

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	196591370
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"/>

For Intermediary use only

- Please tick this box if you have made a personal recommendation to your customer to buy this plan.
- Please tick this box if commission details are to be shown on the Personal Illustration. Please note this only applies to Pure Protection applications.

Application Form

Mortgage | Term Personal | Term Business

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the application.

Important: What product are you applying for? Please tick ONE box.

- Self Assurance Term Personal
- Self Assurance Mortgage
- Self Assurance Term Business

Note: If you do not tick one of the boxes we will not be able to proceed with your application. We will return the form to you to complete this.

Please complete and return to: New Business Department, Scottish Provident, 301 St Vincent Street, Glasgow G2 5PB.

Changes of circumstances

It is very important that you tell us if there is a change to your personal health, your family's medical history, any occupation change, participation in hazardous pursuits, travel or residence – between completing this form and your plan starting. If you do not do this, and this affects our assessment of risk, your insurance may be void.

Important information

You can ask us for copies of the Product Guide, the completed Application Form and the ABI Genetic Testing Code of Practice.

We will use the information you give us on this form to assess the insurance risk. You must fill in the form fully and truthfully to the best of your knowledge and belief. **If you are in any doubt about whether to provide information when filling in the form, please provide the information. You may need to consult a doctor before being able to provide the information. Please note that any new information, not provided when you applied, that comes to light at claim stage (even if it is unconnected to the condition that you are claiming for) could mean your plan will not pay out.**

In line with the ABI's policy on genetics and insurance, you do not need to tell us about any predictive genetic test result you have had unless you are applying for life insurance which, when added to any existing life insurance policies you have, exceeds £500,000 of cover. If you are applying for life insurance which exceeds £500,000 of cover, when combined with any of your existing life insurance policies, you need to tell us in this Application Form about any predictive genetic test results you have had for Huntington's disease. If you have had any genetic test and feel that the result may be in your favour then you may inform us of this if you wish.

If you would like this information in large print, in Braille or on cassette or CD, please call 0845 271 0900

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the application.

Application for protection - Self Assurance is a flexible protection product. After you have set it up you can ask us to change your benefits to suit your changing needs.

How to fill in this form - Please use BLOCK CAPITALS throughout.

Please use a BLACK ballpoint pen. Please use a separate piece of paper if you need any more space for any of your answers.

APPLICANT(S) PERSONAL DETAILS

If lives being assured are NOT the applicants please complete the following details.

	First applicant	Second applicant
Full name	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Address	<input style="width: 100%; height: 40px;" type="text"/>	<input style="width: 100%; height: 40px;" type="text"/>
Postcode	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Date of birth	<input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/>	<input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/>
What is your country of habitual residence (or registration for companies)? Please read the definition of "habitual residence" in the Self Assurance Product Guide.	<input type="checkbox"/> UK <input type="checkbox"/> Channel Islands <input type="checkbox"/> Isle of Man	<input type="checkbox"/> UK <input type="checkbox"/> Channel Islands <input type="checkbox"/> Isle of Man
Country of Nationality?	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Country of Dual Nationality?	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
What is your relationship to or the nature of your interest in the life or lives to be assured?	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>

PERSONAL DETAILS OF LIFE OR LIVES TO BE ASSURED

	First life	Second life
Title (Mr/Mrs/Miss/Ms/Dr or other)	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Sex (please tick)	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F
Surname	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Forenames (in full)	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
If the lives assured are also the applicants we will use the address for the first life assured for all correspondence, otherwise we will use the address for the first applicant from above unless you advise us differently.		
Address	<input style="width: 100%; height: 40px;" type="text"/>	<input style="width: 100%; height: 40px;" type="text"/>
Postcode	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Telephone no.	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Day	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Night	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Mobile	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
E-mail address	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Date of birth	<input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/>	<input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; text-align: center; border: 1px solid black;" type="text"/>
If you want to admit your age on your plan, we will need to see your original birth certificate(s) and, if you are a married woman, your original marriage certificate to authenticate these details.		
What is your country of habitual residence?	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Please read the definition of "habitual residence" in the Self Assurance Product Guide.

