

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	196593854
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"/>

# All in One Application and Data Capture Form

## For PruProtect Plan

# Important information for Advisers.

You can use this document for:

## 1. A Data Capture Form – Online Submission

Submitting online means that you can have an immediate underwriting decision or details of other information required.

Please collect the information required and submit this online on [www.pruprotect.co.uk](http://www.pruprotect.co.uk)

- If you are submitting a full application online, please collect information to the end of Section I which starts on page 24. Please also collect the Direct Debit details on page 31 to submit online.

Please obtain your client(s) signature on the Medical Reports Act Declaration on page 30.

Please detach this declaration and post it to:

**PruProtect**  
Customer Services  
New Business  
Stirling FK9 4UE

Please do not post or fax the Data Capture Form to PruProtect, only send the Medical Reports Act Declaration.

OR

## 2. Paper Submission

- A full application form. Please complete all sections with your client(s). Your client(s) must sign the Medical Reports Act Declaration on page 30, the Direct Debit Instruction on page 31 and The Client Declaration, Authority and Consent starting on page 32.

Please post the paper application to:

**PruProtect**  
Customer Services  
New Business  
Stirling FK9 4UE

## Colour Key

- Core application section to complete
- Extra cover options to complete if applicable

# Essential Adviser Information

For Completion By Financial Adviser. All sections to be completed.

1. FSA Regulatory No  OR \* Other UK/EU Regulator

Registered Individual's Forename  AND

Registered Individual's Surname

## 2. Your Agency Details

Your PruProtect Agency Number

e.g. 1 2 3 4 5 6 X

Commission to be rebated  .  %

## 3. Your Customer Reference Number

(This is a reference number you can allocate for your client(s) that will appear on output that we send to you. You do not have to complete this box.)

## 4. Routing Instructions (if different from your usual instructions)

Acceptance Letter

Direct to Owner with copy to you

Both to you

Plan Documents to:

Owner

You

Special destination\*

Copy plan documents to:

Owner

You

Special destination\*

\* Special destination – Name

Address

Use of this address must have been authorised by the investor, to maintain client confidentiality.

\* Complete as appropriate

## 5. Illustration reference number (only for illustrations produced from [www.pruprotect.co.uk](http://www.pruprotect.co.uk))

## 6. Was advice given? Please tick one box

Yes  No

## Important information for customers

Please use black ink, BLOCK LETTERS and tick or complete answers as appropriate. Please help us by filling in the application form honestly and in full. If you miss any information out, or give us misleading information, this is likely to mean that we will not pay your claim. In addition, this could also delay the processing of your application. If you are uncertain about whether any particular fact would influence our decision, you should include it. If you do not, it is likely that a claim in the future will not be paid. Please disclose all relevant information as we may not contact or obtain a report from your Doctor.

If someone else fills this form in for you (for example, your Financial Adviser), please check that all the details are correct before you sign the declaration. You are responsible for all the answers you or your Financial Adviser provide on this application. If you make a mistake please cross it out, put in the correct word or words and initial next to the correction.

If you would prefer, you may complete the medical questions in private and return the Health Details section direct to our Chief Medical Officer. Please indicate on this form if you have done so.

It is very important that you tell us if there is a change between completion of this form and your plan starting to any of the following:

- your personal health
- your family history
- your occupation
- your participation in any hazardous leisure activities
- your travel or residence
- your lifestyle (smoking/alcohol consumption/etc)

If you do not, your plan may be cancelled and your claim will not be paid.

If this application, taken together with any other insurance policies you already have, is for life insurance up to a sum of £500,000 or serious illness/critical illness up to £300,000 you need not disclose any genetic test you may have had. You need not disclose the result of any genetic test undertaken in the context of research. Genetic test results need only be disclosed where the sum exceeds either £500,000 for life insurance or £300,000 for serious illness/critical illness and their use by insurers has been independently approved. You may, of course, disclose any genetic test result which is in your favour. If you either have a family history of, are experiencing symptoms of, or are having treatment for, a genetic condition, you must tell us.

Further information is available on request which fully explains this policy and details those genetic tests approved for use by insurers.

**Failure to disclose relevant information will result in non payment of a claim.**

Failure to disclose relevant information will result in non payment of a claim.

## A. Your details

### First (or only) Life Assured

If this is a joint application, the first life assured must be the person selecting the highest level of Life Cover. If no Life Cover is selected, then the first life assured is the person with the highest level of Serious Illness Cover. If both lives choose the same level of cover, the first life assured will be the first person on the application form.

### Second Life Assured (if applicable)

You must complete this section if second life benefits are selected.

Mr  Mrs  Miss  Ms

Other

First name(s)

Surname

Gender Male  Female

Date of Birth 

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

Telephone (Home)

Telephone (Work)

Mobile

Marital status

Please select one option only:

Married  Single

Separated  Divorced

Widowed  Civil Partner

Dissolved Civil Partnership  Surviving Partner of Civil Partnership

E-mail address

Current Address

Postcode

Mr  Mrs  Miss  Ms

Other

First name(s)

Surname

Gender Male  Female

Date of Birth 

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

Telephone (Home)

Telephone (Work)

Mobile

Marital status

Please select one option only:

Married  Single

Separated  Divorced

Widowed  Civil Partner

Dissolved Civil Partnership  Surviving Partner of Civil Partnership

E-mail address

Current Address

Postcode

Failure to disclose relevant information will result in non payment of a claim.

## A. Your details – continued

First (or only) Life Assured

Second Life Assured (if applicable)

1. Do you already have any Life Cover, Critical Illness/Serious Illness cover or Income Protection cover with Prudential, PruProtect or Scottish Amicable?

Yes  No

Yes  No

Contract Number(s)

Contract Number(s)

If you are applying for Life Cover only, please go to Question 3.

2. Do you have any Critical Illness/Serious Illness or Income Protection insurance cover **with any other companies** including any you are currently applying for?

