <input type="text" value="County"/>	<input type="text"/> <input type="text"/> <input type="text" value="Town"/> <input type="text" value="County"/>
	Postcode	<input type="text"/>	<input type="text"/>
2	Contact telephone number (including STD code)	<input type="text"/>	<input type="text"/>
3	Email address	<input type="text"/>	<input type="text"/>

Part 12 – Access to medical reports (applicable to the life or lives to be assured)

Please note we may not contact your doctor. Even if we do, you must still give accurate and complete information when completing this application.

We may need to get medical reports to support your 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 the following:

1 Your current health:

- any care, medication or treatment you are currently receiving; and
- the results of referrals or tests you are waiting for.

2 Any time off work in the last three years.

3 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.

4 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 part 9 - Health details.

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

- refusing to provide insurance;
- increasing premiums above standard rates;
- 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.

Part 13 – Declaration

This declaration must be signed by all persons involved in this application.

- 1 • As applicant, this application is my official request to enter into a contract or contracts with Friends Provident together providing the covers and benefits applied for. I understand that each contract will be on Friends Provident’s normal terms and conditions which have been explained to me.
 - I understand Friends Provident may require access to the medical records of the life/lives assured to consider this application or any claim.
 - I understand that a copy of the terms and conditions and a copy of this completed application are available on request.
- 2 • I have read my answers to the questions in this application and declare that, to the best of my knowledge and belief, all the information I have given is true and that no relevant fact has been withheld. I understand that failure to disclose accurate and complete information or the giving of false information by any life/lives assured or any applicant(s) will give Friends Provident the right to cancel from inception any policy issued as a result of this application and may invalidate any future claim.
 - I accept that if the life/lives assured are required to have a medical examination, the replies to the medical examiner’s questions will form part of this application.
 - **I understand that I must tell Friends Provident without delay if the health or circumstances of the life/lives assured change before Friends Provident assumes risk.**
- 3 • I understand that information given to Friends Provident in connection with this application may be used by Friends Provident in its consideration of any claim in future and may be shared with a third party for example, medical examiner, to help in the assessment of a claim.
 - I understand that you will pass the information about any claim concerning critical illness insurance and waiver of premium benefit to the Association of British Insurers (ABI) so that they can make it available to other insurers. I also understand that, in response to any searches you make in connection with this claim, the ABI may pass you information it has received from other insurers.
- 4 • I authorise Friends Provident to pass medical information to any life insurance company, to any medical examiner, or to any company arranging these examinations on Friends Provident’s behalf.
 - I agree Friends Provident will use the information I give (as well as information about me relating to any existing policy I may have with Friends Provident) for administration, underwriting, claims, research and statistical purposes. I agree Friends Provident may pass information to medical practitioners, underwriters and reinsurers and any agency appointed for these purposes. These agencies may be located in countries outside the UK that do not have laws to protect the information. Details of the companies and countries involved in your case will be provided on request. Friends Provident will remain responsible for making sure that the information is held securely.
 - I also agree Friends Provident may pass the information to third parties for the prevention of crime or detection of fraud, enabling assets to be rightfully claimed or where required by law or regulation.
 - I understand and agree that the terms for providing cover, including any exclusion from cover or any refusal or postponement of cover resulting from a specified medical condition will be communicated to the applicant(s), either directly or through the applicant’s agent where there is one, even where the applicant is not the life assured.
- 5 • As life assured, 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 any other applications for life, critical illness, sickness, disability, accident or private medical insurance on my life. I authorise those asked to provide medical information when they see a copy of this declaration (including after my death) to support any claim made on the plan. This information can also be used to maintain management information for business analysis.
 - **I have read and understood part 12 relating to access to medical reports.**
 - **As life assured, I do not want to see the report before it is sent to the company.**
 - **As life assured, I do want to see the report before it is sent to the company.**
- 6 • I would like Friends Provident to use the information supplied to let me know about other products and services in the Friends Provident group of companies that may interest me.
- 7 **The following applies if critical illness and disability benefit is selected**
 - I have read the Important notes (part 15) describing the alternative definition of permanently disabled for the purposes of permanent and total disability benefit. The alternative definition may apply to this benefit for any life assured where, as a result of their occupation, Friends Provident is only able to offer terms subject to the alternative definition of permanently disabled.
 - **As applicant I agree and accept the alternative definition if applied** **As applicant I do not accept the alternative definition**

**First (or only) life assured
(and applicant if part 11 not completed)**

Signature
Date

**Second life assured
(and applicant if part 11 not completed)**

Signature
Date

**PLEASE ENSURE THAT YOU
HAVE TICKED THE
APPROPRIATE BOXES ABOVE**

Only complete the following if part 11 completed.