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PERSONAL DETAILS OF LIFE OR LIVES TO BE ASSURED (CONT'D)

	First life	Second life
Country of Nationality?	<input type="text"/>	<input type="text"/>
Country of Dual Nationality?	<input type="text"/>	<input type="text"/>
Were you born outside the UK, Channel Islands or the Isle of Man?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, have you been resident in the UK, Channel Islands or Isle of Man for less than 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how long have you been resident in the UK, Channel Islands or Isle of Man?	<input type="text"/> months	<input type="text"/> months
In the last 24 months have you been outside the UK, Channel Islands or Isle of Man for more than 30 consecutive days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, which country?	<input type="text"/>	<input type="text"/>
For how long?	<input type="text"/> weeks	<input type="text"/> weeks
Marital status	<input type="checkbox"/> Single <input type="checkbox"/> Married/civil partnership <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow(er) <input type="checkbox"/> Partner	<input type="checkbox"/> Single <input type="checkbox"/> Married/civil partnership <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow(er) <input type="checkbox"/> Partner

HEIGHT AND WEIGHT

It is very important that you provide accurate height and weight readings in these boxes. If you are in any doubt, please measure and weigh yourself now before completing this section.

What is your height?	<input type="text"/> ft/in or <input type="text"/> m/cm	<input type="text"/> ft/in or <input type="text"/> m/cm
What is your weight?	<input type="text"/> st/lbs or <input type="text"/> kg	<input type="text"/> st/lbs or <input type="text"/> kg

In the last six months has your weight decreased by more than 3kg/7lbs, through non-diet loss?

Yes No Yes No

If yes, please supply details (please advise how much weight over what period of time and was there any known reason?)

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NAME AND ADDRESS OF YOUR DOCTOR

Please provide details of your previous doctor in the additional information section on page 12 if you have changed doctor in the last 6 months. See page 23 for consent to access to personal files and medical reports.

Name of doctor or practice	<input type="text"/>	<input type="text"/>
Address/postcode	<input type="text"/>	<input type="text"/>
Telephone no.	<input type="text"/>	<input type="text"/>

TRUST

If required, please tick box

If you tick this box we will not issue the policy until you send us the trust form.

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the application.

OCCUPATION DETAILS

First life

Second life

What is your occupation? (please tell us your exact job title or state whether unemployed or retired)

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Sometimes your job title may not clearly describe the type of work you do. If this is the case, it will help us to process your application if you give us a full description of your job. If you need more space, please use the additional information section on page 12.

Job description

--	--

The industry in which you work

--	--

Are you employed or self-employed?

--	--

How many hours do you usually work each week?

--	--

Are you a member of the Armed Forces, TA or reservists?

Yes No

Yes No

If yes, please advise Rank

--	--

Are you under orders or on standby to serve abroad or in any area of conflict?

Yes No

Yes No

If yes, please supply full details

--	--

Are you involved in any hazardous activities, for example, aviation, diving, parachuting, bomb disposal or special service groups?

Yes No

Yes No

If yes, please provide details

--	--

Have you been advised that any part of your unit, wing, crew or military equivalent is under orders or on standby for any troubled area?

Yes No

Yes No

If yes, please supply full details

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Does your occupation involve manual work, driving or working at heights?

Yes No

Yes No

If yes, please advise the percentage of your working day. If some of these activities do not apply to you, please state NIL in the box provided. Failure to give details of your activities may result in us not being able to pay a claim. If you want a second occupation to be covered under disability income benefit, please provide full occupational details in the additional information section on page 12.

%	Manual work
%	Driving
%	Working at heights
	Typical height (ft/m)

%	Manual work
%	Driving
%	Working at heights
	Typical height (ft/m)

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the application.

SMOKING

First life

Second life

Have you used any tobacco products in the last 12 months? If no, we may ask for a simple medical test to confirm this.

Yes No

Yes No

If yes, state your average WEEKLY usage:

Cigarettes

Cigars

Grammes of pipe tobacco

If no, have you ever smoked?

Yes No

Yes No

If yes, when did you stop?

ALCOHOL

Do you drink, or have you ever drunk, more than 35 units of alcohol per week on a regular basis? One unit is defined as 1/2 pint of beer, or 1 glass of wine (125ml), or 1 measure (25ml) of spirits.

