

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.**

**apply online**

**apply extranet**

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:**

John Garcia

186 Treffry Road

Truro

Cornwall

TR1 1UF

**For office use only**

Webline Quote Reference	<input type="text"/>	Webline Response Reference	196592057
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	004840
FRN	493391
Contact	John Garcia
Company Name	Charlotte James IFA Ltd
Trading Name	Quoteme4
Address	Quoteme4
	186 Treffry Road
	Truro
	Cornwall
	TR1 1UF
Phone	01872 277291
Fax	<input type="text"/>
Email	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"/>

## Personal Protection Menu application form (December 2008)

Advisers should use this form to capture the information you will need from your client to use our online quote and apply system or submit as a paper application form.

### Important information for the person completing this form

Please answer all questions honestly and in full. If you miss any information out, or give us misleading information, this could mean that we do not pay your claim. This could also delay the processing of your application.

Important information for financial advisers	
Please remind your client how important it is to answer all the questions on this form honestly and in full.	
quote number	
<i>Please give us the quote number and attach the quote. This helps us process the application more quickly.</i>	
adviser name	
company name	
<i>This is the company we will process this application for.</i>	
account number	
<i>If you know your Bright Grey agency account number please tell us.</i>	
special commission instructions	
<i>Please tell us any special commission instructions such as non-indemnity.</i>	
company address	
postcode	
telephone	fax
email	
your unique reference	
<i>If you would like us to use a reference for future correspondence, please write your unique reference here.</i>	

Important information for customers
It is very important that you tell us if there is a change to your health, occupation or leisure activities between completing this form and your plan starting.
If you have had a genetic test, you only have to tell us the results if this application, when added together with any cover you have of the same type, is for more than: <ul style="list-style-type: none"> <li>• £500,000 of Life Cover;</li> <li>• £300,000 of Critical Illness Cover or Life or Critical Illness Cover; or</li> <li>• £30,000 each year of Income Cover for Sickness.</li> </ul>
However, if you have had a test and the results are in your favour, you can choose whether to tell us the results or not. You must tell us however, if you think you are having treatment for, or are experiencing symptoms of, a genetic condition.

**Please note:** if your plan is not in force 6 months after the date you sign this form we will request a new application from.

Completed forms should be returned to:

**Bright Grey**  
2 Queen Street  
Edinburgh  
EH2 1BG

# Adviser use only

Please DO NOT complete this section if you are attaching a quote.

If you want Income Cover for Sickness or Payment Cover for Sickness you must complete this column.

	Life Cover	Life or Critical Illness Cover	Critical Illness Cover	Income Cover for Sickness	Payment Cover for Sickness
<b>Amount of cover</b>					
Lump sum or Yearly income	£ <input type="text"/>	£ <input type="text"/>	£ <input type="text"/>	-	-
	£ <input type="text"/>	£ <input type="text"/> *	£ <input type="text"/>	-	-
<b>Which person</b>					
First person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Second person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint life first event	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	<input type="checkbox"/>
<b>Term of cover</b>	<input type="text"/> 1-40 years	<input type="text"/> 1-40 years	<input type="text"/> 5-40 years	<input type="text"/> 5-40 years	-
<b>Payment of cover</b>					
Level lump sum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	-
Level income	<input type="checkbox"/>	<input type="checkbox"/> *	<input type="checkbox"/>	<input type="checkbox"/>	-
Increasing lump sum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	-
Increasing income	<input type="checkbox"/>	<input type="checkbox"/> *	<input type="checkbox"/>	<input type="checkbox"/>	-
Increase rate (2-5%) or RPI	<input type="text"/> %	<input type="text"/> %	<input type="text"/> %	<input type="text"/> %	-
Decreasing lump sum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	-
Interest rate (0-15%)	<input type="text"/> %	<input type="text"/> %	<input type="text"/> %	-	-
Decreasing lump sum with mortgage guarantee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	-
<b>Whether payments change or not</b>					
Guaranteed payments	<input checked="" type="checkbox"/>	<input type="checkbox"/>	-	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Reviewable after 5 years	-	<input type="checkbox"/>	<input checked="" type="checkbox"/>	-	-
<b>Definition of disability/incapacity</b>					
Own occupation	-	<input type="checkbox"/> Person 1	<input type="checkbox"/> Person 1	<input type="checkbox"/> Person 1	<input type="checkbox"/> Person 1
	-	<input type="checkbox"/> Person 2	<input type="checkbox"/> Person 2	<input type="checkbox"/> Person 2	<input type="checkbox"/> Person 2
Working tasks	-	<input type="checkbox"/> Person 1	<input type="checkbox"/> Person 1	<input type="checkbox"/> Person 1	<input type="checkbox"/> Person 1
	-	<input type="checkbox"/> Person 2	<input type="checkbox"/> Person 2	<input type="checkbox"/> Person 2	<input type="checkbox"/> Person 2
<b>Life Cover Reinstatement Option</b>	-	<input type="checkbox"/> *	-	-	-
<b>Deferred period</b>					
4 weeks	-	-	-	<input type="checkbox"/>	-
13 weeks	-	-	-	<input type="checkbox"/>	-
26 weeks	-	-	-	<input type="checkbox"/>	-
52 weeks	-	-	-	<input type="checkbox"/>	-
<b>Cover payment period</b>					
Throughout	-	-	-	<input type="checkbox"/>	-
1 year	-	-	-	<input type="checkbox"/>	-
2 years	-	-	-	<input type="checkbox"/>	-

\* only available if payments are reviewable

**Total payment**

£

## Adviser use only – important information about this application form

Please tell us what this application form is for by ticking the relevant box(es) below:

- A new Personal Protection Menu plan only
- Replacing an existing application form that is out of date  application number (i.e. completed over 6 months ago)
- Alteration to an existing plan  plan number

