

The following pages represent a “paper” application form. **In many cases you may be able to obtain an enhanced commission, or better terms, and sometimes immediate acceptance, by submitting your case “online” using Webline’s Electronic Submission services.**

To submit your business electronically, watch out for these buttons on our Web site, once you have obtained an illustration. If you have previously quoted this case, you may apply online by recalling the quote (using “track” and then “find quote” – and entering the Webline quote number, or the client’s surname or DoB). Look for the “eApply” link on an illustration, or simply “requote” and then proceed to an online application.

Alternatively, click the “apply” button on our main menu to obtain a blank application form at any time – then complete the form online, and submit it directly to the provider.

This form needs to be printed, completed and submitted to:

For office use only

Webline Quote Reference	<input type="text"/>	Webline Response Reference	<input type="text" value="251403723"/>
Firm Name	<input type="text"/>		
Adviser Name	<input type="text"/>		
Agency Code	<input type="text"/>		
Commission Details	<input type="text"/>		
Please Send Correspondence To	<input type="text"/>		

Vendor Details

Webline Number	<input type="text" value="004840"/>
FRN	<input type="text" value="493391"/>
Contact	<input type="text" value="John Garcia"/>
Company Name	<input type="text" value="Charlotte James IFA Ltd"/>
Trading Name	<input type="text" value="Quoteme4"/>
Address	<input type="text" value="Quoteme4"/>
	<input type="text" value="186 Treffry Road"/>
	<input type="text" value="Truro"/>
	<input type="text" value="Cornwall"/>
	<input type="text" value="TR1 1UF"/>
Phone	<input type="text" value="0800 0226571"/>
Fax	<input type="text"/>
Email	<input type="text" value="enquiries@quoteme4.co.uk"/>

Parent Group (if applicable)

Webline Number	<input type="text"/>
FRN	<input type="text"/>
Company Name	<input type="text"/>

Subagency Details (if applicable)

Webline Number	<input type="text"/>
FRN	<input type="text"/>
Contact	<input type="text"/>
Company Name	<input type="text"/>
Address	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
Phone	<input type="text"/>
Email	<input type="text"/>

FOR OFFICE USE ONLY

Is the agency regulated? Yes No

FOR FINANCIAL ADVISER USE ONLY



Term Assurance Application form

Please read this section carefully before completing the form

Getting started

To help you complete this form you will need the following information to hand:

- any information relating to existing or previous life insurance
- details of any medication or treatment that you are currently taking
- information about your doctor, including their name, address and telephone number
- your bank account details.

You will also need a black ink or ballpoint pen.

How to fill in the form

- Please use BLOCK LETTERS and complete in **BLACK INK**.
- Please correct and initial any alterations.
- Please ensure that all questions are **fully answered**. **Failure to do so may lead to delays processing the application.**
- When you have completed all the relevant sections of this application, **please read and sign the Declaration**, which applies to each Planholder and the people covered by the insurance.
- If any other person fills in this application for you, please remember that they act on your behalf and you must satisfy yourself before signing the Declaration that they have **accurately recorded** all your answers and provided any other relevant information you have volunteered.
- A copy of your completed application together with a copy of our standard policy terms and conditions are available on request.
- **You can find notes to assist you in completing certain questions on the page overleaf.**

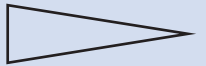
Disclosure of all relevant information

- It is important that you answer all questions fully, truthfully and accurately. Please remember that the answers you give will be used to assess the terms and the extent of benefits we can offer you. Even if you have already provided us with information in a previous application you must provide it to us again as our systems may not identify the previous information.
- If you do not disclose all relevant information or you provide incorrect information this may result in the non-payment of a claim. If you are in any doubt as to the relevance of certain information please disclose it.
- We have a confidentiality policy in place, which means we hold your medical information securely and access is limited to authorised individuals who have a need to see it.

Changes before the contract comes into force

- Until we tell you the cover is in force, you must notify us immediately of any change in the circumstances relating to the health, activities, occupation or residence of the person(s) covered which would change any of the answers or information provided in this application form. This includes attending any medical appointment or consultation after submitting the application.
- Any changes may affect the terms and the extent of the benefits that we can offer you.
- Aviva reserves the right to offer amended terms or decline cover.

Please fold this page out so that you can refer to the notes whilst completing this application.



Notes to assist in the completion of this application

Certain questions have notes listed on this page to assist you; they are highlighted by instructions within square brackets e.g. [see note ...].

If you leave this page open as you complete the application you can easily refer to each note as indicated.

Sections 1 and 2 – Personal and Planholder's details

[note 1] A valid insurable interest means that if the planholder(s) and people covered are not husband and wife, registered civil partners, common law partners, share a mortgage or are business partners, they must have a common and valid interest in insuring each others lives up to the amount of cover they are applying for.

Section 3 – Cover details

[note 2] You will need to include the trust details with this application. Cover will not start until the trust forms have been received. A trust form will be available from your adviser.

Section 5 – Activities and other life applications

[note 3] Equestrian sports include any competitive horse riding or racing e.g. three-day eventing, polo, show jumping, horse racing etc.
Extreme sports include activities such as base jumping, canyoning, white water rafting etc.
Flying includes pastimes such as parachuting, private flying, hang gliding etc.
Motor sport includes using motor cars or motor cycles for any type of racing including rallies, sprints, hill trials, time trials and pursuits.

[note 4] If you are not sure which countries are members of the European Union, please contact us.

Section 6 – Health and medical

[note 5] Transient Ischaemic Attack (TIA) – a minor form of stroke.

[note 6] You do not need to tell us about an occasional stomach upset, food poisoning or an appendectomy without complication.

[note 7] Systemic Lupus Erythematosus (SLE) – a connective tissue autoimmune disease.