Yes No

Yes No

If yes, please provide details

Have you ever been given, or sought, advice from any medical practitioner in relation to your consumption of alcohol?

Yes No

Yes No

If yes, please provide details

TRAVEL AND PURSUITS

Please answer the following questions in as much detail as possible. In some circumstances we may have to contact you for further information.

a) Have you any intention of travelling abroad (other than for holidays of less than 30 consecutive days)?

Yes No

Yes No

If yes, please provide details

b) Have you any intention to participate in any hazardous sport or leisure activity? Hazardous pursuits could include, for example, aviation, caving/potholing, climbing, diving, horseriding, motorsports, mountaineering or yachting.

Yes No

Yes No

c) What is the activity you participate in?

d) Do you participate in an amateur or professional basis?

e) How long have you been involved in this?

f) How often do you participate per year (hours or events)?

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TRAVEL AND PURSUITS (CONT'D)

First life

Second life

- g) Will this increase in the future? Yes No Yes No
 If yes, please provide details
- h) Are you a member of a professional organisation or do you hold approved qualifications (e.g. SMC, PADI etc)
- i) Please give maximum heights, depths or other extremes involved
- j) Do you participate in any racing, record attempts or any other competitive or specialist events?
- k) Do you, or do you intend to receive sponsorship or participate in activity outside the UK?
- l) Have you ever suffered any injury as a result of this activity?

Please complete the following additional sections if relevant to you

Motor Sport

- a) What type of vehicle do you use (include engine capacity)?
- b) What categories/formula do you compete in?
- c) What type of licence do you hold?

Diving

- a) In which locations do you dive? (e.g. lakes, rivers, caves, wrecks etc)
- b) Do you ever dive alone? Yes No Yes No
- c) When was your last medical exam and what was the result?

Aviation

- a) What type of aircraft do you fly as a pilot?
- b) How many hours each year do you fly as a pilot?
- c) How many hours each year do you fly as a passenger?
- d) Are all flights between licensed airfields? Yes No Yes No
- e) Do you have any additional qualifications? (e.g. night rating, instructor, IMC)

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TRAVEL AND PURSUITS (CONT'D)

First life

Second life

Climbing or Mountaineering

a) Which best describes your activity – Hillwalking, Rock Climbing or Mountaineering?

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b) To which level do you participate? (Easy, Moderate, Difficult, Very Difficult, Severe, Very Severe, Hard Very Severe, Extremely Severe)

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c) How many climbs do you undertake per year?

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d) Where do you climb? (e.g. UK, Europe, Other)

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PREVIOUS PROPOSALS

a) Have you any existing policies or pending applications (other than this one) for life insurance, critical illness cover or income protection for Scottish Provident Self Assurance or Pegasus products?

Yes No

Yes No

b) Does the total amount of death benefit that you already have (including any cover that is currently proposed or contemplated) with any insurance companies, in total exceed £10 million? Death benefits could include life assurance, accelerated critical illness cover, endowments etc.

Yes No

Yes No

c) Do you have any existing, or are you currently applying for, any other insurance covers?

Yes No

Yes No

If yes, please supply benefit amounts (ticking NIL if applicable) and names of insurers:

Death Benefit	£	or NIL <input type="checkbox"/>		£	or NIL <input type="checkbox"/>	
Critical Illness	£	or NIL <input type="checkbox"/>		£	or NIL <input type="checkbox"/>	
Income Protection	£	or NIL <input type="checkbox"/>		£	or NIL <input type="checkbox"/>	
Accident, Sickness and Unemployment	£	or NIL <input type="checkbox"/>		£	or NIL <input type="checkbox"/>	

d) Have you ever had an application for life insurance, critical illness cover or income protection insurance on your life refused, postponed or accepted on special terms by any insurance company?

Yes No

Yes No

If yes, please give dates and names of insurers:

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PREMIUMS

How you can pay premiums

Monthly Annually

Premium amount

£

Monthly premiums must be by Direct Debit. Annual payments must be by either cheque or Direct Debit.

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the application.

PREMIUM PAYMENT DETAILS

If the premium for the plan is over £50 per month or £600 per year, please complete the following sections, which will allow us to determine if a 'Source of funds' concession can be applied (see page 25 for more details).