# About the plan owner

<p><b>1 Will the people covered also be the plan owner?</b></p>	<p><input type="checkbox"/> No If No, go to Q2</p> <p><input type="checkbox"/> Yes If Yes, go to Section A</p>
<p><b>2 Who will be the plan owner?</b></p>	<p><input type="checkbox"/> Other applicant <input type="checkbox"/> Person 1 only <input type="checkbox"/> Person 2 only</p> <p>(For an "other applicant" please answer the questions below)</p> <p>other applicant</p>
<p><b>3 What is the plan owner's name?</b></p> <p><b>What is the plan owner's date of birth?</b></p>	<p>title</p> <p>first name</p> <p>middle name</p> <p>last name</p> <p> / /</p>
<p><b>4 What is the plan owner's relationship to the person or people covered?</b></p>	<p><input type="checkbox"/> Wife <input type="checkbox"/> Business partner <input type="checkbox"/> Husband <input type="checkbox"/> Company <input type="checkbox"/> Partner <input type="checkbox"/> Employer <input type="checkbox"/> Cohabitant <input type="checkbox"/> Other <input type="checkbox"/> Common law spouse</p> <p>If Other, please give full details</p>
<p><b>5 In which country is the plan owner permanently resident?</b></p>	<p><input type="checkbox"/> UK <input type="checkbox"/> Isle of Man <input type="checkbox"/> Jersey <input type="checkbox"/> Other <input type="checkbox"/> Guernsey</p> <p>If Other, please give full details</p>
<p><b>6 In the next 6 months will the plan owner be moving from the country in which they are permanently resident?</b></p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes, please give full details</p>
<p><b>7 What is the plan owner's address?</b></p>	<p>house name</p> <p>house/building number</p> <p>street name</p> <p>town/city</p> <p>county</p> <p>country</p> <p>postcode</p>

## Section A – About the people covered

	Person 1	Person 2
<b>1 Your name</b>	<input type="text" value="title"/> <input type="text" value="first name"/> <input type="text" value="middle name"/> <input type="text" value="last name"/>	<input type="text" value="title"/> <input type="text" value="first name"/> <input type="text" value="middle name"/> <input type="text" value="last name"/>
<b>2 Date of birth</b>	<input type="text" value=" / /"/>	<input type="text" value=" / /"/>
<b>3 Sex</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>4 Marital status</b>	<input type="checkbox"/> Married <input type="checkbox"/> Living together as partners <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Civil partnership <input type="checkbox"/> Surviving civil partner	<input type="checkbox"/> Married <input type="checkbox"/> Living together as partners <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Civil partnership <input type="checkbox"/> Surviving civil partner
<b>5 What is your relationship to Person 1?</b>		<input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Partner <input type="checkbox"/> Cohabitant <input type="checkbox"/> Common law spouse <input type="checkbox"/> Business partner <input type="checkbox"/> Other If Other, please give full details <input type="text"/>
<b>6 Your home address</b>	<input type="text" value="house name"/> <input type="text" value="house number"/> <input type="text" value="street name"/> <input type="text" value="town/city"/> <input type="text" value="county"/> <input type="text" value="country"/> <input type="text" value="postcode"/> <input type="text" value="phone daytime"/> <input type="text" value="phone evening"/> <input type="text" value="mobile"/> <input type="text" value="email"/>	<input type="text" value="house name"/> <input type="text" value="house number"/> <input type="text" value="street name"/> <input type="text" value="town/city"/> <input type="text" value="county"/> <input type="text" value="country"/> <input type="text" value="postcode"/> <input type="text" value="phone daytime"/> <input type="text" value="phone evening"/> <input type="text" value="mobile"/> <input type="text" value="email"/>

## Section A continued

	Person 1	Person 2
<p><b>7 Have you smoked in the last 12 months?</b></p> <p>A smoker is anyone who has used any form of tobacco or nicotine replacement products in the last 12 months.</p> <p>If you answer No, we may carry out tests to check that you are a non-smoker.</p> <p><b>How old were you when you started smoking?</b></p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes, please tell us how much you smoke a day.</p> <p>cigarettes a day</p> <p>cigars a day</p> <p>pipes a day</p> <p>other</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes, please tell us how much you smoke a day.</p> <p>cigarettes a day</p> <p>cigars a day</p> <p>pipes a day</p> <p>other</p>

### ONLY ANSWER THE FOLLOWING QUESTION IF YOU HAVE NOT SMOKED IN THE LAST 12 MONTHS

<p><b>Have you ever smoked any form of tobacco products?</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes, please tell us how much you smoked a day.</p> <p>cigarettes a day</p> <p>cigars a day</p> <p>pipes a day</p> <p>other</p> <p><b>How old were you when you started smoking?</b></p> <p><b>When did you stop smoking?</b></p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes, please tell us how much you smoked a day.</p> <p>cigarettes a day</p> <p>cigars a day</p> <p>pipes a day</p> <p>other</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes, please tell us how much you smoked a day.</p> <p>cigarettes a day</p> <p>cigars a day</p> <p>pipes a day</p> <p>other</p>
<p><b>8 Have you ever had an application on your life accepted on special terms, deferred or declined?</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details)</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details)</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details)</p>
<p><b>9 Do you have an existing plan or application with Bright Grey?</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes, please give us the plan/application number.</p> <p><b>Is this existing plan being replaced by this application?</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>

If you need to tell us about more plans, please use page 31.

## Section A continued

	Person 1	Person 2
<p><b>10 Do you have, or are currently applying for, insurance cover with other insurance companies that means the total amount of insurance cover you have, or will have, with all insurance companies, including this application to Bright Grey, will be higher than:</b></p> <p><b>- £750,000 Life Cover OR</b> <b>- £400,000 Critical Illness Cover?</b></p> <p><b>Cover 1</b> <b>What is the cover for?</b></p> <p><b>What is the amount of cover?</b></p> <p><b>At claim, will the cover be paid as a lump sum or income?</b></p> <p><b>What is the remaining term of the cover?</b></p> <p><b>Do you intend to cancel this cover when your Bright Grey plan starts?</b></p> <p><b>Cover 2</b> <b>What is the cover for?</b></p> <p><b>What is the amount of cover?</b></p> <p><b>At claim, will the cover be paid as a lump sum or income?</b></p> <p><b>What is the remaining term of the cover?</b></p> <p><b>Do you intend to cancel this cover when your Bright Grey plan starts?</b></p>	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, please give us details of all plans you have, or are applying for, with other companies.	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, please give us details of all plans you have, or are applying for, with other companies.
	<input type="checkbox"/> Life Cover <input type="checkbox"/> Critical Illness Cover <input type="checkbox"/> Life of Critical Illness Cover	<input type="checkbox"/> Life Cover <input type="checkbox"/> Critical Illness Cover <input type="checkbox"/> Life of Critical Illness Cover
	<input type="checkbox"/> Lump sum <input type="checkbox"/> Income	<input type="checkbox"/> Lump sum <input type="checkbox"/> Income
	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<input type="checkbox"/> Life Cover <input type="checkbox"/> Critical Illness Cover <input type="checkbox"/> Life of Critical Illness Cover	<input type="checkbox"/> Life Cover <input type="checkbox"/> Critical Illness Cover <input type="checkbox"/> Life of Critical Illness Cover
	<input type="checkbox"/> Lump sum <input type="checkbox"/> Income	<input type="checkbox"/> Lump sum <input type="checkbox"/> Income
	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<input type="checkbox"/> Life Cover <input type="checkbox"/> Critical Illness Cover <input type="checkbox"/> Life of Critical Illness Cover	<input type="checkbox"/> Life Cover <input type="checkbox"/> Critical Illness Cover <input type="checkbox"/> Life of Critical Illness Cover
	<input type="checkbox"/> Lump sum <input type="checkbox"/> Income	<input type="checkbox"/> Lump sum <input type="checkbox"/> Income
	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

If you need to tell us about more plans, please use page 31.