[note 8] You do not need to tell us about any confirmed:

- | | |
|---|---------------------------|
| ■ athletes foot | ■ infertility treatment |
| ■ cold sore | ■ influenza |
| ■ conjunctivitis | ■ ingrowing toe nail |
| ■ contraception | ■ miscarriage |
| ■ ear syringing | ■ tonsillitis |
| ■ food poisoning | ■ uncomplicated pregnancy |
| ■ hayfever | ■ vaccinations |
| ■ HRT (where no hospital investigation has been involved) | ■ wisdom teeth. |

You do not need to tell us about negative tests for Hepatitis B and C.

[note 9] Haemochromatosis – a genetic disorder resulting in excess iron deposits throughout the body.
Cardiomyopathy – a genetic disorder affecting the heart muscle.
Polyposis coli – a genetic disorder resulting in polyps and cancer of the colon at an early age.

Section 8 – Doctor's details

[note 10] The more complete and detailed the information you can give us in Sections 4, 5 and 6, the more likely it is that we will be able to proceed without further enquiries.

Please complete ALL NINE SECTIONS of this instruction and send it to: Aviva BCC, PO Box 520, Norwich, NR1 3WG.

1	Name and full postal address of your Bank or Building Society	<input style="width: 100%; height: 40px;" type="text"/>
2	Name(s) of Account Holder(s)	<input style="width: 100%; height: 20px;" type="text"/>
3	Bank/Building Society Account Number	<input style="width: 100%; height: 20px;" type="text"/>
4	Branch Sort Code	<input style="width: 100%; height: 20px;" type="text"/>
5	Reference No (Policy/Plan/Scheme Number)	<input style="width: 100%; height: 20px;" type="text"/>
	Service User Number	<input style="width: 100%; height: 20px;" type="text" value="9 9 4 0 5 1"/>

Please pay Aviva 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 Aviva and, if so, details will be passed electronically to my Bank/Building Society.

6	Signature	<input style="width: 100%; height: 20px;" type="text"/>
7	Date	<input style="width: 100%; height: 20px;" type="text"/>

Banks and Building Societies may not accept Direct Debit Instructions for some types of account.

NO PERFORATION IN APPLICATIONS

This is not part of the Instruction to your Bank or Building Society and must be detached by Aviva before submission to the Paying Bank.

8	Account Holders address	<input style="width: 100%; height: 40px;" type="text"/>
9	Preferred Collection Date (between 1st and 28th)	<input style="width: 100%; height: 20px;" type="text"/>

NO PERFORATION IN APPLICATIONS

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 your own Bank or Building Society.
- If the amounts to be paid or the payment dates change, Aviva will notify you five working days in advance of your account being debited or as otherwise agreed.
- If an error is made by Aviva or your Bank or Building Society, you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a Direct Debit at any time by writing to your Bank or Building Society. Please also send a copy of your letter to us.



Aviva Life & Pensions UK Limited. Registered in England No 3253947. 2 Rougier Street, York, YO90 1UU.
Aviva Life & Pensions UK Limited is authorised and regulated by the Financial Services Authority.
Member of the Association of British Insurers.
www.aviva.co.uk



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Section 1 – Personal details

First person covered

Title

Surname (e.g. Smith)

Forenames (e.g. John)

Address

Second person covered (if any)

Title

Telephone number including code and any extension

(We may need to phone you to discuss information you have provided in this application.)

If you're due to move house shortly please give us details of your new address below.

New address

Expected date of address change

Personal information

Date of birth

Marital status Married Divorced
 In a Registered Civil Partnership
 Single Widowed
 Separated Common law partner

Married Divorced
 In a Registered Civil Partnership
 Single Widowed
 Separated Common law partner

Sex Male Female

Male Female

Relationship to other persons covered

If two lives are to be covered please state relationship to other person e.g. spouse, employer, power of attorney.

[A valid insurable interest must exist. See note 1 for details]

Section 2 – Planholder’s details

The planholder is the person who owns the plan. This section should only be completed if the planholder is to be different to the person(s) covered by the plan.

	First planholder	Second planholder (if any)
Title	<input type="text"/>	<input type="text"/>
Surname (e.g. Smith)	<input type="text"/>	<input type="text"/>
Forenames (e.g. John)	<input type="text"/>	<input type="text"/>
Company name (if any)	<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"/>
	<input type="text"/>	<input type="text"/>
	Postcode	Postcode
Telephone number including code and any extension	Daytime number <input type="text"/>	Daytime number <input type="text"/>
	Evening number <input type="text"/>	Evening number <input type="text"/>

(We may need to phone you to discuss information you have provided in this application.)

Please state relationship to:

First person covered	<input type="text"/>	<input type="text"/>
Second person covered (if any)	<input type="text"/>	<input type="text"/>

[A valid insurable interest must exist. See note 1 for details]

Section 3 – Cover details

Please use the illustration provided with your Key Features document to complete this section.

Amount of cover

Term of cover

Please tick if you require the following extra cover options (for more information about each option please refer to the Key Features document).

Critical Illness cover (guaranteed premiums) Yes No If Joint Lives case, Critical Illness cover will apply to both lives.
– premiums are guaranteed throughout the term of the plan)

OR

Critical Illness cover (reviewable premiums) Yes No If Joint Lives case, Critical Illness cover will apply to both lives.
– premiums are reviewed every five years)

Will the amount of critical illness insurance you are now applying for, when added to the amount you already hold exceed £500,000? (Please note you need to include any existing policies you hold or applications you plan to make at the same time as this one whether they are with Aviva or to any other insurance company)

First person covered Yes No Second person covered (if any) Yes No

Conversion option (Not available if Critical Illness cover is required.) Yes No

Renewal option (Not available if Critical Illness cover with guaranteed premiums is required.) Yes No

Premium Protection Yes No If 'Yes', please specify: First person covered
 Second person covered
 Both

Payment frequency

(Please tick ONE box) monthly* yearly

*Direct Debit is required for all monthly payments and is recommended if you are paying yearly. The first premium will be payable from the date your cover starts. If premiums are paid monthly, two payments will be collected when the first Direct Debit collection is due. This is approximately one month after the start of your plan.