Yes  No

Yes  No

If Yes please state the type of cover and the total sum assured you are covered for.

Serious Illness/  
Critical Illness cover:

 £

Serious Illness/  
Critical Illness cover:

 £

Income Protection Cover each  
month:

 £

Income Protection Cover each  
month:

 £

3. Do you intend to cancel any of the insurance cover outlined in Questions 1 and 2 above when your PruProtect Plan starts?

Yes  No

Yes  No

If the insurance you are cancelling is Life Cover only, please proceed to Question 4 below. Otherwise please provide full details of type of cover and amount being cancelled.

Serious Illness/  
Critical Illness cover:

 £

Serious Illness/  
Critical Illness cover:

 £

Income Protection Cover each  
month:

 £

Income Protection Cover each  
month:

 £

4. Please give your total gross annual earnings (to the nearest £)

 £

 £

## A. Your details – continued

This section must be completed by all Applicants.

5. Who is/are the plan owner(s)? (please tick one box)

- 5.1 the first or only life assured  Please proceed to Section B below.
- 5.2 both lives  Please proceed to Section B below.
- 5.3 the following party  Please complete the details below where appropriate.

Trust(ee)

Surname

First name(s)

Title

Mr  Mrs  Miss  Ms  Other

Telephone (Home)

Telephone (Work)

Mobile

E-mail address

Address for correspondence

<input type="text"/>	
<input type="text"/>	Postcode

Relationship to life/lives assured

Reason for assurance

## B. Plan start date (choose one option)

1. Plan start date

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

OR

Start immediately on standard term acceptance

## C. Plan Accounts structure

### 1. Amount of Plan Account

What amount do you want for your Plan Account?

### 2. Minimum Protected Account

Do you require the Minimum Protected Account option? Yes  No  If No please proceed to Question 3

What percentage of your Plan Account do you want to protect with the Minimum Protected Account option? (The minimum amount you can choose is 25%. This option applies to Serious Illness Cover and Optional Serious Illness Cover for Children only).

 %

### 3. Fixed Term or Whole of Life?

Do you require your Plan Account to be set up on a:

Fixed term basis?

OR

Whole of life basis?

### 4. Plan Details (for Fixed Term Plans only. Please go to Question 5 for Whole of Life Plans)

4.1 What term do you want for your Plan Account?  years

(The minimum term is 5 years.)

4.2 Do you want your premiums for benefits linked to the Plan Account and Disability Cover to be:

Guaranteed

OR

Reviewable

### 5. Plan Account basis

Do you want your Plan Account and Disability Cover to be:

Level  OR Indexed  OR Decreasing  (A decreasing plan account basis is not available for whole of life plans)

### 6. Is this plan to be used in connection with a mortgage?

Yes – new mortgage  Yes – existing or other mortgage  No

## D. Product options

If you have selected the plan Account to be set up on a decreasing basis, then product options D1 – D4 must have the same term as the Plan Account.

### 1. Life Cover

Do you require this benefit? Yes  No  If No please go to Section D2.

	First (or only) Life Assured	Second Life Assured (if applicable)
1.1 Life Cover required? For the second life assured please complete either as a percentage of the Plan Account or as a monetary amount.	Life Cover for the first life will be the amount of the Plan Account in Section C1.	£ <input style="width: 100%;" type="text"/> OR <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> % of Plan Account
If the Plan Account is set up on a decreasing basis do not complete Question 1.2 and go to Section D2.		
1.2 What term does the second life require?	same term as Plan Account in Section C <input type="checkbox"/> OR <input style="width: 40px;" type="text"/> Years	

### 2. Serious Illness Cover

Do you require this benefit? Yes  No  If No please go to Section D3.

2.1 Serious Illness Cover required? Please complete either as a percentage of the Plan Account or as a monetary amount.	£ <input style="width: 100%;" type="text"/> If you are not applying for Life Cover, the monetary amount must be the same as the Plan Account amount in Section C1. OR <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> % of Plan Account. This cannot exceed 100% of your Plan Account.	£ <input style="width: 100%;" type="text"/>  OR <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> % of Plan Account
2.2 What type of Serious Illness Cover do you require?	Primary <input type="checkbox"/> OR Comprehensive <input type="checkbox"/>	Primary <input type="checkbox"/> OR Comprehensive <input type="checkbox"/>
Questions 2.3 and 2.4 relate to the term required for Serious Illness Cover. If the Plan Account is set up on a decreasing basis do not complete and go to Section D3. If the Plan Account is set up on a level or indexed basis, please complete Question 2.3 if Life Cover has been selected OR please complete Question 2.4 if Life Cover has not been selected. <b>Please complete one question only.</b>		
2.3 What term is required for Serious Illness Cover?	same term as Plan Account in Section C <input type="checkbox"/> OR <input style="width: 40px;" type="text"/> Years OR <input type="checkbox"/> To Age 70 exactly	same term as Plan Account in Section C <input type="checkbox"/> OR <input style="width: 40px;" type="text"/> Years OR <input type="checkbox"/> To Age 70 exactly
2.4 What term does the second life require?	same term as Plan Account in Section C <input type="checkbox"/> OR <input style="width: 40px;" type="text"/> Years OR <input type="checkbox"/> To Age 70 exactly	

Please note this option is not available on a decreasing plan account

## D. Product options – continued

### 3. Optional Serious Illness Cover for Children

Do you require this benefit?

Yes

No

If No please go to Section D4.