# Section A continued

ONLY ANSWER QUESTION 11 IF YOU ARE APPLYING FOR INCOME COVER FOR SICKNESS

	Person 1	Person 2
<b>11 Do you have, or are you making an application for, any other income protection, mortgage payment protection insurance or accident and sickness cover plan?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, please give us details of all plans you have, or are applying for, with other companies.	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, please give us details of all plans you have, or are applying for, with other companies.
<b>Cover 1</b> <b>What is the cover for?</b>	<input type="checkbox"/> Income protection <input type="checkbox"/> Mortgage payment protection insurance <input type="checkbox"/> Accident and sickness	<input type="checkbox"/> Income protection <input type="checkbox"/> Mortgage payment protection insurance <input type="checkbox"/> Accident and sickness
<b>What is the amount of cover?</b>	<input type="text"/>	<input type="text"/>
<b>At claim, what is the deferred period before payment is made?</b>	<input type="text"/>	<input type="text"/>
<b>At claim, what is the payment period of the cover?</b>	<input type="text"/>	<input type="text"/>
<b>Do you intend to cancel this cover when your Bright Grey plan starts?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Cover 2</b> <b>What is the cover for?</b>	<input type="checkbox"/> Income protection <input type="checkbox"/> Mortgage payment protection insurance <input type="checkbox"/> Accident and sickness	<input type="checkbox"/> Income protection <input type="checkbox"/> Mortgage payment protection insurance <input type="checkbox"/> Accident and sickness
<b>What is the amount of cover?</b>	<input type="text"/>	<input type="text"/>
<b>At claim, what is the deferred period before payment is made?</b>	<input type="text"/>	<input type="text"/>
<b>At claim, what is the payment period of the cover?</b>	<input type="text"/>	<input type="text"/>
<b>Do you intend to cancel this cover when your Bright Grey plan starts?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

If you need to tell us about more plans, please use page 31.

## Section B – Your job and lifestyle

	Person 1	Person 2
1 In which country are you permanently resident?	<input type="checkbox"/> UK <input type="checkbox"/> Jersey <input type="checkbox"/> Guernsey <input type="checkbox"/> Isle of Man <input type="checkbox"/> Other If Other, please give full details <div style="border: 1px solid black; height: 60px; width: 100%;"></div>	<input type="checkbox"/> UK <input type="checkbox"/> Jersey <input type="checkbox"/> Guernsey <input type="checkbox"/> Isle of Man <input type="checkbox"/> Other If Other, please give full details <div style="border: 1px solid black; height: 60px; width: 100%;"></div>
2 In the next 6 months, will you be moving from the country in which you are permanently resident?	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 60px; width: 100%;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 60px; width: 100%;"></div>
3 In the last 2 years, have you lived outside the UK, Channel Islands or Isle of Man for more than 6 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 60px; width: 100%;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 60px; width: 100%;"></div>
4 Other than holidays of less than 3 months, have you any intention of going outside the UK, Channel Islands or Isle of Man?	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 60px; width: 100%;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 60px; width: 100%;"></div>
5 What is your current job?	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>
6 Do you work in one of the following industries: Armed forces Aviation Construction Demolition Diving Docks Merchant Marine Fishing Mining/Tunnelling Oil/Gas Rigs Offshore Quarrying Railways Ship Building or Repair?	<input type="checkbox"/> No <input type="checkbox"/> Yes (please tell us which of the industries you work in) <div style="border: 1px solid black; height: 60px; width: 100%;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please tell us which of the industries you work in) <div style="border: 1px solid black; height: 60px; width: 100%;"></div>

## Section B continued

	Person 1	Person 2
<b>7 What is your employment status?</b>	<input type="checkbox"/> Salaried employee <input type="checkbox"/> Self-employed <input type="checkbox"/> House person <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Not employed	<input type="checkbox"/> Salaried employee <input type="checkbox"/> Self-employed <input type="checkbox"/> House person <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Not employed
<b>8 Does your job involve hazardous duties?</b> <i>e.g. working at heights, working with explosives or handling asbestos.            If working at heights, please tell us how often you work at heights and the maximum and average height worked at.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 60px; width: 100%;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 60px; width: 100%;"></div>
<b>9 Are you a member of the Territorial Army (TA) or Armed Forces reservists?</b>  <b>Approximately what percentage of time do you spend each week on these activities?</b>  <i>e.g. A breakdown of your activities is still needed if you are a house person, student, retired or not employed. This information is only needed if you are applying for Critical Illness Cover, Life or Critical Illness Cover, Income Cover for Sickness or Payment Cover for Sickness.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>10 Administrative or office duties</b>	<input type="text" value=""/> %	<input type="text" value=""/> %
<b>11 Manual or physical work</b>	<input type="text" value=""/> %	<input type="text" value=""/> %
<b>12 Driving (excluding commuting)</b>	<input type="text" value=""/> %	<input type="text" value=""/> %
<b>Total</b>	<b>100%</b>	<b>100%</b>
<b>If your work includes driving what is your average annual mileage</b>	<input type="text" value=""/>	<input type="text" value=""/>
<b>Please give details of your manual or physical work.</b> <i>Note: If you apply on-line we may not always require this information</i>	<div style="border: 1px solid black; height: 60px; width: 100%;"></div>	<div style="border: 1px solid black; height: 60px; width: 100%;"></div>
<b>13 How many hours a week do you work on average? Please exclude commuting and on-call time.</b>	<input type="text" value=""/>	<input type="text" value=""/>
<b>14 What are your gross annual earnings from your employment or self-employment?</b>	<input type="text" value=""/>	<input type="text" value=""/>