Is the cover to be written under trust from the start? Yes No
(See note 2)

If 'NO', is cover to start immediately if accepted on normal terms? Yes No

IMPORTANT: You must answer all questions fully, accurately and truthfully. Failure to do so may result in the non-payment of a claim.

Section 4 – Health and lifestyle (to be completed by each person covered)

To decide whether to offer you insurance or the terms on which we will offer you insurance, we need information about your medical history. This section of the form asks you for information which we'll use for insurance administration. We may pass it to reinsurers or third parties who provide services to Aviva and other companies within the Aviva Group.

First person covered

Second person covered (if any)

Occupation

What is your occupation?

In which industry or service do you work?

(Please tick ONE box)

- Armed Forces
- Aviation
- Diving
- Fishing
- Mining
- Oil/gas rigs - offshore
- Police Service
- Prison Service
- Quarrying/Tunnelling
- None of the above

- Armed Forces
- Aviation
- Diving
- Fishing
- Mining
- Oil/gas rigs - offshore
- Police Service
- Prison Service
- Quarrying/Tunnelling
- None of the above

% of physical/manual work

% of physical/manual work

Does your occupation require you to work regularly:

at heights over 40 feet?

Yes No

Yes No

Are you a member of the Armed Forces Reserves?

Yes No

Yes No

Height and weight

First person covered

Second person covered (if any)

Please state your height without shoes.

ft ins or m

ft ins or m

Please state your weight in indoor clothes. If you are currently pregnant, please state your pre-pregnancy weight.

st lbs or kg

st lbs or kg

Cigarettes

Have you smoked any cigarettes in the last 12 months?

Yes No

Yes No

If 'Yes', please state number of cigarettes smoked

per day

per day

If you have given up smoking cigarettes within the last twelve months, please state your previous average daily consumption prior to giving up.

(We may ask you to undergo a simple test to confirm your answers to these questions.)

Other tobacco and nicotine replacement products

Have you used any other tobacco products or any nicotine replacement products in the last 12 months?

Yes No

Yes No

Other tobacco products include cigars, pipe smoking, and chewing tobacco.

(We may ask you to undergo a simple test to confirm your answer to this question.)

Section 4 – Health and lifestyle continued

First person covered

Second person covered (if any)

Alcohol

Do you consume alcoholic drinks? Yes No

Yes No

If 'Yes', how many units of alcohol do you drink on average each week? units

units

A unit of alcohol is the equivalent to each of the following:

- a half pint of normal strength beer, lager or cider
- one standard glass of wine
- a single measure of spirit.

Alcohol advice

Have you ever sought or been given medical advice to reduce the level of your drinking? Yes No

Yes No

If 'Yes', please tell us when you were given such advice, the reason and the number of units you were drinking at the time.

If 'Yes', please tell us when you were given such advice, the reason and the number of units you were drinking at the time.

Recreational drugs

Many people need to take drugs to treat a medical condition. But, have you taken any 'recreational' drug such as cocaine or heroin in the last five years? Yes No

Yes No

If 'Yes', please give details and dates below, or if you would rather tell us in confidence, you can send the information in a sealed envelope addressed to the Chief Medical Officer with this application.

If 'Yes', please give details and dates below, or if you would rather tell us in confidence, you can send the information in a sealed envelope addressed to the Chief Medical Officer with this application.

IMPORTANT: You must answer all questions fully, accurately and truthfully. Failure to do so may result in the non-payment of a claim.

Section 5 – Activities and other life applications (to be completed by each person covered)

First person covered

Second person covered (if any)

Activities

5.1. Do you take part in any of the activities below? **[see note 3]** Yes No

Yes No

If 'Yes', please tick which of the following activities you take part in:

Caving/Potholing

Climbing

Diving

Equestrian sports (other than private hacking)

Extreme sports

Flying (other than as aircrew or as a fare-paying passenger)

Motor sport

Trans-ocean sailing and/or yacht racing

Powerboat racing

Caving/Potholing

Climbing

Diving

Equestrian sports (other than private hacking)

Extreme sports

Flying (other than as aircrew or as a fare-paying passenger)

Motor sport

Trans-ocean sailing and/or yacht racing

Powerboat racing

Overseas travel and residence

5.2.a. Within the last **five years**, have you travelled, lived or worked outside of the European Union (EU), North America, Australia or New Zealand? **You do not need to tell us about any holiday you've taken which was less than 30 days in a year.** **[see note 4]**

Yes No

If 'Yes', please give details below.

Please state name of country, please do not state region or city.

Country	Total number of days spent in this country in last five years
	days
	days
	days
	days
	days

Yes No

If 'Yes', please give details below.

Please state name of country, please do not state region or city.

Country	Total number of days spent in this country in last five years
	days
	days
	days
	days
	days

If you need to include information for more countries, please continue on a supplementary sheet of paper and attach this to the application form.

5.2.b. In the next two years, are you planning to travel, live or work outside of the European Union (EU), North America, Australia or New Zealand? **You do not need to tell us about any holiday you're taking which is less than 30 days in a year.** **[see note 4]**

Yes No

If 'Yes', please give details below.

Please state name of country, please do not state region or city.

Country	Expected number of days to be spent in this country
	days
	days
	days
	days
	days

Yes No

If 'Yes', please give details below.

Please state name of country, please do not state region or city.

Country	Expected number of days to be spent in this country
	days
	days
	days
	days
	days

If you need to include information for more countries, please continue on a supplementary sheet of paper and attach this to the application form.