<p>3.1 Optional Serious Illness Cover for Children required? Please complete as a percentage of the Plan Account or as a monetary amount.</p>	<p>£ <input style="width: 100%;" type="text"/></p> <p>OR</p> <p><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/> . <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/> %</p> <p>(This cannot exceed 100% of your Plan Account. The amount of cover applies to each child.)</p>			
<p>3.2 What type of Serious Illness Cover do you want for Optional Serious Illness Cover for Children?</p>	<p>Primary <input type="checkbox"/> OR Comprehensive <input type="checkbox"/></p>			
<p>3.3 Please provide details of children to be covered.</p>				
Child	First Name	Surname	Gender	Date of birth
1.	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>
2.	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>
3.	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>
4.	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>

If you want to cover more children, please continue on a separate sheet.

## D. Product options – continued

### 4. Disability Cover

Do you require this benefit? Yes  No  If No please go to Section D5.

	First (or only) Life Assured	Second Life Assured (if applicable)
4.1 Disability Cover required?	£ <input type="text"/>	£ <input type="text"/>
4.2 What type of Disability Cover do you require?	Level 1 <input type="checkbox"/> OR Level 2 <input type="checkbox"/> OR Level 3 <input type="checkbox"/>	Level 1 <input type="checkbox"/> OR Level 2 <input type="checkbox"/> OR Level 3 <input type="checkbox"/>
If the Plan Account is set up on a decreasing basis, do not complete Question 4.3 and go to Section D5. Question 4.3 also applies to a Plan Account set up on a whole of life basis.		
4.3 What term do you require?	If your Plan Account has been set up on a fixed term basis, the same term as Plan Account in Section C <input type="checkbox"/> OR <input type="text"/> years OR <input type="checkbox"/> To Age 65 exactly OR <input type="checkbox"/> To Age 70 exactly	If your Plan Account has been set up on a fixed term basis, the same term as Plan Account in Section C <input type="checkbox"/> OR <input type="text"/> years OR <input type="checkbox"/> To Age 65 exactly OR <input type="checkbox"/> To Age 70 exactly

## D. Product options – continued

### 5. Income Protection Cover – if you select this option you must choose the Incapacity Waiver option in Section D7

Do you require this benefit? Yes  No  If No, please go to Section D6.

5.1 Do you want the monthly replacement income cover level, selected in 5.4 below, to be indexed in line with RPI? Yes  No

5.2 Do you want your premiums for Income Protection Cover to be guaranteed or reviewable? Guaranteed  OR Reviewable

5.3 If you make a claim, do you want the monthly replacement income benefit payment to be indexed in line with RPI? Yes  No

	First (or only) life assured	Second life assured (if applicable)
5.4 What amount of replacement income do you require each month?	£ <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"/> <input type="text"/> <input type="text"/>
The maximum amount of benefit that each applicant can choose is the monthly equivalent of 60% of the first £30,000 of pre-disability earnings and 50% of pre-disability earnings in excess of £30,000. This is subject to an overall maximum benefit of £12,500 each month.		
5.5 What deferred period do you want? You must choose the same deferred period for Waiver of Premium on Incapacity – see Section D7	1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Please choose one option only.	1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Please choose one option only.
5.6 What term do you require?	<input type="text"/> years OR <input type="checkbox"/> To Age 60 exactly OR <input type="checkbox"/> To Age 65 exactly OR <input type="checkbox"/> To Age 70 exactly	<input type="text"/> years OR <input type="checkbox"/> To Age 60 exactly OR <input type="checkbox"/> To Age 65 exactly OR <input type="checkbox"/> To Age 70 exactly
5.7 At what level and for how long would your income from employment continue if you are unable to work due to sickness or accident? This may affect any benefit you receive from us. For more details please see your Policy Summary document.	£ <input type="text"/> each month for <input type="text"/> months followed by £ <input type="text"/> each month for <input type="text"/> months	£ <input type="text"/> each month for <input type="text"/> months followed by £ <input type="text"/> each month for <input type="text"/> months

## D. Product options – continued

### 6. Unemployment Cover (UC)

Do you require this benefit? Yes  No  If No, please go to Section D7.

6.1 Do you want the monthly Unemployment Cover amount to be indexed in line with RPI? Yes  No

	First (or only) Life Assured	Second Life Assured (if applicable)
6.2 What amount of Unemployment Cover do you require each month?	£ <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"/>
The maximum amount of monthly benefit that each applicant can choose is 50% of the first £3,750 of gross monthly income and 33 <sup>1</sup> / <sub>3</sub> % of gross monthly income in excess of £3,750. This is subject to an overall maximum benefit of £2,500 each month.		
6.3 What deferred period do you require?	4 weeks <input type="checkbox"/> OR 13 weeks <input type="checkbox"/>	4 weeks <input type="checkbox"/> OR 13 weeks <input type="checkbox"/>
6.4 Do you want a maximum benefit payment period of 12 or 24 months?	12 months <input type="checkbox"/> OR 24 months <input type="checkbox"/>	12 months <input type="checkbox"/> OR 24 months <input type="checkbox"/>
6.5 What term do you require? (The minimum term is 5 years.)	<input type="text"/> years	<input type="text"/> years
<b>Unemployment Cover Eligibility</b>		
Please complete if you are applying for Unemployment Cover. If you answer Yes to any of the following questions, you will not be eligible for Unemployment Cover.		
6.6 Have you been unemployed or started/ceased trading (if self employed) in the last 6 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6.7 Are you aware of any impending redundancies or unemployment?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6.8 Are you going to be living and working outside of the UK when this plan starts?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

## D. Product options – continued

### 7. Waiver of Premium options

In the event of a claim, the benefits we pay under any of the Waiver of Premium options below will cover all Plan premiums for the first and second life assured (if applicable)

	First (or only) Life Assured	Second Life Assured (if applicable)
7.1 Do you require Waiver of Premium on Death? (This benefit is only available on joint life plans, where Life Cover isn't the only benefit.)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7.2 Do you require Waiver of Premium on Serious Illness? (This benefit is not available if Life Cover and/or Serious Illness Cover (at 100%) are the only benefits selected.)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7.3 Do you require Waiver of Premium on Incapacity?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7.3.1 Deferred period required. Please choose one option only.	1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/>	1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/>

Failure to disclose relevant information will result in non payment of a claim.