## Section B *continued*

	Person 1	Person 2								
<b>15 Do you take part in any hazardous leisure activity?</b> <i>e.g. caving or potholing, hang-gliding, motor sports, yachting. Do not include one-off events such as a parachute jump for charity.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes								
<b>16 What is your height?</b>	<table border="1"> <tr> <td>feet</td> <td>inches</td> </tr> <tr> <td>metres</td> <td>centimetres</td> </tr> </table>	feet	inches	metres	centimetres	<table border="1"> <tr> <td>feet</td> <td>inches</td> </tr> <tr> <td>metres</td> <td>centimetres</td> </tr> </table>	feet	inches	metres	centimetres
feet	inches									
metres	centimetres									
feet	inches									
metres	centimetres									
<b>17 What is your weight?</b>	<table border="1"> <tr> <td>stones</td> <td>lbs</td> </tr> <tr> <td colspan="2">kilos</td> </tr> </table>	stones	lbs	kilos		<table border="1"> <tr> <td>stones</td> <td>lbs</td> </tr> <tr> <td colspan="2">kilos</td> </tr> </table>	stones	lbs	kilos	
stones	lbs									
kilos										
stones	lbs									
kilos										
<b>18 In the last 3 months, has your weight increased or decreased by 7lbs (3kgs) or more, for reasons other than pregnancy?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 60px; width: 100%;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 60px; width: 100%;"></div>								
<b>19 How many units of alcohol do you drink in an average week?</b> <i>1 pint of beer = 2 units;            1 small glass of wine = 1 unit;            1 measure of spirits = 1 unit.</i>	<div style="border: 1px solid black; padding: 2px;">units</div>	<div style="border: 1px solid black; padding: 2px;">units</div>								
<b>20 Have you ever been advised by a medical practitioner to reduce your smoking or alcohol intake?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 60px; width: 100%;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 60px; width: 100%;"></div>								
<b>21 Have you ever used illegal or recreational drugs or injected non-prescription drugs?</b> <i>e.g. cocaine, heroin, cannabis, ecstasy.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 60px; width: 100%;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 60px; width: 100%;"></div>								

## Section C – Your health

	Person 1	Person 2
<p><b>1 Before the age of 60, have any of your parents, brothers or sisters had:</b></p> <p><b>Alzheimer's disease</b>  <b>Cancer</b>  <b>Cardiomyopathy</b>  <b>Diabetes</b>  <b>Haemochromatosis</b>  <b>Heart disease</b> (including heart attack or angina)  <b>Huntington's disease</b>  <b>Motor neurone disease</b>  <b>Multiple sclerosis</b>  <b>Muscular dystrophy</b>  <b>Parkinson's disease</b>  <b>Polycystic kidney disease</b>  <b>Stroke</b>  <b>Or any hereditary disorder?</b></p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes            (Please also complete additional questions - family history on page 15).</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes            (Please also complete additional questions - family history on page 15).</p>
<p><b>2 Have you ever tested positive, or are you awaiting test results for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or Hepatitis B or C?</b></p> <p>If the result is negative, the fact that you had an HIV test will not itself have any effect on your acceptance terms for insurance.</p>	<p><input type="checkbox"/> No  <input type="checkbox"/> Yes (please give full details)</p> <div style="border: 1px solid black; height: 60px; width: 100%;"></div>	<p><input type="checkbox"/> No  <input type="checkbox"/> Yes (please give full details)</p> <div style="border: 1px solid black; height: 60px; width: 100%;"></div>
<p><b>3 In the last 5 years have you had any exposure to the risk of Human Immunodeficiency Virus (HIV) infection?</b></p> <p>This can be caught through unsafe sex, intravenous drug abuse or blood transfusions or surgery undertaken outside the EU.</p>	<p><input type="checkbox"/> No  <input type="checkbox"/> Yes (please give full details)</p> <div style="border: 1px solid black; height: 60px; width: 100%;"></div>	<p><input type="checkbox"/> No  <input type="checkbox"/> Yes (please give full details)</p> <div style="border: 1px solid black; height: 60px; width: 100%;"></div>
<p><b>4 In the last 5 years have you tested positive or been treated for any disease that was transmitted sexually?</b></p>	<p><input type="checkbox"/> No  <input type="checkbox"/> Yes (please give full details)</p> <div style="border: 1px solid black; height: 60px; width: 100%;"></div>	<p><input type="checkbox"/> No  <input type="checkbox"/> Yes (please give full details)</p> <div style="border: 1px solid black; height: 60px; width: 100%;"></div>
<p><b>For questions 5 to 14, do you have, or have you ever had, any of the following?</b></p>		
<p><b>5 Multiple sclerosis, Parkinson's disease, paralysis, epilepsy, Alzheimer's disease, dementia or cerebral palsy</b></p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes            (if Yes, please also complete the additional questions on page 16).</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes            (if Yes, please also complete the additional questions on page 16).</p>
<p><b>6 Any neurological complaint, dizziness, involuntary shaking, loss of feeling or tingling of limbs or face</b></p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes            (if Yes, please also complete the additional questions on page 16).</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes            (if Yes, please also complete the additional questions on page 16).</p>

## Section C continued

	Person 1	Person 2
<b>7</b> <b>Cancer, tumour, leukaemia, Hodgkin's disease, lymphoma, melanoma or any malignant condition</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>8</b> <b>Irregular heartbeat, heart murmur or heart disease including angina, heart attack or chest pains</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>9</b> <b>Stroke, Transient Ischaemic Attack (TIA), brain haemorrhage or brain injury</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>10</b> <b>Diabetes or sugar in the urine</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>11</b> <b>Any nervous or mental disorder</b> <i>e.g. anxiety, stress, depression, schizophrenia, suicide attempts.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>12</b> <b>Any hereditary disorder</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>13</b> <b>Any disorder of the eyes or blurred or double vision, not fully corrected by glasses or contact lenses</b> <i>e.g. glaucoma, optic neuritis.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>14</b> <b>MALES ONLY</b> <b>Any prostate enlargement or abnormal PSA (Prostate specific antigen), testicular or urinary problems</b> <i>e.g. undescended testicle, difficulty or urgency in passing urine.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>For questions 15 to 25, in the last 5 years have you had any of the following?</b>		
<b>15</b> <b>Any cysts, growth, lump, or any mole or freckle that has bled, become painful, changed colour or increased in size</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>16</b> <b>Bronchitis, pneumonia or other lung disorder</b> <i>other than asthma.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>17</b> <b>Any disorder of the digestive system, gall bladder, stomach, bowel or liver</b> <i>e.g. gastric ulcer, duodenal ulcer, hepatitis, jaundice, colitis, Crohn's disease.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>18</b> <b>Any disorder of the thyroid</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).