DIRECT DEBIT AND CHEQUE

Premiums being paid by?

- First Applicant
- Second Applicant
- Both Applicants
- Third Party Payer

If joint life case and premiums only paid by one applicant what is the Relationship of the premium payer to other applicant?

- Spouse/Civil Partner
- Other

Source of funds concession can be applied to the premium payer and non premium paying applicant if the relationship is "Spouse/Civil partner". If the relationship is "Other" an IVC (Introduction Verification Certificate) is required in respect of the non premium paying applicant or copy documents must be submitted for Execution Only applications.

If third party payer, what is the Relationship of the third party payer to applicant(s)?

- Relative/Spouse/Civil Partner
- Employer
- Other

If "Other" what type of account is the premium payment being paid from?

- Individual
- Corporate

Third party payer name

Additional third party payer name

(e.g. if A/C name is Mr & Mrs Smith)

If premiums are being paid by a third party payer an IVC completion is required in respect of the applicant(s).

Source of funds concession can be applied to the third party payer if the relationship to the applicant(s) is Relative/Spouse/Partner or Employer. If the relationship is "Other" an IVC is also required in respect of the third party payer(s) or copy documents must be submitted for Execution Only applications.

If required we can carry out in-house identity checks on the third party payer(s) if you provide the following additional details:

Date of birth

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

Address

Postcode

Please note: if our in-house checks are unsuccessful we will require completion of an IVC in order to proceed.

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the application.

START DATE AND FREE COVER

Please complete option A), B), C) or D). If any benefit you apply for is NOT accepted at ordinary rates we will refer back to you or your Intermediary, irrespective of the instructions below.

A) The plan is to start on acceptance (if ordinary rates). Tick box for immediate free cover.
Free cover is only available if you choose either option A) or B).

B) The plan is to protect a mortgage when I move house. Enter plan start date (if known) or tick box for mortgage free cover. Mortgage free cover applies from date of exchange of contracts/missives.

C) The plan is to start on date shown (no free cover applies).
your plan start date should be no later than four months after we have sent you acceptance terms for your plan. We will contact you or your Intermediary if there is a problem with the date you have given.

D) To be advised. Tick box (no free cover applies).

Which day of the month would you prefer us to collect your premiums if not the same as the start date of your plan? If you choose the 29th, 30th or 31st we will collect your premium on the last working day of the month where these dates don't fall.

Remember you must inform us of any change of personal health, your family's medical history, any occupational change, participation in hazardous pursuits, travel or residence between now and the date the plan starts.

BENEFITS

What plan interest rate should we use for any decreasing benefit? %

Please select a choice of benefits below. Alternatively you can attach the Benefit Summary Form (BSF) showing the benefits you have selected without having to complete the section below. The BSF is supplied as part of your Personal Illustration.

If you have attached the BSF, please remember to show the illustration reference from the BSF here. If you do not complete this we cannot proceed with setting up your plan.

Illustration reference:

Death only benefit

All death benefits under this plan must pay out on the same event. This is to avoid a tax liability that could occur on the second death if the plan paid out on each of two deaths.

Who will this benefit apply to? First life Second life Both lives (first event)

Amount of benefit (£)	Type of premium rate	Type of benefit	How we pay your benefit	Term of benefit (years)
<input type="text"/>	Guaranteed <input type="checkbox"/> Reviewable <input type="checkbox"/>	Level <input type="checkbox"/> Increasing <input type="checkbox"/>	Income (fixed term) <input type="checkbox"/> Lump sum (fixed term) <input type="checkbox"/> Lump sum (renewable term) <input type="checkbox"/> 3 year payment terms <input type="checkbox"/> 5 year payment terms <input type="checkbox"/>	<input type="text"/> Renewable term 5yrs <input type="checkbox"/> 10yrs <input type="checkbox"/>
		Decreasing <input type="checkbox"/>	Lump sum (fixed term) ONLY	<input type="text"/>

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Death or earlier critical illness benefit

If the term applied for extends past age 65, the maximum lump sum benefit amount is £500,000. Income benefits also have varying maximum limits. We will tell you or your Intermediary if the income benefit you have applied for exceeds the maximum income limit. Other policies you have with us may be taken into account in these limits.