Section 5 – Activities and other life applications continued

First person covered

Second person covered (if any)

Previous applications

5.3.a. In the last 12 months have you applied for or taken out life or critical illness insurance(s) with Aviva which total(s) more than £250,000? (You do not need to include this application.)

You do not need to tell us about other applications in the last 12 months which:

- have been cancelled/ lapsed, or
- are outstanding but are for comparison purposes only and where only one application will proceed as long as they have not been declined or offered cover with special terms.

Yes No

Yes No

If 'Yes', please give details of type of cover applied for, the company applied to, the special terms applied and the dates.

If 'Yes', please give details of type of cover applied for, the company applied to, the special terms applied and the dates.

5.3.b. Will the amount of life insurance you are now applying for, when added to the amount you already hold exceed £750,000? (Please note you need to include any existing policies you hold or applications you plan to make at the same time as this one whether they are with Aviva or to any other insurance company.)

You do not need to tell us about other applications in the last 12 months which:

- have been cancelled/ lapsed, or
- are outstanding but are for comparison purposes only and where only one application will proceed as long as they have not been declined or offered cover with special terms.

Yes No

Yes No

If 'Yes', please give details and dates below.

If 'Yes', please give details and dates below.

Section 6 – Health and medical details (to be completed by each person covered)

In order to decide whether to offer you insurance or the terms on which we will offer you insurance, we need information about your medical history. The next section of this form asks you to provide the relevant information, which will be used for the purposes of insurance administration and may be passed to reinsurers, third parties that provide services to Aviva and other companies within the Aviva Group.

It is important that you read the notes at the front of this form carefully before answering the following questions, in order to save you time. Each note explains what kind of information we are looking for and/or any exceptions.

Genetic test results

In accordance with the Association of British Insurers' policy on genetics and insurance, you do not need to tell us about any genetic test results you have had if the total combined sum assured of all the life insurance policies you hold, including this application is £500,000 or less. However, you must answer the individual application form questions fully and accurately giving details, where appropriate, of any family history, current symptoms or treatment being received in respect of any medical conditions including any genetically inherited condition.

Above £500,000 you may need to tell us about certain genetic test results when applying for life insurance. However, we will only be interested in genetic test results which the Government's Genetics and Insurance Committee (GAIC) has approved for insurers to use.

If you think that this may apply to you please ask us for details of the current position or refer to the Consumer section of the ABI website (www.abi.org.uk/consumer2/disclosure.htm).

If you wish to tell us about a negative genetic test result, which shows that you have not inherited a genetic disorder we will take this into account when assessing your application.

	First person covered		Second person covered (if any)	
6.1. Have you ever experienced:				
6.1.a. angina, heart attack or any other disorder of the heart? You do not need to answer this question in respect of raised or high blood pressure, as there is a separate raised blood pressure question. This question does include heart valve disorders, rheumatic fever, cardiomyopathy and heart abnormalities or defects present at birth.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.1.b. stroke, Transient Ischaemic Attack (TIA), brain haemorrhage or any permanent brain injury through accident? [see note 5]	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.1.c. any form of cancer, leukaemia, Hodgkins disease, lymphoma, brain or spinal tumour?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.1.d. multiple sclerosis, optic neuritis, Parkinson's disease, paralysis, cerebral palsy, dementia or Alzheimer's disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.1.e. blurred or double vision, loss of feeling, numbness, pins and needles, tingling of the limbs or face or any disease or disorder of the central nervous system (the brain, spinal cord and nerves), which has not already been mentioned in earlier questions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.1.f. diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.1.g. any disease or disorder of the arteries including disease in the legs or of the aorta?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(If you have answered YES to health question 6.1.a to g please provide us with further information by completing the supplementary health questions on pages 13 or 14.)				
6.2. Within the last five years have you experienced:				
6.2.a. anxiety state, stress, depression, chronic fatigue, any other mental or nervous illness? If 'Yes', have you ever been treated as a hospital outpatient or inpatient or required treatment in a casualty department for anxiety state, stress, depression, chronic fatigue or any other mental or nervous illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.2.b. chest pain, irregular heart beat or raised cholesterol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.2.c. a lump, growth or cyst of any kind, or any mole or freckle that has bled, become painful, changed in colour or increased in size?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.2.d. blackouts, fits, giddiness, tremor, epilepsy or any other disorder affecting your nervous system or muscles?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.2.e. breathlessness, bronchitis, sarcoidosis, or any lung disorder other than asthma? You do not need to answer this question in respect of asthma, as there is a separate asthma question.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.2.f. any problem, disease or disorder affecting your digestive system, stomach, bowel, liver, pancreas or gall bladder? [see note 6]	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Section 6 – Health and medical details continued

6.2. Within the last five years have you experienced: (continued)

6.2.g. arthritis, rheumatoid arthritis, Systemic Lupus Erythematosus (SLE) or gout? **[see note 7]**

First person covered

Second person covered (if any)

Yes No

Yes No

6.2.h. blood disorder or anaemia?

Yes No

Yes No

6.2.i. thyroid disorder?

Yes No

Yes No

6.2.j. kidney or bladder disorder, including blood or protein in the urine, urinary tract infections or prostate disorder?

Yes No

Yes No

(Females only)

6.2.k. cervical smear for which you needed further investigations, tests, advice, or for which you have not yet been discharged from follow up?

Yes No

Yes No

(If you have answered YES to health questions 6.2.a to k please provide us with further information by completing the supplementary health questions on pages 13 or 14. The information given may allow us to come to a decision without having to delay your application for further enquiries.)

6.3.a. Within the last two years, have you had asthma?

First person covered

Second person covered (if any)

Yes No

Yes No

If 'Yes', please complete the supplementary asthma questions below:

6.3.b. When did you last experience symptoms of this condition?

m	m	y	y	y	y

m	m	y	y	y	y

6.3.c. Have you been admitted to hospital within the last two years with this condition?