## Section C continued

	Person 1	Person 2
<b>19 Any disorder of the kidneys or bladder</b> <i>e.g. blood or protein in the urine or multiple urinary infections.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>20 Any fit or blackout</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>21 Any disorder of the muscles, bones, joints or limbs</b> <i>e.g. arthritis, rheumatoid arthritis.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>22 A slipped disc or other back or neck disorder</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>23 Any disorder of the skin or ears</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>24 Any disorder of the blood</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>25 FEMALES ONLY</b> <b>Any abnormal cervical smear, mammogram or biopsy of the breast, uterus or cervix</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>26 Are you currently certified by a doctor as unfit for work?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>27 Are you currently experiencing any symptoms or complaints for which you have not consulted a doctor?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>28 Are you currently awaiting, or been advised to seek, any medical or surgical consultation or follow-up?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).
<b>29 In the last 5 years have you</b> - attended any other medical appointment, - taken any other test or medication, or - received any other treatment?	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete the additional questions on page 16).

You do not need to tell us about any of the following treatments and confirmed conditions: acne, athlete's foot, blisters, cold sores, common colds, conjunctivitis, contraception, ear wax or syringing, food poisoning, hay fever, indigestion, infected or extracted wisdom teeth, infertility treatment, influenza, ingrowing toenails, miscarriage, pregnancy, shingles, sinus trouble, tonsillitis, uncomplicated fractures, vaccinations or vasectomy.

## Section C *continued*

	Person 1	Person 2
For questions 30 to 32, in the last 5 years have you had any of the following?		
<b>30 High blood pressure, or</b> - taken, or been advised to take, treatment for high blood pressure or - had, or been advised to have your blood pressure monitored (other than as part of pregnancy)	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete <b>blood pressure</b> questions on page 18).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete <b>blood pressure</b> questions on page 18).
<b>31 High cholesterol, or</b> - taken, or been advised to take, treatment for raised cholesterol, or - had, or been advised to have, your cholesterol levels monitored	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete <b>cholesterol</b> questions on page 19).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete <b>cholesterol</b> questions on page 19).
<b>32 Asthma</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete <b>asthma</b> questions on page 21).	<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please also complete <b>asthma</b> questions on page 21).

# Additional questions - Family history

If you answered Yes to question 1 in section C please also answer these questions.

## Family history condition 1

	Person 1	Person 2
What is the name of the first condition that any of your parents, brothers or sisters has suffered from, before the age of 60?	<input type="text"/>	<input type="text"/>
How many of your parents, brothers or sisters have had this condition?	<input type="text"/>	<input type="text"/>
For each relative with this condition, please tell us their relationship to you and the age they were diagnosed with this condition.	relative 1	relative 1
	age at diagnosis	age at diagnosis
	relative 2	relative 2
	age at diagnosis	age at diagnosis
	relative 3	relative 3
	age at diagnosis	age at diagnosis
If you have any other relatives that have been diagnosed with this condition, please tell us their relationship to you and the age they were diagnosed with this condition.	<input type="text"/>	<input type="text"/>

## Family history condition 2

	Person 1	Person 2
What is the name of the second condition that any of your parents, brothers or sisters has suffered from, before the age of 60?	<input type="text"/>	<input type="text"/>
How many of your parents, brothers or sisters have had this condition?	<input type="text"/>	<input type="text"/>
For each relative with this condition, please tell us their relationship to you and the age they were diagnosed with this condition.	relative 1	relative 1
	age at diagnosis	age at diagnosis
	relative 2	relative 2
	age at diagnosis	age at diagnosis
	relative 3	relative 3
	age at diagnosis	age at diagnosis
If you have any other relatives that have been diagnosed with this condition, please tell us their relationship to you and the age they were diagnosed with this condition.	<input type="text"/>	<input type="text"/>

If you need to tell us about more plans, please use page 31.

## Additional questions *continued*

If you answered Yes to any of questions 5 to 29 in section C please also answer these questions.

### Condition 1

	Person 1	Person 2
1 What is the name of the medical condition or injury that you have had or currently have?	<input type="text"/>	<input type="text"/>
2 When did your symptoms start? <i>Please give a date.</i>	<input type="text"/>	<input type="text"/>
3 How often do you have symptoms?	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Once or twice a year <input type="checkbox"/> No longer have symptoms	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Once or twice a year <input type="checkbox"/> No longer have symptoms
4 If the symptoms have stopped, when was the last time you had symptoms of this condition? <i>Please give a date.</i>	<input type="text"/>	<input type="text"/>
5 Have you had any surgery, investigations or tests for this condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <input type="text"/>
6 Do you expect or have you been advised to have surgery, tests or investigations, including any hospital referrals, for this condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <input type="text"/>
7 What was the treatment prescribed?	<input type="text"/>	<input type="text"/>
8 Is it still continuing?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
9 How many days have you been off work because of this condition?	<input type="text"/> days	<input type="text"/> days
10 Which of the following best describes the severity of your condition?	<input type="checkbox"/> Fully recovered with no remaining disability <input type="checkbox"/> Ongoing condition with no restrictions of daily activities or mobility <input type="checkbox"/> Mild symptoms with infrequent restriction of daily activities or mobility <input type="checkbox"/> Severe symptoms with infrequent restriction of daily activities or mobility <input type="checkbox"/> Daily activities and tasks significantly restricted	<input type="checkbox"/> Fully recovered with no remaining disability <input type="checkbox"/> Ongoing condition with no restrictions of daily activities or mobility <input type="checkbox"/> Mild symptoms with infrequent restriction of daily activities or mobility <input type="checkbox"/> Severe symptoms with infrequent restriction of daily activities or mobility <input type="checkbox"/> Daily activities and tasks significantly restricted

## Additional questions *continued*

### Condition 2

	Person 1	Person 2
<b>1</b> What is the name of the medical condition or injury that you have had or currently have?	<input type="text"/>	<input type="text"/>
<b>2</b> When did your symptoms start? <i>Please give a date.</i>	<input type="text"/>	<input type="text"/>
<b>3</b> How often do you have symptoms?	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Once or twice a year <input type="checkbox"/> No longer have symptoms	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Once or twice a year <input type="checkbox"/> No longer have symptoms
<b>4</b> If the symptoms have stopped, when was the last time you had symptoms of this condition? <i>Please give a date.</i>	<input type="text"/>	<input type="text"/>
<b>5</b> Have you had any surgery, investigations or tests for this condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <input type="text"/>
<b>6</b> Do you expect or have you been advised to have surgery, tests or investigations, including any hospital referrals, for this condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <input type="text"/>
<b>7</b> What was the treatment prescribed?	<input type="text"/>	<input type="text"/>
<b>8</b> Is it still continuing?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>9</b> How many days have you been off work because of this condition?	<input type="text"/> days	<input type="text"/> days
<b>10</b> Which of the following best describes the severity of your condition?	<input type="checkbox"/> Fully recovered with no remaining disability <input type="checkbox"/> Ongoing condition with no restrictions of daily activities or mobility <input type="checkbox"/> Mild symptoms with infrequent restriction of daily activities or mobility <input type="checkbox"/> Severe symptoms with infrequent restriction of daily activities or mobility <input type="checkbox"/> Daily activities and tasks significantly restricted	<input type="checkbox"/> Fully recovered with no remaining disability <input type="checkbox"/> Ongoing condition with no restrictions of daily activities or mobility <input type="checkbox"/> Mild symptoms with infrequent restriction of daily activities or mobility <input type="checkbox"/> Severe symptoms with infrequent restriction of daily activities or mobility <input type="checkbox"/> Daily activities and tasks significantly restricted

If you need to tell us about more plans, please use page 31.