## E. Health and occupation details

First (or only) Life Assured

Second Life Assured (if applicable)

1. What is your height, weight and waist measurement? You should give your exact measurements. If unsure of these please check. Please provide imperial or metric measurements.

Please do not assume that we will contact or obtain a report from your Doctor.

Height	<input type="text"/>	Weight	<input type="text"/>	Height	<input type="text"/>	Weight	<input type="text"/>
Waist measurement	<input type="text"/>		Waist measurement	<input type="text"/>			

2. Have you smoked or used any tobacco products in the past 12 months? (Includes cigarettes, cigars, pipe, loose tobacco and any nicotine replacement therapy)

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

If Yes, please provide details of daily amounts:

If Yes, please provide details of daily amounts:

Cigarettes	<input type="text"/>	Cigarettes	<input type="text"/>
Cigars	<input type="text"/>	Cigars	<input type="text"/>
Pipe	<input type="text"/>	Pipe	<input type="text"/>
Tobacco	<input type="text"/>	Tobacco	<input type="text"/>
Nicotine Replacement Products	<input type="text"/>	Nicotine Replacement Products	<input type="text"/>

We will carry out random tests to confirm non-smoker status

3. (i) What is your occupation?

Occupation	<input type="text"/>	Occupation	<input type="text"/>
Business/Industry	<input type="text"/>	Business/Industry	<input type="text"/>

- (ii) Does your occupation involve any form of manual or physical activity (including, but not limited to, lifting and carrying or, standing for long periods)?

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

If Yes, please detail the main manual or physical tasks you do, starting with the task you do the most and specify the percentage of your day spent doing this task.

Task	% of day	Task	% of day
<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"/> %	<input type="text"/>	<input type="text"/> %
<input type="text"/>	<input type="text"/> %	<input type="text"/>	<input type="text"/> %

- (iii) Does your occupation involve any work at heights over 40 feet?

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

If Yes, please give full details i.e. maximum height at which you work

<input type="text"/>	<input type="text"/>
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Failure to disclose relevant information will result in non payment of a claim.

Where Yes is answered, please provide details.

## E. Health and occupation details – continued

First (or only) Life Assured

Second Life Assured (if applicable)

3. (iv) Does your occupation involve any work underground?

Yes  No

Yes  No

If Yes, please give full details including any use of explosives



(v) Does your occupation involve any work underwater?

Yes  No

Yes  No

If Yes, please give full details including any use of explosives, qualifications held, exactly where the underwater work takes place, and the reason for being underwater e.g. cable laying, research etc:



(vi) Does your occupation involve driving more than 18,000 miles each year?

Yes  No

Yes  No

(vii) Does your occupation involve working with any form of machinery or tool?

Yes  No

Yes  No

If Yes, please give full details i.e. Type of machinery/tools and % of day spent using machinery/tool



(viii) Are you self employed?

Yes  No

Yes  No

If No, please proceed to Question 3 (ix) below.

If Yes, have you been in your present occupation for less than two years?

Yes  No

Yes  No

If Yes, please provide details of how long you have been self-employed and details of your previous occupation



(ix) Are you a member of the armed forces, territorial army or a reservist?

Yes  No

Yes  No

If Yes, please provide the reason for cover, current location, future orders and details of duties and activities

Failure to disclose relevant information will result in non payment of a claim.

## E. Health and occupation details – continued

First (or only) Life Assured

Second Life Assured (if applicable)

4. Have you in the last 5 years or do you intend to:

(i) Take part in any sport or pastime which involves any additional risk of accident

Yes  No

Yes  No

If yes, please provide full details using the sports and pastimes questionnaire on page 23

(ii) Travel or reside abroad (apart from holiday visits)?

Yes  No

Yes  No

If Yes, please provide full details including exact area and country, dates, nature of visit and whether you intend to return abroad or to the UK

5. (i) Do you or have you ever consumed alcohol?

Yes  No

Yes  No

If Yes, what is your current average consumption of alcohol units per week? (1 unit = 1 single pub measure of spirits/ small (125ml) glass of wine or ½ pint of standard strength beer, lager or cider)

(ii) Have you ever sought or been advised to seek medical help for an alcohol problem or been advised to reduce your intake or have you ever consumed more than a weekly average of 28 units?

Yes  No

Yes  No

If YES, please provide details.

If YES, please provide details.

(iii) Have you ever used recreational drugs? This includes cannabis, ecstasy, cocaine, heroin or similar substances

Yes  No

Yes  No

If YES, please provide details.

If YES, please provide details.

Failure to disclose relevant information will result in non payment of a claim.

Please do not assume that we will contact or obtain a report from your Doctor.

### E. Health and occupation details – continued

First (or only) Life Assured

Second Life Assured (if applicable)

6. Have you ever tested positive for HIV, Hepatitis B or C, or are you awaiting the results of such a test? Note: If the result is negative, the fact of having an HIV test will not, in itself, have any effect on your acceptance terms for insurance

Yes  No

Yes  No

If YES, please give full details, including nature and date of test.

This information may be sent in confidence direct to our Chief Medical Officer, PruProtect, Stirling FK9 4UE.

If you answer any part of Questions 7 – 11 Yes, then please complete the Medical Questionnaire(s) beginning on page 24 for each Yes answer.

7. Have you ever had any of the following:

(i) Cancer, leukaemia, Hodgkin's disease, lymphoma, brain or spinal tumour?

Yes  No

Yes  No

(ii) Heart disease or disorder – including heart attack, angina, heart murmur, cardiomyopathy, heart valve defect or heart surgery?

Yes  No

Yes  No

(iii) Stroke or transient ischaemic attacks, brain haemorrhage or permanent brain injury through accident?