Yes No

Yes No

6.3.d. How many days have you taken oral steroid tablets in the last two years?

 days

 days

6.3.e. How many days have you taken off work, or been unable to perform your normal daily activities, because of this condition in the last two years?

 days

 days

Section 6 – Health and medical details continued

6.4.a. Within the last two years, have you had any treatment for raised blood pressure or been advised to take treatment, or to have your blood pressure monitored?

First person covered

Yes No

Second person covered (if any)

Yes No

If 'Yes', please complete the supplementary blood pressure questions below:

6.4.b. When was your blood pressure first noted to be raised?

m	m	y	y	y	y

m	m	y	y	y	y

6.4.c. What was your last blood pressure reading? Please enter in the format 150/90 or tick if unknown.

-	-	/	-	-
---	---	---	---	---

 Tick if unknown

-	-	/	-	-
---	---	---	---	---

 Tick if unknown

6.4.d. What was the date of this reading?

m	m	y	y	y	y

m	m	y	y	y	y

6.4.e. Have you ever had any heart or circulatory problems, or raised cholesterol?

Yes No

Yes No

6.4.f. Have you ever had any kidney problems, such as protein in your urine?

Yes No

Yes No

6.4.g. Do you experience any symptoms or side effects, such as dizziness or headaches?

Yes No

Yes No

6.4.h. If you are on treatment, has this treatment changed within the last six months?

Yes No or Not Applicable

Yes No or Not Applicable

6.4.i. Have you ever not taken or stopped treatment without your doctor's approval?

Yes No

Yes No

6.4.j. Are you awaiting hospital referral or investigations for your condition?

Yes No

Yes No

If 'Yes', please give details and dates below.

If 'Yes', please give details and dates below.

6.5. Within the last five years, other than in respect of the conditions that you have already declared have you either:

■ received any medical attention at a hospital as an inpatient or outpatient

or Yes No

■ had or been advised to have any investigations, scans or blood tests?

Yes No

6.6. Other than in respect of the conditions that you have already declared, are you currently: [see note 8]

■ experiencing any symptoms or complaints for which you have not consulted a doctor

or ■ receiving any form of treatment or medication

or ■ awaiting any medical or surgical consultation or follow up

or ■ awaiting any test or investigation? Yes No

Yes No

(If you have answered YES to health questions 6.5 or 6.6 please provide us with further information by completing the supplementary health questions on pages 13 or 14.)

Section 6 – Health and medical details continued

6.7. Have any of your **parents, brothers or sisters** been diagnosed **BEFORE THEIR 65TH BIRTHDAY** as having: angina, heart attack, cancer, diabetes, stroke, haemochromatosis, Huntington's disease, hypertrophic cardiomyopathy, motor neurone disease, multiple sclerosis, muscular dystrophy, Parkinson's disease, polycystic kidney disease, polyposis coli or any other hereditary disease or disorder?

[see note 9]

First person covered

Yes No

If 'Yes', please complete the sections below:
If cancer, please also state area affected, e.g. lung, breast, stomach. If the relation is an identical twin please state.

Condition	Relation e.g. Father	Age at occurrence

Second person covered (if any)

Yes No

If 'Yes', please complete the sections below:
If cancer, please also state area affected, e.g. lung, breast, stomach. If the relation is an identical twin please state.

Condition	Relation e.g. Father	Age at occurrence

If you need to include information for more family members, please continue on a supplementary sheet of paper and attach this to the application form.

6.8. Some situations may expose you to the risk of HIV infection, including having unsafe sex, using intravenous drugs which have not been prescribed by a doctor, or having a blood transfusion outside of the European Union (EU). Have you experienced any of these situations within the last five years?

Yes No

If 'Yes', please give details and dates below, or if you would rather tell us in confidence, you can send the information in a sealed envelope addressed to the Chief Medical Officer with this application.

Yes No

If 'Yes', please give details and dates below, or if you would rather tell us in confidence, you can send the information in a sealed envelope addressed to the Chief Medical Officer with this application.

6.9. Have you ever tested positive for HIV/AIDS or Hepatitis B or C, or are you waiting for the result of such a test? (If the result of a test you're waiting for turns out to be negative, the fact you had a test won't affect the acceptance terms we offer you.)

Yes No

If 'Yes', please give details and dates below, or if you would rather tell us in confidence, you can send the information in a sealed envelope addressed to the Chief Medical Officer with this application.

Yes No

If 'Yes', please give details and dates below, or if you would rather tell us in confidence, you can send the information in a sealed envelope addressed to the Chief Medical Officer with this application.

6.10. Have you tested positive or been treated for more than one episode of any sexually transmitted infection within the last five years?

Yes No

If 'Yes', please give details and dates below, or if you would rather tell us in confidence, you can send the information in a sealed envelope addressed to the Chief Medical Officer with this application.

Yes No

If 'Yes', please give details and dates below, or if you would rather tell us in confidence, you can send the information in a sealed envelope addressed to the Chief Medical Officer with this application.

IMPORTANT: You must answer all questions fully, accurately and truthfully. Failure to do so may result in the non-payment of a claim.

Section 6 – Health and medical details continued

First person covered

6.11. Have you ever had surgery or received blood products when you have been outside the European Union (EU)?

Yes No

If 'Yes', please provide date(s), the country or countries, and the reason(s) for each procedure or transfusion undergone.

Second person covered (if any)

Yes No

If 'Yes', please provide date(s), the country or countries, and the reason(s) for each procedure or transfusion undergone.

Only complete the next questions if you have selected Critical Illness cover or Premium Protection in Section 3.

First person covered

6.12. Within the last three years, have you had any illness or injury including back and neck pain, or any other muscular, skeletal or joint problem, which has placed restrictions on your normal daily activities or has resulted in more than 10 days off work in a year?