# Blood pressure

If you answered Yes to question 30 in section C please also answer these questions.

	Person 1	Person 2
<b>1 When did you first find out that you had raised blood pressure?</b> <i>Please give a date.</i>	<input type="text"/>	<input type="text"/>
<b>2 When did you last have your blood pressure read by a medical practitioner?</b> <i>Please give a date.</i>	<input type="text"/>	<input type="text"/>
<b>3 Do you know what your last blood pressure was?</b>  <b>(i) In the last year, have all the medical practitioners treating your raised blood pressure, confirmed that all your blood pressure readings have been normal?</b>  <b>(ii) In the last year, have any of the medical practitioners treating your raised blood pressure:</b> - changed your medication or treatment or - increased the dosage of your medication or treatment  <b>(iii) Please tell us your last reading:</b>	<input type="checkbox"/> No (If No, please answer (i) and (ii)) <input type="checkbox"/> Yes (If Yes, please answer (iii) below)  <input type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> No <input type="checkbox"/> Yes  Systolic <input type="text"/> <i>The first number in the reading, e.g. '150' in a reading of 150/95.</i>  Diastolic <input type="text"/> <i>The second number in the reading, e.g. '95' in a reading of 150/95.</i>	<input type="checkbox"/> No (If No, please answer (i) and (ii)) <input type="checkbox"/> Yes (If Yes, please answer (iii) below)  <input type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> No <input type="checkbox"/> Yes  Systolic <input type="text"/> <i>The first number in the reading, e.g. '150' in a reading of 150/95.</i>  Diastolic <input type="text"/> <i>The second number in the reading, e.g. '95' in a reading of 150/95.</i>
<b>4 Are you currently taking any medication for blood pressure?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, is more than 1 drug used to control your blood pressure? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, what medication are you taking? <input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, is more than 1 drug used to control your blood pressure? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, what medication are you taking? <input type="text"/>
<b>5 Have you ever stopped taking medication without your doctor's approval?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

## Blood pressure *continued*

	Person 1	Person 2
<b>6 Have you had, or do you expect to have, any hospital referrals for raised blood pressure?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>
<b>7 Do you have, or have you ever had, any complications or side effects as a result of raised blood pressure?</b> <i>e.g. dizziness, headaches, circulatory problems, chest pains.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>

## Cholesterol

If you answered Yes to question 31 in section C please also answer these questions.

	Person 1	Person 2
<b>8 When did you first find out that your cholesterol levels were raised?</b> <i>Please give a date.</i>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>9 When did you last have your cholesterol read by a medical practitioner?</b> <i>Please give a date.</i>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>10 Do you know what your last cholesterol reading was?</b>  <b>(i) In the last year, have all the medical practitioners treating your raised cholesterol, confirmed that all your cholesterol readings have been normal?</b>  <b>(ii) In the last year, have any of the medical practitioners treating your raised cholesterol:</b> - changed your medication or treatment or - increased the dosage of your medication or treatment  <b>(iii) Please tell us your last reading:</b>	<input type="checkbox"/> No (If No, please answer (i) and (ii)) <input type="checkbox"/> Yes (If Yes, please answer (iii) below)  <input type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> No <input type="checkbox"/> Yes  Total cholesterol <input style="width: 100px;" type="text"/>  HDL cholesterol <input style="width: 100px;" type="text"/> <small>(high density lipoprotein)</small> <i>Leave blank if HDL is unknown</i>	<input type="checkbox"/> No (If No, please answer (i) and (ii)) <input type="checkbox"/> Yes (If Yes, please answer (iii) below)  <input type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> No <input type="checkbox"/> Yes  Total cholesterol <input style="width: 100px;" type="text"/>  HDL cholesterol <input style="width: 100px;" type="text"/> <small>(high density lipoprotein)</small> <i>Leave blank if HDL is unknown</i>

## Cholesterol *continued*

	Person 1	Person 2
<b>11 Are you currently taking any medication for your cholesterol levels?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, is more than 1 drug used to control your cholesterol levels? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, what medication are you taking? <div style="border: 1px solid black; height: 60px; margin-top: 5px;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, is more than 1 drug used to control your cholesterol levels? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, what medication are you taking? <div style="border: 1px solid black; height: 60px; margin-top: 5px;"></div>
<b>12 Have you ever stopped taking medication without your doctor's approval?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>13 Have you had, or do you expect to have, any hospital referrals for raised cholesterol?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 60px; margin-top: 5px;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 60px; margin-top: 5px;"></div>
<b>14 Do you have, or have you ever had, any complications or side effects as a result of raised cholesterol?</b> <i>e.g. circulatory problems, chest pains.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 60px; margin-top: 5px;"></div>	<input type="checkbox"/> No <input type="checkbox"/> Yes (please give full details) <div style="border: 1px solid black; height: 60px; margin-top: 5px;"></div>

# Asthma

If you answered Yes to question 32 in section C please also answer these questions