Yes  No

Yes  No

(iv) Multiple sclerosis, optic neuritis, epilepsy, paralysis, muscular dystrophy, Parkinson's disease, dementia, Alzheimer's, cerebral palsy, motor neurone disease or any other disorders of the brain or nerves.

Yes  No

Yes  No

(v) Disease, or disorder of the blood vessels – including circulation problems in the legs?

Yes  No

Yes  No

(vi) Diabetes or sugar in the urine?

Yes  No

Yes  No

(vii) Mental illness that has required hospital treatment or referral to a psychiatrist or other specialist?

Yes  No

Yes  No

## E. Health and occupation details – continued

First (or only) Life Assured

Second Life Assured (if applicable)

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

- (i) A lump or growth of any kind; or any mole or freckle that has bled, become painful, changed colour or increased in size?

Yes

No

Yes

No

- (ii) Chest pain, irregular heart beat, raised blood pressure or raised cholesterol?

Yes

No

Yes

No

- (iii) Numbness, tremor, tingling, facial pain, visual disturbance including blurred vision or double vision, dizziness, chronic fatigue or tiredness?

Yes

No

Yes

No

- (iv) Seizure, fits, fainting or blackouts?

Yes

No

Yes

No

- (v) Any disorder of the digestive system, liver, stomach, pancreas or bowel – including gastric or duodenal ulcer, hepatitis, colitis or Crohn's disease?

Yes

No

Yes

No

- (vi) Any disorders of the kidneys, bladder or prostate – including blood or protein in the urine or urinary tract infections?

Yes

No

Yes

No

- (vii) Blood disorder or anaemia?

Yes

No

Yes

No

- (viii) Any disorder of the adrenal, pituitary or thyroid glands?

Yes

No

Yes

No

- (ix) Any disorder of the lungs or respiratory system – including asthma or bronchitis?

Yes

No

Yes

No

- (x) Any pain or problem relating to your back, neck, joints, bones or muscles including arthritis, slipped disc, rheumatism or gout?

Yes

No

Yes

No

- (xi) Any form of mental illness including anxiety, depression, stress, nervous breakdown or eating disorders?

Yes

No

Yes

No

- (xii) Disorder of the eyes including blindness or problems with sight – you can ignore sight problems fully corrected by glasses or contact lenses?

Yes

No

Yes

No

Failure to disclose relevant information will result in non payment of a claim.

## E. Health and occupation details – continued

First (or only) Life Assured

Second Life Assured (if applicable)

(xiii) Disorder of the ears including difficulty hearing?

Yes  No

Yes  No

(xiv) Any gynaecological disorder (including abnormal cervical smears) or breast condition for which you have been referred to a specialist or required investigations or treatment?

Yes  No

Yes  No

(xv) Syphilis or gonorrhoea?

Yes  No

Yes  No

9. In the last 5 years have you:

(i) Undergone or been advised to have any investigation, x-ray, scan or blood test for any condition not already mentioned?

Yes  No

Yes  No

(ii) Received any form of medical attention, including any surgical procedures at a hospital, for any condition not already mentioned?

Yes  No

Yes  No

10. In the last 5 years have you been **off work** for **2 weeks or more** for any medical condition, illness or injury not already mentioned?

Yes  No

Yes  No

11. (i) Are you aware of any other medical condition or symptoms where you intend to seek medical advice or are you waiting for the results of any medical investigation?

Yes  No

Yes  No

(ii) Are you currently taking prescribed drugs, medicines, tablets or any other form of treatment? (Oral contraception can be disregarded)

Yes  No

Yes  No

## E. Health and occupation details – continued

First (or only) Life Assured

Second Life Assured (if applicable)

12. Before the age of 65, did either of your parents or any brothers or sisters, suffer or die from:

Cancer?

Yes  No

Yes  No

Heart disease, stroke or diabetes?

Yes  No

Yes  No

Multiple sclerosis or Alzheimers disease?

Yes  No

Yes  No

Muscular dystrophy, Parkinson's disease, motor neurone disease or haemochromatosis?

Yes  No

Yes  No

Huntington's disease, polycystic kidney disease or polyposis of the colon?

Yes  No

Yes  No

Any other potentially hereditary disease or disorder?

Yes  No

Yes  No

First Life – If Yes, please complete this table

Relative	Current age of relative	Age of relative at diagnosis	Medical condition(s) – if cancer please state which part of the body is affected	Age at death (if applicable)

Second Life – If Yes, please complete this table.

Relative	Current age of relative	Age of relative at diagnosis	Medical condition(s) – if cancer please state which part of the body is affected	Age at death (if applicable)

Failure to disclose relevant information will result in non payment of a claim.

### F. Doctor/Clinic details

#### First (or only) Life Assured

1. Please provide doctor/clinic details

Name of Doctor

Address/Clinic

  
  

Telephone Number

#### Second Life Assured (if applicable)

Name of Doctor

Address/Clinic

  
  

Telephone Number

i) Have you been with your doctor/clinic for less than 6 months?

Yes  No

Yes  No

If 'Yes', please provide previous doctor/clinic details.

Name of Doctor

Address/Clinic

  
  

Telephone Number

Name of Doctor

Address/Clinic

  
  

Telephone Number

2. In the event that a Medical Examination might be required, please select the doctor/clinic that you would prefer to carry out this examination:

PruProtect nominated doctor/clinic

PruProtect nominated doctor/clinic

Own doctor

Own doctor

### G. Confirmation schedule details – for joint online submission only, otherwise go to section H

Are you using this form for full online submission? Yes  Please complete Question 1 below unless this is a single life application in which case please proceed to Section H.

No  Please go to Question 2 below.

1. We will be issuing the Confirmation Schedule for both lives to the address of the first life. Is this acceptable? Yes  No

If no is selected then we will issue a separate Confirmation Schedule to each life individually. Go to section H

2. If you are using this document as:

- a full paper application, please go to Section H on page 23

Failure to disclose relevant information will result in non payment of a claim.