Buyback option is allowed on benefit amounts up to £200,000 per plan. If this option is selected on more than one benefit and the total benefit amount is greater than £200,000, please refer to the Self Assurance Product Guide for guidance.

Who will this benefit apply to? First life Second life Both lives (first event)

Amount of benefit (£)	Type of premium rate	Critical illness definition*	Type of benefit	How we pay your benefit	Term of benefit (years)
<input type="text"/>	Guaranteed <input type="checkbox"/> Reviewable <input type="checkbox"/>	First Life A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>	Level <input type="checkbox"/> Increasing <input type="checkbox"/>	Income (fixed term) <input type="checkbox"/> Lump sum (fixed term) <input type="checkbox"/> Lump sum (renewable term) <input type="checkbox"/> 3 year payment terms <input type="checkbox"/> 5 year payment terms <input type="checkbox"/>	<input type="text"/> Renewable term 5yrs <input type="checkbox"/> 10yrs <input type="checkbox"/>
		Second Life A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>		Decreasing <input type="checkbox"/> Lump sum (fixed term) ONLY <input type="checkbox"/>	<input type="text"/>

If you require buyback option, please tick box

Critical illness benefit

The maximum lump sum benefit amount is £500,000. Income benefits also have varying maximum limits. We will tell you or your Intermediary if the income benefit you have applied for exceeds the maximum income limit. Other policies you have with us may be taken into account in these limits.

Buyback option is allowed on benefit amounts up to £200,000 per plan. If this option is selected on more than one benefit and the total benefit amount is greater than £200,000, please refer to the Self Assurance Product Guide for guidance.

Who will this benefit apply to? First life Second life Both lives (first event)

Amount of benefit (£)	Type of premium rate	Critical illness definition*	Type of benefit	How we pay your benefit	Term of benefit (years)
<input type="text"/>	Guaranteed <input type="checkbox"/> Reviewable <input type="checkbox"/>	First Life A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>	Level <input type="checkbox"/> Increasing <input type="checkbox"/>	Income (fixed term) <input type="checkbox"/> Lump sum (fixed term) <input type="checkbox"/> Lump sum (renewable term) <input type="checkbox"/> 3 year payment terms <input type="checkbox"/> 5 year payment terms <input type="checkbox"/>	<input type="text"/> Renewable term 5yrs <input type="checkbox"/> 10yrs <input type="checkbox"/>
		Second Life A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>		Decreasing <input type="checkbox"/> Lump sum (fixed term) ONLY <input type="checkbox"/>	<input type="text"/>

If you require buyback option, please tick box

* The following critical illness benefit types are available. Please tick the appropriate coverage definition box.

- A) The full list of critical illnesses plus total permanent disability benefit based on an OWN occupation definition.
- B) The full list of critical illnesses plus total permanent disability benefit based on a work tasks definition.
- C) The full list of critical illnesses with no total permanent disability benefit.

Disability income benefit (sickness, accident or disability)

Who will this benefit apply to? First life Second life Both lives

Amount of benefit (£p.a.)	Type of premium rate	Type of benefit	Deferred period (weeks)	Disability definition	Term of benefit (years)
<input type="text"/>	Guaranteed <input type="checkbox"/> Reviewable <input type="checkbox"/>	Level <input type="checkbox"/> Increasing <input type="checkbox"/>	4 <input type="checkbox"/> 13 <input type="checkbox"/> 26 <input type="checkbox"/> 52 <input type="checkbox"/>	OWN occupation <input type="checkbox"/> <input type="checkbox"/> 1st 2nd Work tasks <input type="checkbox"/> <input type="checkbox"/>	Fixed <input type="text"/> For fixed term benefits you can choose a term between 5 and 40 years. The maximum age at the end of the benefit term is 65. Renewable term 5yrs <input type="checkbox"/> 10yrs <input type="checkbox"/>

If disability income benefit (sickness, accident or disability) is required, please complete the salary details section on page 11.

Premium payment benefit (sickness, accident or disability)

Who will this benefit apply to? First life Second life Both lives
Deferred period 13 weeks 26 weeks 52 weeks

If disability income benefit has been included premium payment benefit is included automatically for each life covered. The deferred period will be the same as chosen for the disability income benefit shown above unless a different deferred period is shown here.