Yes No

6.13. Do you have any disorder of your eyes or ears which is not fully corrected by glasses, contact lenses or by hearing aids?

Yes No

6.14. Do you have any allergies or skin conditions, which place restrictions on your normal daily activities or your ability to carry out any aspect of your occupation?

Yes No

Second person covered (if any)

Yes No

Yes No

Yes No

(If you have answered YES to health question 6.12, 6.13, or 6.14 please provide us with further information by completing the supplementary health questions on pages 13 or 14. The information given may allow us to come to a decision without having to delay your application for further enquiries.)

IMPORTANT: You must answer all questions fully, accurately and truthfully. Failure to do so may result in the non-payment of a claim.

Section 7 – Supplementary health questions (If you have answered 'Yes' to health questions 6.1.a to g, 6.2.a to k, 6.5, 6.6, 6.12, 6.13 or 6.14 please provide us with further information by completing this section.)

(If you have more than three medical conditions please continue on a separate sheet.)

FIRST LIFE COVERED

	Condition 1	Condition 2	Condition 3
What is the name of the medical condition, illness or injury that you have had or currently have?	<input type="text"/>	<input type="text"/>	<input type="text"/>
Please indicate which health question this condition refers to, e.g. 6.1.a.	<input type="text"/>	<input type="text"/>	<input type="text"/>
How many days have you taken off work because of this condition in the last two years ?	<input type="text"/> days	<input type="text"/> days	<input type="text"/> days
Are you still/currently receiving treatment or counselling for this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
When did you last experience symptoms or take treatment for this condition? (Please give date.)	<input type="text"/> m <input type="text"/> m <input type="text"/> y <input type="text"/> y <input type="text"/> y <input type="text"/> y	<input type="text"/> m <input type="text"/> m <input type="text"/> y <input type="text"/> y <input type="text"/> y <input type="text"/> y	<input type="text"/> m <input type="text"/> m <input type="text"/> y <input type="text"/> y <input type="text"/> y <input type="text"/> y
If current, please give current month and year.			
Are you awaiting hospital referral, investigation or surgery for this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many times have you experienced symptoms of this condition? (Please tick ONE box only)	Once <input type="checkbox"/> More than once <input type="checkbox"/> Continuously <input type="checkbox"/> None <input type="checkbox"/>	Once <input type="checkbox"/> More than once <input type="checkbox"/> Continuously <input type="checkbox"/> None <input type="checkbox"/>	Once <input type="checkbox"/> More than once <input type="checkbox"/> Continuously <input type="checkbox"/> None <input type="checkbox"/>
Which of the following best describes the severity of your condition? (Please tick ONE box only)	Significant restriction in activities or pastimes <input type="checkbox"/> More persistent symptoms, some or occasional restriction in activities or pastimes <input type="checkbox"/> Minor symptoms, some or occasional restriction in activities or pastimes <input type="checkbox"/> Ongoing condition, no restrictions in lifestyle or mobility <input type="checkbox"/> Fully recovered <input type="checkbox"/>	Significant restriction in activities or pastimes <input type="checkbox"/> More persistent symptoms, some or occasional restriction in activities or pastimes <input type="checkbox"/> Minor symptoms, some or occasional restriction in activities or pastimes <input type="checkbox"/> Ongoing condition, no restrictions in lifestyle or mobility <input type="checkbox"/> Fully recovered <input type="checkbox"/>	Significant restriction in activities or pastimes <input type="checkbox"/> More persistent symptoms, some or occasional restriction in activities or pastimes <input type="checkbox"/> Minor symptoms, some or occasional restriction in activities or pastimes <input type="checkbox"/> Ongoing condition, no restrictions in lifestyle or mobility <input type="checkbox"/> Fully recovered <input type="checkbox"/>
Does your condition affect your neck, back, joints, ligaments, tendons, cartilage or muscles?	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' which of the following areas are affected by your condition?	knee(s) <input type="checkbox"/> elbow(s) <input type="checkbox"/> shoulder(s) <input type="checkbox"/> neck/back/spine <input type="checkbox"/> feet/ankle(s) <input type="checkbox"/> hand(s)/wrist(s) <input type="checkbox"/> hip(s) <input type="checkbox"/> other area <input type="checkbox"/>	knee(s) <input type="checkbox"/> elbow(s) <input type="checkbox"/> shoulder(s) <input type="checkbox"/> neck/back/spine <input type="checkbox"/> feet/ankle(s) <input type="checkbox"/> hand(s)/wrist(s) <input type="checkbox"/> hip(s) <input type="checkbox"/> other area <input type="checkbox"/>	knee(s) <input type="checkbox"/> elbow(s) <input type="checkbox"/> shoulder(s) <input type="checkbox"/> neck/back/spine <input type="checkbox"/> feet/ankle(s) <input type="checkbox"/> hand(s)/wrist(s) <input type="checkbox"/> hip(s) <input type="checkbox"/> other area <input type="checkbox"/>
	If 'other area' please specify <input type="text"/>	If 'other area' please specify <input type="text"/>	If 'other area' please specify <input type="text"/>

IMPORTANT: You must answer all questions fully, accurately and truthfully. Failure to do so may result in the non-payment of a claim.

Section 7 – Supplementary health questions (If you have answered ‘Yes’ to health questions 6.1.a to g, 6.2.a to k, 6.5, 6.6, 6.12, 6.13 or 6.14 please provide us with further information by completing this section.)

(If you have more than three medical conditions please continue on a separate sheet.)