## H. Sports and pastimes supplementary questionnaire

– Only complete if you have answered Yes to Question 4 (i) on page 17.

First (or only) Life Assured

Second Life Assured (if applicable)

### Disclosure 1:

Name of activity(s) – include names of ALL aspects of the activity you take part in.

Names of any qualifications held and how long it has been held.

Qualification(s):  
  
Years held:

Qualification(s):  
  
Years held:

Where do you take part in this activity – i.e venue type, area of the world etc?

How many times a year do you take part?

How many times a year do you take part?

Do you ever take part alone? Yes  No

Do you ever take part alone? Yes  No

What heights/depths do you go to?

Height  m Depth  m

Height  m Depth  m

### DISCLOSURE 2:

Name of activity(s) – include names of ALL aspects of the activity you take part in.

Names of any qualifications held and how long it has been held.

Qualification(s):  
  
Years held:

Qualification(s):  
  
Years held:

Where do you take part in this activity – i.e venue type, area of the world etc?

How many times a year do you take part?

How many times a year do you take part?

Do you ever take part alone? Yes  No

Do you ever take part alone? Yes  No

What heights/depths do you go to?

Height  m Depth  m

Height  m Depth  m

Failure to disclose relevant information will result in non payment of a claim.

Please do not assume that we will contact or obtain a report from your Doctor.

### I. Medical questionnaire – Disclosure 1:

– Only complete if you have answered Yes to any parts of Questions 7 – 11 in section E.

Which Yes answer are you completing this questionnaire for?

First (or only) Life Assured

Second Life Assured (if applicable)

(Please note that not all questions will be relevant for each Medical Disclosure made)

First (or only) Life Assured

Second Life Assured (if applicable)

What is the medical condition?

What is the medical condition?

Has the diagnosis been confirmed?

Yes  No

Yes  No

Are you having investigations into a cause for your symptoms?

Yes  No

Yes  No

When did symptoms of this condition first occur?

When did symptoms of this condition first occur?

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

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

When did you last have symptoms?

When did you last have symptoms?

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

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

Do you have recurrent symptoms?

Yes  No

Do you have recurrent symptoms?

Yes  No

If yes, please give details of how many episodes or attacks of symptoms you have had since onset of condition and describe the nature and severity of the symptoms.

Do they restrict you in any way? Yes  No

Do they restrict you in any way? Yes  No

If yes, please give details of the problems experienced

Have you seen a specialist for the condition?

Yes  No

Have you seen a specialist for the condition?

Yes  No

If yes, please give their name and address, the last date you attended and whether you are still attending them or not.

What medical investigations have been performed?

What were the results (if known) and the dates they were done?

Failure to disclose relevant information will result in non payment of a claim.

Please do not assume that we will contact or obtain a report from your Doctor.

## I. Medical questionnaire – continued

– Only complete if you have answered Yes to any parts of Questions 7 – 11 in section E.

### First (or only) Life Assured

Have all investigations now been completed?

Yes  No

Are you waiting for any follow-ups or reviews?

Yes  No

When did you last see your GP with this condition?

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

### Second Life Assured (if applicable)

Have all investigations now been completed?

Yes  No

Are you waiting for any follow-ups or reviews?

Yes  No

When did you last see your GP with this condition?

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

How many times have you been admitted to hospital for this condition and when was the last time?

No. of admissions

Date 

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

No. of admissions

Date 

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

When was the last time you went to hospital as an outpatient for investigations or check-ups for this condition?

Date 

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

Date 

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

What treatment has been prescribed? (This should include details of all oral steroid prescriptions, e.g. prednisolone.) Please continue on a separate sheet if necessary.

Name of treatment

Dose (if known)

Is the treatment continuing? Yes  No

If not, when did it stop?

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

Have you required time off work? Yes  No

If Yes, please give date(s) of time off work and for how long you were absent from work.

When was this? 

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

Name of treatment

Dose (if known)

Is the treatment continuing? Yes  No

If not, when did it stop?

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

Have you required time off work? Yes  No

If Yes, please give date(s) of time off work and for how long you were absent from work.

When was this? 

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

Is any operation planned or being considered?

Yes  No

What type of operation?

If Yes, when is it planned?

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

Is any operation planned or being considered?

Yes  No

What type of operation?

If Yes, when is it planned?

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

Failure to disclose relevant information will result in non payment of a claim.

Please do not assume that we will contact or obtain a report from your Doctor.

### I. Medical questionnaire – Disclosure 2:

– Only complete if you have answered Yes to any parts of Questions 7 – 11 in section E.

Which Yes answer are you completing this questionnaire for?

First (or only) Life Assured

Second Life Assured (if applicable)

(Please note that not all questions will be relevant for each Medical Disclosure made)

First (or only) Life Assured

Second Life Assured (if applicable)

What is the medical condition?

What is the medical condition?

Has the diagnosis been confirmed?

Yes  No

Yes  No

Are you having investigations into a cause for your symptoms?

Yes  No

Yes  No

When did symptoms of this condition first occur?

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

When did symptoms of this condition first occur?

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

When did you last have symptoms?

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

When did you last have symptoms?

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

Do you have recurrent symptoms?

Yes  No

Do you have recurrent symptoms?

Yes  No

If yes, please give details of how many episodes or attacks of symptoms you have had since onset of condition and describe the nature and severity of the symptoms.

Do they restrict you in any way? Yes  No

Do they restrict you in any way? Yes  No

If yes, please give details of the problems experienced

Have you seen a specialist for the condition?

Yes  No

Have you seen a specialist for the condition?

Yes  No

If yes, please give their name and address, the last date you attended and whether you are still attending them or not.

What medical investigations have been performed?

What were the results (if known) and the dates they were done?

Failure to disclose relevant information will result in non payment of a claim.