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the application.

SALARY DETAILS

First life

Second life

Only complete if disability income benefit (sickness, accident or disability) or unemployment benefit has been chosen.

To enable us to underwrite your plan thoroughly, and ensure that you do not exceed the maximum benefit limits, we require information on your current annual earned income.

Annual earned income £ a year £ a year

Please read the definition of earned income in the Self Assurance Product Guide.

Unemployment benefit (Self Assurance Mortgage Only)

Please read the definition of "Employed" and "Self employed" in the Self Assurance Product Guide before you answer the following questions to see if you are eligible for this benefit.

Unemployment benefit cannot be taken out on its own. You must take it out with one of the other benefits listed above.

This benefit will be underwritten by and your contract for unemployment benefit and premium benefit (unemployment) will be with, a General Insurer.

Question 1

Have you been employed continuously (or trading continuously under the same name if self employed) for the past six consecutive months?

Yes No

Yes No

Question 2

Are you currently in dispute or in the course of any disciplinary action with your employer or do you know of any circumstances which could result in or put you at risk of becoming unemployed? Circumstances could include, but are not restricted to:

Loss of major contract

Internal restructure

Profits warning

Strategic reviews of part or all of the business

Change of ownership

Any cost cutting programme

Yes No

Yes No

Please note: If you have answered 'No' to Question 1 or 'Yes' to Question 2 then we are unable to offer you unemployment benefit. If we are able to offer you unemployment benefit please complete the information requested below.

Who will this benefit apply to? First life Second life Both lives

What is the amount of your mortgage? £

Please note: By mortgage, we mean a secured loan which is used to purchase your home/principal private residence and you must not be currently in arrears on your mortgage repayments.

Amount of benefit (£p.a.)	Type of benefit	Deferred period	Benefit payment period	Term of benefit (years)
<input type="text"/>	Level <input type="checkbox"/>	8 weeks <input type="checkbox"/>	52 weeks <input type="checkbox"/>	<input type="text"/>
	Increasing <input type="checkbox"/>	13 weeks <input type="checkbox"/>	104 weeks <input type="checkbox"/>	

The maximum age at the end of the benefit term is 65.

When you select unemployment benefit, premium payment benefit (unemployment) is included automatically for each life covered. The deferred period and benefit payment period will normally be the same as chosen for the unemployment benefit shown above. If you want a different deferred or benefit payment period for premium payment benefit (unemployment) please provide details here:

Deferred period	Benefit payment period
8 weeks <input type="checkbox"/>	52 weeks <input type="checkbox"/>
13 weeks <input type="checkbox"/>	104 weeks <input type="checkbox"/>

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the application.

EXTRA BENEFIT REQUIREMENTS

If you have shown on page 12 that you want extra benefits please provide details below.

Death only benefit

All death benefits under this plan must pay out on the same event. This is to avoid a tax liability that could occur on the second death if the plan paid out on each of two deaths.

Who will this benefit apply to? First life Second life Both lives (first event)

Amount of benefit (£)	Type of premium rate	Type of benefit	How we pay your benefit	Term of benefit (years)
<input type="text"/>	Guaranteed <input type="checkbox"/>	Level <input type="checkbox"/>	Income (fixed term) <input type="checkbox"/>	<input type="text"/>
	Reviewable <input type="checkbox"/>	Increasing <input type="checkbox"/>	Lump sum (fixed term) <input type="checkbox"/>	Renewable term
			Lump sum (renewable term) <input type="checkbox"/>	5yrs <input type="checkbox"/>
			3 year payment terms <input type="checkbox"/>	10yrs <input type="checkbox"/>
			5 year payment terms <input type="checkbox"/>	
		Decreasing <input type="checkbox"/>	Lump sum (fixed term) ONLY	<input type="text"/>

Death or earlier critical illness benefit

If the term applied for extends past age 65, the maximum lump sum benefit amount is £500,000. Income benefits also have varying maximum limits. We will tell you or your Intermediary if the income benefit you have applied for exceeds the maximum income limit. Other policies you have with us may be taken into account in these limits.