SECOND LIFE COVERED

	Condition 1	Condition 2	Condition 3
What is the name of the medical condition, illness or injury that you have had or currently have?	<input type="text"/>	<input type="text"/>	<input type="text"/>
Please indicate which health question this condition refers to, e.g. 6.1.a.	<input type="text"/>	<input type="text"/>	<input type="text"/>
How many days have you taken off work because of this condition in the last two years ?	<input type="text"/> days	<input type="text"/> days	<input type="text"/> days
Are you still/currently receiving treatment or counselling for this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
When did you last experience symptoms or take treatment for this condition? (Please give date.)	<input type="text"/> m <input type="text"/> m <input type="text"/> y <input type="text"/> y <input type="text"/> y <input type="text"/> y	<input type="text"/> m <input type="text"/> m <input type="text"/> y <input type="text"/> y <input type="text"/> y <input type="text"/> y	<input type="text"/> m <input type="text"/> m <input type="text"/> y <input type="text"/> y <input type="text"/> y <input type="text"/> y
If current, please give current month and year.			
Are you awaiting hospital referral, investigation or surgery for this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many times have you experienced symptoms of this condition? (Please tick ONE box only)	Once <input type="checkbox"/> More than once <input type="checkbox"/> Continuously <input type="checkbox"/> None <input type="checkbox"/>	Once <input type="checkbox"/> More than once <input type="checkbox"/> Continuously <input type="checkbox"/> None <input type="checkbox"/>	Once <input type="checkbox"/> More than once <input type="checkbox"/> Continuously <input type="checkbox"/> None <input type="checkbox"/>
Which of the following best describes the severity of your condition? (Please tick ONE box only)	Significant restriction in activities or pastimes <input type="checkbox"/> More persistent symptoms, some or occasional restriction in activities or pastimes <input type="checkbox"/> Minor symptoms, some or occasional restriction in activities or pastimes <input type="checkbox"/> Ongoing condition, no restrictions in lifestyle or mobility <input type="checkbox"/> Fully recovered <input type="checkbox"/>	Significant restriction in activities or pastimes <input type="checkbox"/> More persistent symptoms, some or occasional restriction in activities or pastimes <input type="checkbox"/> Minor symptoms, some or occasional restriction in activities or pastimes <input type="checkbox"/> Ongoing condition, no restrictions in lifestyle or mobility <input type="checkbox"/> Fully recovered <input type="checkbox"/>	Significant restriction in activities or pastimes <input type="checkbox"/> More persistent symptoms, some or occasional restriction in activities or pastimes <input type="checkbox"/> Minor symptoms, some or occasional restriction in activities or pastimes <input type="checkbox"/> Ongoing condition, no restrictions in lifestyle or mobility <input type="checkbox"/> Fully recovered <input type="checkbox"/>
Does your condition affect your neck, back, joints, ligaments, tendons, cartilage or muscles?	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’ which of the following areas are affected by your condition?	knee(s) <input type="checkbox"/> elbow(s) <input type="checkbox"/> shoulder(s) <input type="checkbox"/> neck/back/spine <input type="checkbox"/> feet/ankle(s) <input type="checkbox"/> hand(s)/wrist(s) <input type="checkbox"/> hip(s) <input type="checkbox"/> other area <input type="checkbox"/>	knee(s) <input type="checkbox"/> elbow(s) <input type="checkbox"/> shoulder(s) <input type="checkbox"/> neck/back/spine <input type="checkbox"/> feet/ankle(s) <input type="checkbox"/> hand(s)/wrist(s) <input type="checkbox"/> hip(s) <input type="checkbox"/> other area <input type="checkbox"/>	knee(s) <input type="checkbox"/> elbow(s) <input type="checkbox"/> shoulder(s) <input type="checkbox"/> neck/back/spine <input type="checkbox"/> feet/ankle(s) <input type="checkbox"/> hand(s)/wrist(s) <input type="checkbox"/> hip(s) <input type="checkbox"/> other area <input type="checkbox"/>
	If ‘other area’ please specify <input type="text"/>	If ‘other area’ please specify <input type="text"/>	If ‘other area’ please specify <input type="text"/>

IMPORTANT: You must answer all questions fully, accurately and truthfully. Failure to do so may result in the non-payment of a claim.

Section 8 – Doctor's Details

(A report from your doctor will not always be requested.)

[see note 10]

First person covered

Second person covered (if any)

Title

Doctor's initials

Doctor's surname

or

Medical centre

Practice address

Telephone number

Postcode

Postcode

(Please include the full code and any extensions.)

Important notes

Data Protection

When you proceed with this application, we take this as consent to Aviva using the information supplied to process your application and administer your plan and you acknowledge that it will be held, and your plan may be processed by any company within the Aviva Group, by reinsurers and by third parties who provide services to Aviva. It may be transferred to any country, including those outside the European Economic Area, for any of these purposes. Any information may be used for underwriting or claims handling purposes and disclosed in confidence to regulatory bodies, other insurance companies (directly or via shared databases), to other Aviva Group companies and your insurance intermediary (including third parties providing services to them). Insurers and their agents share information with each other to prevent fraudulent claims and to assess whether to offer insurance, including the terms.

In addition, the Company or, if applicable, the business partner that introduced you to the Company, may use some of the information which is held on the Company's computer system to advise you by post or telephone of other products and services offered by the Aviva Group Companies, or by the business partner.

Please tick this box if you do not wish to receive this material.

In the event of a claim, the information you supply in this application and the claim form, together with other relevant information relating to the claim may, on request, be supplied to other insurers or to relevant registers or databases. All information supplied, including information relating to your health and activities, may be saved and/or printed by your insurance intermediary as part of the application process and may be disclosed by Aviva to your insurance intermediary as a record of the application.

Consent to obtain a medical report

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 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 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 including 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 including 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.

Customer Due Diligence – Prevention of Money Laundering

In accordance with EU and UK legislation relating to the prevention of money laundering we are obliged to verify the identity and address of all parties (e.g. planholder, premium payer, settlor, third parties including beneficial owners) to this contract. In the case of legal arrangements we are also required to establish the identity of any controllers that are not named parties as well as individuals who have a specific beneficial interest in the contract.