Please do not assume that we will contact or obtain a report from your Doctor.

### I. Medical questionnaire – continued

– Only complete if you have answered Yes to any parts of Questions 7 – 11 in section E.

#### First (or only) Life Assured

Have all investigations now been completed?

Yes  No

Are you waiting for any follow-ups or reviews?

Yes  No

When did you last see your GP with this condition?

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

How many times have you been admitted to hospital for this condition and when was the last time?

No. of admissions

Date 

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

When was the last time you went to hospital as an outpatient for investigations or check-ups for this condition?

Date 

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

What treatment has been prescribed? (This should include details of all oral steroid prescriptions, e.g. prednisolone.) Please continue on a separate sheet if necessary.

Name of treatment

Dose (if known)

Is the treatment continuing? Yes  No

If not, when did it stop?

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

Have you required time off work? Yes  No

If Yes, please give date(s) of time off work and for how long you were absent from work.

When was this? 

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

Is any operation planned or being considered?

Yes  No

What type of operation?

If Yes, when is it planned?

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

#### Second Life Assured (if applicable)

Have all investigations now been completed?

Yes  No

Are you waiting for any follow-ups or reviews?

Yes  No

When did you last see your GP with this condition?

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

No. of admissions

Date 

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

Date 

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

Name of treatment

Dose (if known)

Is the treatment continuing? Yes  No

If not, when did it stop?

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

Have you required time off work? Yes  No

When was this? 

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

Is any operation planned or being considered?

Yes  No

What type of operation?

If Yes, when is it planned?

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

Please continue on a separate sheet if necessary.

## J. Access to Medical Records

Please read the following information relating to your medical records

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.
- Any care, medication or treatment you are currently receiving.
- The results of referrals or tests you are waiting for.
- Any time off work in the last three years.
- Your past health.
- Details of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your GP or any other medical adviser, therapist or counsellor, in particular whether you have a history of:

- malignancy (cancer), cardiovascular (heart) disease, diabetes, and degenerative (gradually worsening) diseases;
- musculo-skeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles;
- anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue;
- suicidal thoughts or attempts at suicide; or
- conditions related to drug or alcohol misuse or smoking or chewing tobacco.
- Details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations.
- Any blood pressure readings in the last three years.
- Any history of disease among your parents or brothers or sisters that you have told your doctor about.

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

**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:

**Chief Medical Officer**  
PruProtect,  
Stirling FK9 4UE

**Important notes**

The plan will not start until we have assessed and accepted your application, and we have been advised of the start date. If you have a birthday while your application is being processed, the terms may differ from those originally quoted.

In most instances your payments will be as originally quoted. We may offer you revised terms, but occasionally we may not be able to offer any terms.

We may ask you to contact your doctor if we are waiting for reports which we have asked for.

If we ask you to undertake a medical examination, we will need to share the application information with

another company we have authorised. They will make the arrangements for the examination to take place.

We may need to send your application and relevant medical reports to our reassurers for their opinion or agreement of the terms offered. Or, we may need to send them at a later stage for purposes relating to managing the policy. You can get details of general reinsurance principles and details of any company we use to assess your application, from our head office.

We have a confidentiality policy in place which means we hold your medical information securely and access is limited to authorised individuals who need to see it.

**K. Medical Report Act Declaration**

You are entitled to ask for a copy of our standard terms and conditions and a copy of your application form at any time.

It is our policy to obtain a random sample of medical reports shortly after acceptance of insurance contracts to monitor the accuracy and completeness of the information given. By signing the declaration you will

be giving us the right to request a medical report.

We will write to tell you if we require such a report.

Your rights under the Access to Medical Reports Act remain the same. In the event that the medical report highlights a material fact that you have knowingly failed to disclose, we reserve the right to reconsider the terms offered to you or cancel the policy.

**PLEASE SIGN DECLARATION ON PAGE 30**

## K. Medical Report Act Declaration

■ I/We agree to you asking any doctor I/we have consulted about my/our physical or mental health to provide medical information so you may assess my/our proposal. You may gather relevant information from other insurers about any other applications for life, critical illness, sickness, disability, accident or private medical insurance that I/we have applied for. I/We authorise those asked to provide medical information when they see a copy of this consent form. This form allows

you to gather medical reports within six months of the start of the plan, or after my/our death, to support any claim made on the plan proceeds.

■ This information can also be used to maintain management information for business analysis.

I/We have read the declaration, important notes and information relating to my rights under the Access to Medical Reports Act 1988.

### SIGNATURE OF FIRST OR ONLY LIFE ASSURED

First Name

Surname

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

Signature

Date of birth

Date

### SIGNATURE OF SECOND LIFE ASSURED

First Name

Surname

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.

Signature

Date of birth

Date

If you are applying online, please record the Application Reference Number in the box below, as shown on the adviser zone at [www.pruprotect.co.uk](http://www.pruprotect.co.uk)

Application Reference Number:

(to be completed by the Financial Adviser)

## L. Direct Debit form

Please record the customer details below.

First (or only) Life Assured

(to be completed by the Financial Adviser)

Date of Birth

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

(to be completed by the Financial Adviser)

On what date of the month do you want us to collect your premiums?  
(this must be between 1st and 28th of the month)

of the month

### Paper Submission

For a full application, please ensure your client completes and signs the Direct Debit instruction below.

### Data Capture Form

Please collect the direct debit details below so that you can submit the details online. However, your clients can complete and sign the Direct Debit instruction below and you can send this to us at:

### PruProtect

Customer Services  
New Business  
Stirling FK9 4UE

## PRU PROTECT

Instruction to your Bank or Building Society to pay Direct Debits



Please fill in the form and send to: PruProtect, Stirling, FK9 4UE.