First applicant

Signature
Capacity
Date

Second applicant (if applicable)

Signature
Capacity
Date

**If signing on behalf of a
company or partnership
please state in what capacity
you are signing (for example
Company Secretary)**

Part 14 – Effective date

Should anything about your health or other circumstances change before all the cover you have applied for starts, you 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.

Non-mortgage related applications

If all the covers you have applied for are assessed and accepted on our normal terms then, unless you have stated below a date on which you would like the covers to start or have instructed otherwise, we will start the cover immediately.

If any of the covers you have applied for are not accepted on our normal terms then no cover will start until we receive written confirmation of your acceptance of the revised terms.

We also need to have received your first premium payment or a completed direct debit instruction.

Effective date

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Mortgage related applications

When all the covers you have applied for are assessed and accepted on our normal terms, we shall assume risk and begin cover when you instruct us unless you have stated below a date on which you would like cover to start.

If any of the covers you have applied for are not accepted on our normal terms then no cover will start until we receive written confirmation of your acceptance of the revised terms and your instructions to go on risk.

We also need to have received your first premium payment or a completed direct debit instruction.

Effective date

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Free accidental death cover

This is provided automatically on all applications for life cover. The free accidental death cover on each life assured is the lower of the life cover applied for in respect of each life and £125,000. When the cover is paid out on one of joint lives, note that it will cease for the remaining life in respect of the joint life cover applied for but will continue on the surviving life for any single life cover applied for.

Free accidental death cover will continue until the earliest of:

- the date risk is assumed under the life cover applied for
- the death of the life assured, or either of the lives assured in a joint application, by accident as defined below
- free life cover as defined below starts
- the sixtieth day after free accidental death cover starts
- the twenty first day after the date Friends Provident issues any letter giving special terms for the acceptance of any life cover
- the date on which Friends Provident issues any letter postponing or declining any life cover in the application
- the date on which the applicant writes to or verbally informs their financial adviser or Friends Provident of their decision to cancel the application.

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

Accidental death cover will not be paid if death is caused directly or indirectly by any of the following:

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

Free life and critical illness cover

If you are taking out a new mortgage on your main home and your application for life cover has been assessed and accepted on our normal terms, you are entitled to free life cover which will start when:

- you have a definite contract for the purchase of a property (for example you have exchanged contracts or missives in Scotland) or when improvements or repair work has actually begun

and

- you have received a letter from your lender offering you a mortgage.

The amount of free life cover is limited to the least of; the amount of your mortgage, £200,000 and the amount of mortgage related life cover you have applied for and has been accepted.

If you have been accepted on our normal terms for any type of critical illness cover, we shall include this during the period of free life cover above, provided you are:

- below 50 years old
- the plan is being used in connection with your mortgage on your main home, and
- the benefit does not exceed £125,000.

Once the free life or critical illness cover has started, please let us know when you would like the cover to start. This must be within three months of the start of the free cover and is usually the completion date of your mortgage. If the cover does not start within this three month period, your mortgage will no longer be covered if you die or, if applicable, you are diagnosed with a critical illness or disability. If cover is paid out, no matter whether the payment is for free life or critical illness cover, all cover in respect of the life assured, or both of the lives assured in a joint application, ends immediately.

Part 15 – Important notes

Critical illness and disability – permanent and total disability benefit

Definition of permanently disabled

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 a 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 cover and the policy anniversary following their 60th birthday, is

- permanently and totally unable, throughout the remainder of their lifetime, no matter when the cover ends or the life assured retires, because of illness or injury, other than a deliberately self-inflicted injury, to perform three or more 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 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

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

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 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 registered 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.

Instruction to your bank or building society to pay by Direct Debit

Please fill in the whole form using a ball point pen and send it to:

Friends Provident
PO BOX 1550
Milford
Salisbury SP1 2TW
Tel: 0845 602 9199

Service user Number

9 9 0 4 5 7

3 Branch sort code (from the top right hand corner of your cheque) — —

4 Bank/building society account number

5 Friends Provident reference number

6 Instruction to your bank or building society
 Please pay Friends Provident Direct Debits from the account detailed in 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.

Signature(s)

Date

1 Name and full postal address of your bank or building society

To: The Manager	Bank/building society
Address	
Postcode	

2 Name(s) of account holder(s)

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.**

Friends Provident Life Assurance Limited

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

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

Incorporated company limited by shares and registered in England number 782698

www.friendsprovident.com Telephone 0845 602 9199

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