Where a financial adviser or Aviva Representative is involved they will let you know what evidence you need to produce. If you are applying to us direct we will verify your identity with a third party identity verification company. In certain circumstances you may be required to provide further evidence of your identity and confirmation of address, in which case Aviva will contact you.

If the product you are applying for allows payment by cheque and you wish to pay with a Building Society cheque or Bankers Draft, the Society or Bank must endorse the cheque with the full name of the person who holds the account from which the funds are drawn.

Sharing medical information

If we ask you to have a medical examination or screening we will need to share the relevant information from your application with another company we have authorised to arrange such examinations or screenings.

We may need to share with your usual doctor any information we have obtained from a medical examination or screening.

We may need to send your application and relevant medical reports to those authorised to underwrite on our behalf and to our reinsurers for their opinion and agreement. We may also need to send them at a later stage for purposes related to managing the plan.

- 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 will 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.

Where the amount of cover you have requested in respect of life insurance is £500,000 or less we will ask your doctor not to reveal information about:

- predictive genetic test results unless there is a favourable test result which shows that you have not inherited a condition your family suffers from.

Where the amount of cover you have requested in respect of life insurance is £500,001 or more we will ask your doctor to reveal information about predictive genetic test results that you have taken that the Governments Genetics and Insurance Committee has approved. We will ask about the following tests:

- Huntington's disease.

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

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

If you have any questions about your rights under the act or questions relating to the process of getting, assessing or storing medical information, please write to: Head of Underwriting, Aviva, 2 Rougier Street, York, YO90 1UU.

Declaration

All the information provided and questions answered in this application and any attached or associated statements or questionnaires are truthful, accurate and complete. These disclosures will form part of the contract of insurance which is being proposed on my life. I understand that you may undertake a search with third party companies who provide identity verification services for the purposes of verifying my identity and the details I have submitted as part of this application. To do so the third party companies may check the details I supply against any particulars on any database (public or otherwise) to which they have access. They may also use my details in the future to assist other companies for verification purposes. A record of the search will be retained. I also understand that failure to provide all relevant and correct information may result in a contract being declared invalid and the non-payment of a claim.

I agree:

- The Company's liability will not commence before it has assessed and formally accepted the application, received any outstanding documentation or information and received the first premium, or an acceptable method of collecting it. If the application is not accepted at normal terms, the Company will advise me of its revised terms and await my agreement before starting the cover. The Company will tell me when the cover is in force.
- To immediately notify the Company of any changes to the answers or the information provided in this application before the company notifies me that the cover is in force. I understand that such changes may affect the terms and the extent of benefits the Company can provide and that failure to notify the Company may result in the contract being declared invalid and the non-payment of a claim.
- To the Company seeking information, including medical reports, from any doctor I have consulted about anything that affects my physical or mental health and I authorise the giving of such information. This consent shall remain valid for a period of up to six months after the start of the contract and I agree that if I have not disclosed all information relevant to my application, the Company may need to reconsider the terms offered to me or cancel my cover.

- To the Company seeking relevant information from other insurers to whom I have applied or am currently applying and I authorise the giving of such information.
- To authorise those who are asked for such information to provide it on production of a copy of this consent.
- To the Company processing all information associated with my application and resulting plan as set out in the Important notes section of this application under Data Protection.
- That in the event of a claim being made, including a claim on death, the Company may seek information, including medical reports from any doctor I have consulted about anything that affects my physical or mental health and I authorise the giving of such information. I agree that if I have not disclosed all information relevant to my application or my claim the Company may not pay the claim or may reduce the amount of the claim.
- This plan will be subject to the law of England.

Electronic submission:

I agree that my Insurance Intermediary may submit this application electronically by re-keying the data and transmitting this to the Company. If this happens:

- I will receive a Confirmation Schedule from the Company confirming details of the application received by the Company.
- I must check these details are correct and complete.
- If any of the details are incorrect or incomplete I must amend and return the confirmation Schedule within 14 days. In such cases, the Company reserves the right to amend the terms or decline cover.
- I agree the contract will be governed by the Confirmation Schedule, Plan Schedule and the Plan Conditions.

Signature(s) to Declarations and Consents by each planholder and person covered

Policy number (required only if you are submitting the case electronically)

First person covered
Signature

Today's date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

First person covered: I have read and understood the Declaration and Important notes. I have read the notes relating to my rights of access to medical reports:

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

I do want to see the report before it is sent to the company.

Second person covered (if any)
Signature

Today's date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Second person covered: I have read and understood the Declaration and Important notes. I have read the notes relating to my rights of access to medical reports:

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

I do want to see the report before it is sent to the company.

First planholder (if different from above)
Signature

Today's date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Second planholder (if any – if different from above) Signature

Today's date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Additional Notes

COMMENCEMENT OF CONTRACT:

The cover will start from the date we complete our assessment and acceptance of your application provided a) your application is accepted at normal terms, b) we have received the first payment or direct debit, and c) you have indicated you wish the cover to start immediately. In this event, we will begin preparing the statutory cancellation notice and the plan conditions.

If these conditions do not apply, or the cover is to be written under trust, we will advise you, in writing, of our terms and await your agreement before starting the cover or progressing the payment method.

For Financial Adviser use only

Company name

FSA reference number

Financial Adviser Business Terms (Term Assurance)

Please tick the box to indicate which option you require for this application.

Your normal commission level (i.e. initial and renewal commission)

Level commission terms (to provide a set amount of commission throughout the policy term i.e. spread commission)

Nil commission (no initial and no renewal commission, commission sacrifice will be reflected in the premiums paid)

If none of these apply, please state commission sacrificed as a percentage of Lautro

%

It is an FSA requirement that we provide data as to whether advice was given on the sale of this product.

Tick one

Was financial advice given?

YES NO