Buyback option is allowed on benefit amounts up to £200,000 per plan. If this option is selected on more than one benefit and the total benefit amount is greater than £200,000, please refer to the Self Assurance Product Guide for guidance.

Who will this benefit apply to? First life Second life Both lives (first event)

Amount of benefit (£)	Type of premium rate	Critical illness definition*	Type of benefit	How we pay your benefit	Term of benefit (years)
<input type="text"/>	Guaranteed <input type="checkbox"/>	First Life	Level <input type="checkbox"/>	Income (fixed term) <input type="checkbox"/>	<input type="text"/>
	Reviewable <input type="checkbox"/>	A B C	Increasing <input type="checkbox"/>	Lump sum (fixed term) <input type="checkbox"/>	Renewable term
		Second Life		Lump sum (renewable term) <input type="checkbox"/>	5yrs <input type="checkbox"/>
		A B C		3 year payment terms <input type="checkbox"/>	10yrs <input type="checkbox"/>
				5 year payment terms <input type="checkbox"/>	
			Decreasing <input type="checkbox"/>	Lump sum (fixed term) ONLY	<input type="text"/>

If you require buyback option, please tick box

Critical illness benefit

The maximum lump sum benefit amount is £500,000. Income benefits also have varying maximum limits. We will tell you or your Intermediary if the income benefit you have applied for exceeds the maximum income limit. Other policies you have with us may be taken into account in these limits.

Buyback option is allowed on benefit amounts up to £200,000 per plan. If this option is selected on more than one benefit and the total benefit amount is greater than £200,000, please refer to the Self Assurance Product Guide for guidance.

Who will this benefit apply to? First life Second life Both lives (first event)

Amount of benefit (£)	Type of premium rate	Critical illness definition*	Type of benefit	How we pay your benefit	Term of benefit (years)
<input type="text"/>	Guaranteed <input type="checkbox"/>	First Life	Level <input type="checkbox"/>	Income (fixed term) <input type="checkbox"/>	<input type="text"/>
	Reviewable <input type="checkbox"/>	A B C	Increasing <input type="checkbox"/>	Lump sum (fixed term) <input type="checkbox"/>	Renewable term
		Second Life		Lump sum (renewable term) <input type="checkbox"/>	5yrs <input type="checkbox"/>
		A B C		3 year payment terms <input type="checkbox"/>	10yrs <input type="checkbox"/>
				5 year payment terms <input type="checkbox"/>	
			Decreasing <input type="checkbox"/>	Lump sum (fixed term) ONLY	<input type="text"/>

If you require buyback option, please tick box

* The following critical illness benefit types are available. Please tick the appropriate coverage definition box.

- A) The full list of critical illnesses plus total permanent disability benefit based on an OWN occupation definition.
- B) The full list of critical illnesses plus total permanent disability benefit based on a work tasks definition.
- C) The full list of critical illnesses with no total permanent disability benefit.

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the application.

Disability income benefit (sickness, accident or disability)

Who will this benefit apply to?

First life Second life Both lives

Amount of benefit (£p.a.)

Type of premium rate

Guaranteed

Reviewable

Type of benefit

Level

Increasing

Deferred period (weeks)

4 13

26 52

Disability definition

OWN occupation

Work tasks

Term of benefit (years)

Fixed

For fixed term benefits you can choose a term between 5 and 40 years. The maximum age at the end of the benefit term is 65.

Renewable term

5yrs

10yrs

If disability income benefit (sickness, accident or disability) is required, please complete the salary details section on page 11.

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the application.

UNDERWRITING QUESTIONS

First life

Second life

Questions 1-5 should be completed for all lives assured.

If you answer "yes" to any of these questions, please give full details and answer all of the additional parts of the question below. If you wish to retain confidentiality, you can send your answers to: The Chief Medical Officer, Scottish Provident, 301 St Vincent Street, Glasgow G2 5PB. If you need more space then please use the underwriting additional information section on pages 20 and 21. We will rely on the information you give us, and you should not assume we will clarify or confirm with your doctor any facts that you give us.

We will use the information you give us on this form to assess the insurance risk. You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void.