	Person 1	Person 2
<p><b>1 How often do you have symptoms of asthma?</b>  <i>e.g. shortness of breath, cough, chest tightness, wheezing.</i></p>	<div style="background-color: #cccccc; padding: 2px;">no longer have any symptoms</div> <div style="border: 1px solid black; padding: 2px;">once or twice a month</div> <div style="border: 1px solid black; padding: 2px;">daily</div> <div style="border: 1px solid black; padding: 2px;">continuous symptoms</div> <div style="border: 1px solid black; padding: 2px;">other</div> <p style="font-size: small;">If Other, please advise how often you have symptoms and the severity of your symptoms.</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<div style="background-color: #cccccc; padding: 2px;">no longer have any symptoms</div> <div style="border: 1px solid black; padding: 2px;">once or twice a month</div> <div style="border: 1px solid black; padding: 2px;">daily</div> <div style="border: 1px solid black; padding: 2px;">continuous symptoms</div> <div style="border: 1px solid black; padding: 2px;">other</div> <p style="font-size: small;">If Other, please advise how often you have symptoms and the severity of your symptoms.</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
<p><b>2 How many asthma attacks have you had in the last 2 years?</b></p>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<p><b>3 In the last 2 years have you been admitted to hospital or had to take oral steroids, other than through an inhaler?</b></p>	<p> <input type="checkbox"/> No  <input type="checkbox"/> Yes (please give full details)         </p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<p> <input type="checkbox"/> No  <input type="checkbox"/> Yes (please give full details)         </p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
<p><b>4 Do you have regular monitoring of your asthma?</b>  <i>Tick Yes if you have had lung function tests.</i></p>	<p> <input type="checkbox"/> No  <input type="checkbox"/> Yes         </p>	<p> <input type="checkbox"/> No  <input type="checkbox"/> Yes         </p>
<p><b>5 In the last 2 years, how many days have you taken off work, or been unable to perform your normal daily activities, because of asthma?</b></p>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>

# Section D – Your GP

	Person 1	Person 2
<p><b>1 Your GP</b></p> <p>If you need to check the GP's address details, please go to <a href="http://www.click-for-health.com">www.click-for-health.com</a>. If you do not give us their full name and address, it could delay your application.</p> <p>We may not always contact your GP to ask for more medical information so please make sure you give us all of the information we ask for when filling in your application.</p>	<p>GP name</p> <p>surgery name</p> <p>surgery address</p> <p>postcode</p> <p>phone</p> <p>fax</p> <p>email</p>	<p>GP name</p> <p>surgery name</p> <p>surgery address</p> <p>postcode</p> <p>phone</p> <p>fax</p> <p>email</p>
<p><b>2 Have you been with this GP for less than 6 months?</b></p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes (please give us your previous GP's name and address)</p> <p>GP name</p> <p>surgery name</p> <p>surgery address</p> <p>postcode</p>	<p>No</p> <p>Yes (please give us your previous GP's name and address)</p> <p>GP name</p> <p>surgery name</p> <p>surgery address</p> <p>postcode</p>

## Section E – Payment details

<p><b>1 Please tell us when you would like the plan to start</b> For a joint life application we will not start your plan until we have accepted both people covered for all covers.</p>	<p><input type="checkbox"/> Immediately you accept my application <input type="checkbox"/> I will tell you later On the date I tell you below</p> <p style="text-align: center;">/ /</p>
<p><b>2 Is the person paying for this plan the plan owner?</b> The plan owner will usually be the person/people covered unless you have told us something different on page 3.</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If the plan owner is paying for this plan, please only answer questions 7 and 8 and complete their bank details. If the plan owner is not paying for this plan, the payer must complete and sign the direct debit details on page 29 and post it to us when you submit the application.</p>
<p><b>3 What is the plan payer's relationship to the plan owner(s)?</b></p>	<p><input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Partner/Cohabitant <input type="checkbox"/> Common Law Spouse <input type="checkbox"/> Business Partner <input type="checkbox"/> Company <input type="checkbox"/> Employer <input type="checkbox"/> Other If Other, please give full details</p>
<p><b>4 What is the plan payer's full name?</b> If a company is paying for this plan and your adviser has not verified the company's identity then we may need to ask for more detailed information when we receive your application.</p>	
<p><b>5 What is the plan payer's address?</b></p>	<p>house name</p> <p>house/building number</p> <p>street name</p> <p>town/city</p> <p>county</p> <p>country</p> <p>postcode</p>
<p><b>6 Plan payer's date of birth (individuals only)</b></p>	<p style="text-align: center;">/ /</p>

## Section E *continued*

**7** How would you, or the person paying for this plan, like to pay?

Monthly by direct debit

Please tell us the day of the month between the 1st and 28th you would like us to collect your payment.

Yearly by direct debit

**8** Is more than one signature required to authorise payments?

No

Yes

If Yes, both people must complete and sign the direct debit mandate on page 29. You must then post the signed direct debit mandate to us when you submit the application.

### Account details for direct debit payments

Name of account holder

Sort code

Account number

# Section F – Data protection, access to medical reports information and declaration and consent

This section is made up of 3 parts:

- 1 Data protection information
- 2 Access to medical reports information
- 3 Declaration and consent

The person covered should

read sections 1, 2 and 3, tick the box in section 3 if they want to see their medical report, and sign section 3.

<b>1</b>	<b>Data protection</b> (please read)
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We, The Royal London Group (including Bright Grey), may obtain personal information either from you directly or, with your consent, from your approved intermediary or from other sources such as your doctor or an identity authentication agency.

**We will use your personal information for the following purposes:**

- Providing our products and services
- Improving customer care
- Verifying your identity and fraud prevention
- Research and analysis
- Marketing
- Legal and regulatory reason
- Administering your plan

We will retain your personal information for a reasonable period and we may also share information about you (in the UK and abroad) with your approved intermediary, our service providers and agents and with third parties such as auditors, underwriters, reinsurers, medical agencies, identity authentication agencies, other financial institutions and legal and regulatory bodies.

We may contact you by mail, phone, fax, email or other electronic messaging either directly or through your approved intermediary with further offers, promotions and information about our products and services that may be relevant to you. Please tick this

box if you do not wish to receive these communications.

- Person 1    Person 2  
 Other applicant

We may also share your information with carefully selected third parties, who may contact you by mail or phone to let you know about products and services which they believe may be relevant to you. Please tick this box if you do not wish to receive such information.

- Person 1    Person 2  
 Other applicant

If you are happy for the third parties to contact you by email, fax and electronic messaging for such purposes, please tick this box.

- Person 1    Person 2  
 Other applicant

We may carry out an identity authentication check to verify your identity. This involves checking the details you supply against those held on any databases that may be accessed by the reputable third party company which carries out our checks. This includes information from the Electoral Register and fraud prevention agencies. We will use scoring methods to verify your identity. A record of this search will be kept and may be used to help other companies verify your identity.

We may also pass information to financial and other organisations involved in money laundering and fraud prevention to protect ourselves and our customers from theft and fraud. If you give us false or inaccurate information and we suspect fraud, we will record this and share this information with other organisations.

We may monitor and record phone calls and retain these for the purposes of training and quality assurance and to ensure that we have an accurate record of your instructions.

If you provide us with information about another person, you confirm that they have appointed you to act for them to consent to the processing of their personal data and that you have informed them of our identity and the purposes (as set out above) for which their personal data will be processed.

You have the right to ask for a copy of the information that we hold on you, for which we are entitled to charge a small fee.