Name and full postal address of your Bank or Building Society

To: The Manager	Bank or Building Society
Address	
Postcode	

Name(s) of Account Holder(s)

Branch Sort Code

--	--	--	--	--	--

Bank/Building Society account number

--	--	--	--	--	--	--	--

Originator's Identification Number

5	9	9	6	7	5
---	---	---	---	---	---

Reference Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Instruction to your Bank or Building Society

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

Signature(s)

Date

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

This guarantee should be detached and retained by the Payer.

## The Direct Debit Guarantee



- 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, PruProtect will notify you at least 5 working days in advance of your account being debited or as otherwise agreed.
- If an error is made by PruProtect 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 PruProtect.

## M. Full Paper Application Client Declaration, Authority and Consent

Please complete this section with your client(s) if you are using this document as a full paper application form.

### Declaration

I/We the Applicant(s) declare that, to the best of my/our knowledge and belief, the information on this form is true and complete and agree that the terms of this Application and Declaration and any statements made by the life or lives to be assured to PruProtect's Medical Examiner together with PruProtect's Letter of Acceptance will be deemed to form part of any resultant contracts.

I/We will inform you immediately of any changes that occur before the plan starts. I/We understand that failure to do so may result in the contract being declared void, and that a claim for the proceeds may not be paid.

\* I/We authorise my/our Financial Adviser to act on my/our behalf to amend the sum(s) to be assured or term of the assurance applied for to correspond with any alteration in detail of the mortgage from that set out in this Application and to agree the commencement date of the plan with PruProtect.

**\* Delete this paragraph only if you do NOT wish your Financial Adviser to act on your behalf to make changes or start the plan**

I/We consent to PruProtect seeking details of the mortgage from the lender.

I/We am/are aware that the income benefits I/we receive could affect the amount of any income support/income based Jobseekers Allowance, should I/we be eligible for state help.

The Direct Debit Guarantee

## M. Full Paper Application Client Declaration, Authority and Consent – continued

### Unemployment Cover

Where I/we have elected to apply for Unemployment Cover, I/we understand that by signing this application form, I am/we are applying for two separate contracts. I/We understand that the Unemployment Cover is provided by St Andrew's Insurance plc. It is noted that Prudential reserve the right to change the provider of this benefit in the future.

I/We further understand that the information supplied will be forwarded to St Andrew's Insurance plc and that insurers share information with each other regarding Unemployment Cover, to prevent fraudulent claims. This system utilises a register of claims, and a list of participants is available on request. I/We accept that information supplied on this form and the claim form, together with any other information relating to the claim, will be provided to the register.

### General information

1. By returning this form to us you consent to our processing sensitive personal data about you where this is necessary.
2. Copies of the Rules for PruProtect Plan, which include the Unemployment Cover Rules, and the completed Application Form are available on request.
3. If anyone else fills in this Application on your behalf, he/she does so as your agent and not as an agent of Prudential. He/she does not have the authority to accept this Application on behalf of Prudential.
4. Completion of the Direct Debiting Instruction does NOT imply commencement of Life Assurance risk. Prudential's Letter of Acceptance will indicate when the Assurance will commence. In most instances your payments will be as originally quoted. Revised terms may be offered to you, for example if you have a birthday while your application is being processed but occasionally we may be unable to offer any terms.
5. The Direct Debiting Instruction attached is designed to enable you to pay premiums to Prudential with the minimum of inconvenience as and when they fall due. If the amount payable under your Instruction is due to be altered, Prudential will advise you of details of the new amount shortly before your account is due for debiting.

Direct Debits under this Instruction will be originated only in respect of premiums payable in accordance with the terms of the plan for which it is drawn.

6. If the Applicant is not the Life or Lives to be assured, you must have sufficient insurable interest to be able to apply for the plan on this basis. If in doubt, please check with your financial adviser that sufficient insurable interest exists.

### How we use your personal data

PruHealth & PruProtect, our group of companies and our business associates, service providers and agents will use your information, together with other information, for administration, customer services, marketing and profiling your purchasing preferences and fraud prevention. We will pass your information to them for these purposes.

We will pass your information to any legal or regulatory body if required to do so.

By submitting this form you consent to us processing your sensitive personal information; such as health data.

For the above purposes it will be necessary to transfer your information to countries that provide a different level of data protection from the UK. We have contracts in place to ensure your information is protected.

You have a right to obtain a copy of your personal information (for which we may charge a fee) and to have any inaccuracies corrected by writing to: The Privacy Manager, Information Risk and Privacy Team, Prudential Assurance Company Ltd, 3 Sheldon Square, London, W2 6PR.

### Acting on someone's behalf?

When giving us information about another person, you confirm that they have appointed you to act on their behalf. This includes providing consent to process the personal data, receive this data protection notice on their behalf and receive marketing information.

## M. Full Paper Application Client Declaration, Authority and Consent – continued

I/We have read the Information relating to my/our rights under the Data Protection Act, the Declaration, Important Notes and General Information.

Signature of First or Only Life Assured

Signature

X
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Date

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

Signature of Second Life Assured

Signature

X
---

Date

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

Signature of Applicant if different

Signature

X
---

Date

D	D	M	M	Y	Y	Y	Y
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Please complete the Direct Debiting Instruction on page 31.

**For more information**  
visit [www.pruprotect.co.uk](http://www.pruprotect.co.uk) or call 0845 601 0072

**PRU PROTECT**  
It pays to be healthy

Prudential Assurance Company provide and manufacture benefits under the plan. Prudential Health Services Limited distribute and service the product and issue the documentation. PruProtect is a trading name of Prudential Health Services Limited and Prudential is a trading name of Prudential Assurance Company. Both companies are registered in England and Wales and have their registered offices at Laurence Pountney Hill, London EC4R 0HH. Prudential Health Services Limited is registered number 5933141 and Prudential Assurance Company Limited is registered number 15454. Prudential Health Services Limited and Prudential Assurance Company Limited are authorised and regulated by the Financial Services Authority.

PRUPT10028 09/2007