**If you have any questions about how we will use your personal information or if you would like to receive our marketing communications by some but not all of the above methods, please contact a member of the Bright Grey Customer Care Team on 0845 6094 500.**

<b>2</b>	<b>Access to medical reports information</b> (please read)
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Before we can process your application, we may need to obtain a medical report from your current GP or specialist, or from a doctor you have seen in the past.

You have specific rights in relation to medical reports, which are covered in the Access to Medical Reports Act 1988 (also the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991, and the Access to Health Records and Reports Act 1993 (Isle of Man)).

Before we ask for such a report, we need your consent, which you can give by signing the declaration in section 3.

You can choose not to give your consent, but then we may not be able to continue with your application. This does not prevent you from applying to other insurance companies for insurance.

We will let you know if we ask for a report. Under the above Acts, you can choose to see your medical report before it is sent

to us. You will then have 21 days to make arrangements with your doctor to see it.

You should indicate below whether you want to see your report. If you do not want to see the report now, you can still contact your doctor later and tell them that you do in fact want to see it. As long as it has not already been sent to us, you will still have 21 days from the time you contact your doctor to make arrangements to see it.

<b>2</b>	<b>Access to medical reports information continued</b> (please read)
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If the report has already been sent to us, you are entitled to see a copy of the report at any time during the 6 months following the date the report was 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 say that you do want to see the report, then it will not be sent to us until:

**either** you have seen the report

**or** 21 days have passed since we requested the report and the doctor has not heard from you.

If you see the report, you can withdraw your consent for the doctor showing it to us, or you can ask the doctor to change it if you disagree with it. If the doctor refuses to change it, you can insist that they attach a statement of your views to the report.

A doctor may refuse to let you see your report if they feel that seeing it will cause physical or mental harm to you or others.

**Note:** Your doctor is entitled to charge you for supplying you with a copy of the report.

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

**Your current health:**

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

**Time off work:**

- any time off work in the last 3 years.

**Your past health:**

- details of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your GP or any other medical adviser, therapist or counsellor, in particular whether you have a history of:
  - malignancy (cancer), cardiovascular (heart) disease, diabetes, and degenerative (gradually worsening) diseases
  - musculoskeletal disease or injury, e.g. 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
  - 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 2 years, urinalyses (tests on urine), X-rays or other investigations
- any blood pressure readings in the last 3 years.

**Family history of disease:**

- any history of disease among your parents or brothers or sisters that you have told your doctor about.

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

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

- setting payments at standard rates
- increasing payments above standard rates
- refusing to provide insurance.

**If you have any questions about your rights under the act please contact:**

Bright Grey, 2 Queen Street, Edinburgh EH2 1BG

<b>3</b>	<b>Declaration and consent</b> (please read)
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**Bright Grey is a division of Royal London. The Royal London Group consists of The Royal London Mutual Insurance Society Limited and its subsidiaries.**

**By signing this declaration, I give Bright Grey permission:**

- to ask for information from any insurance office to which an application has been made for insurance
- to disclose my name, address, phone number and date of birth to an approved medical agency in order to arrange and obtain medical examinations and tests
- to gather medical reports (which may include full medical records) within 6 months of the start of the plan or after my death, in relation to any claim made on the plan
- to ask any doctor I have seen for information about anything which affects my physical or mental health, and I understand my rights under the Access to Medical Reports Act 1988
- to store and use information about me, including sensitive personal data such as health details, in the way described in section 1 Data protection.

**I agree that:**

- if my health changes, or any other detail affecting the application changes, between the date of this application and the date the plan starts, I will inform Bright Grey in writing. I understand that Bright Grey will then have the right to reconsider terms if appropriate
- if I have a financial adviser:
  - they are authorised to give Bright Grey any information that is missing from my application form; and
  - they are authorised to accept any amendment which Bright Grey proposes to make to my plan (including the acceptance of any non-standard terms) and to instruct Bright Grey to start my plan on my behalf, provided that:
    - either** I have indicated my agreement to the amendment, instruction or inclusion of additional information in writing to the financial adviser and the financial adviser has confirmed this to Bright Grey
    - or** the amendment, instruction or inclusion of additional information shall not take effect until I have indicated my agreement in writing to the financial adviser, who has then confirmed this to Bright Grey.

**I understand that:**

- I can request a copy of the plan details for the Personal Protection Menu
- this plan will be issued subject to the law of England and Wales
- if I do not give Bright Grey all facts that are likely to influence the assessment and acceptance of this application form, any plan issued as the result of this application may be cancelled or the terms changed, and any claims may be refused.

**I declare that:**

- I have received a copy of the key facts of the Personal Protection Menu
- if I have applied as a non-smoker that I have not used any form of tobacco or nicotine replacement products in the last 12 months
- the answers in this application form are true and complete, to the best of my knowledge and belief
- I have read the statement in section 2 notifying me of my rights under the Access to Medical Reports legislation, and consent to my doctor providing medical reports to Bright Grey, so that they can deal with my application for a protection plan.

*Person 1 and Person 2 should always complete these boxes.*

*Please only tick this box if you **DO** want to see your medical report before it is sent to Bright Grey.*

	Person 1	Person 2
	name <input style="width: 90%;" type="text"/>	name <input style="width: 90%;" type="text"/>
	postcode <input style="width: 90%;" type="text"/>	postcode <input style="width: 90%;" type="text"/>
	<input type="checkbox"/> Yes I <b>DO</b> want to see my medical report. I understand that it will not be sent to Bright Grey until I have seen it, and that they will not be able to make a decision on my application until then.	<input type="checkbox"/> Yes I <b>DO</b> want to see my medical report. I understand that it will not be sent to Bright Grey until I have seen it, and that they will not be able to make a decision on my application until then.
	Enter plan number here if your financial adviser is sending this page to Bright Grey as an AMRA declaration for an application submitted online. <input style="width: 90%;" type="text"/>	Enter plan number here if your financial adviser is sending this page to Bright Grey as an AMRA declaration for an application submitted online. <input style="width: 90%;" type="text"/>

I/We did **NOT** receive advice from a financial adviser about buying this plan.

*If the person applying for the plan is not Person 1 or Person 2, they should sign and date here and give us their details on page 3.*

**I agree that this application together with the Personal Protection Menu plan quote, key facts and the plan details shall form the basis of the contract between me and Royal London, on behalf of Bright Grey.**

Other applicant	Person 1	Person 2
signature <input style="width: 90%;" type="text"/>	signature <input style="width: 90%;" type="text"/>	signature <input style="width: 90%;" type="text"/>
date                    /                    /	date                    /                    /	date                    /                    /

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# clear and simple thinking from Bright Grey