Question 1:

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

- | | | |
|--|--|--|
| a) cancer, leukaemia, Hodgkin's disease, lymphoma, brain or spinal tumour? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) heart disease – including angina, heart attack or any other disorder of the heart? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c) stroke, brain haemorrhage, permanent brain injury through accident? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d) multiple sclerosis, Parkinson's disease, paralysis, epilepsy, alzheimer's disease, dementia or cerebral palsy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e) any disorder of the central nervous system (the brain, spinal cord and nerves), not already mentioned? (This could include, for example, Huntington's disease, motor neurone disease or myelitis). | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f) disease or disorder of the arteries (including disease in the legs or of the aorta)? (This could include, for example, blockage or narrowing of an artery, intermittent claudication or inflammation of an artery). | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g) diabetes or sugar in the urine? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h) mental illness that has required hospital treatment or referral to a psychiatrist? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you have answered **NO** to all of the above then please proceed to Underwriting Question 2

What is the exact diagnosis of the medical condition?

--	--

When did symptoms of this condition first occur?

--	--

When did you last have symptoms?

--	--

Do you have recurrent symptoms? If so, please state how many episodes or attacks of symptoms you have had since onset of the condition.

--	--

Please describe the nature and severity of the symptoms.

--	--

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the application.

UNDERWRITING QUESTIONS (CONT'D)

First life

Second life

Do they restrict you in any way?

Have you seen a specialist for the condition? If so, please give their name and hospital.

What medical investigations have been performed?

What were the results, if known?

Have all investigations now been completed?

Yes No

Yes No

Are you waiting for any follow-ups or reviews?

Yes No

Yes No

When did you last see your GP with this condition?

Month: Year:

Month: Year:

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

Number of admissions:
 Month (last ad): Year (last ad):

Number of admissions:
 Month (last ad): Year (last ad):

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

Month: Year:

Month: Year:

What treatment has been prescribed? Is it continuing?

How much time off work have you had to take and when was this?

Is any operation planned or being considered? If so, when?

Question 2

Whether or not you have consulted a doctor, do you currently have, or in the last five years have you had, any of the following:

a) a lump, a growth of any kind or any mole or freckle that has bled, become painful, changed colour or increased in size?

Yes No

Yes No

b) chest pain, irregular heart beat, raised blood pressure or raised cholesterol?

Yes No

Yes No

c) asthma, bronchitis or any other respiratory disorder?

Yes No

Yes No

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the application.

UNDERWRITING QUESTIONS (CONT'D)

First life

Second life

- d) numbness, loss of feeling, tingling or temporary loss of muscle power?
 Yes No Yes No
- e) seizure, fits, fainting or blackouts?
 Yes No Yes No
- f) any disorder of the eyes including blurred or double vision, optic or retro bulbar neuritis (you can ignore sight problems corrected by glasses or contact lenses)?
 Yes No Yes No
- g) any disorder of the ears?
 Yes No Yes No
- h) arthritis, spine, neck or joint disorder (including slipped disc, back or neck pain or gout)?
 Yes No Yes No
- i) 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
- j) any blood disorder or anaemia?
 Yes No Yes No
- k) any thyroid disorder?
 Yes No Yes No
- l) any kidney, bladder or any other disorder of the genito-urinary system (including blood or protein in the urine and urinary tract infections)?
 Yes No Yes No
- m) any kind of medical attention for depression, anxiety, stress, nervous breakdown or chronic fatigue?
 Yes No Yes No
- n) any investigation, scan or test not already mentioned? (This could include, for example, smear tests and other tests performed at your GP's clinic).
 Yes No Yes No
- o) any form of medical attention at a hospital as an inpatient or an outpatient?
 Yes No Yes No
- p) a surgical operation?
 Yes No Yes No

If you have answered **NO** to all of the above then please proceed to Underwriting Question 3

What is the exact diagnosis of the medical condition?

When did you last have symptoms?

--	--

When did symptoms of this condition first occur?

Month: _____ Year: _____	Month: _____ Year: _____
Month: _____ Year: _____	Month: _____ Year: _____

Do you have recurrent symptoms? If so, please state how many episodes or attacks of symptoms you have had since onset of the condition.

--	--

Please describe the nature and severity of the symptoms.

--	--

Do they restrict you in any way?

--	--

Have you seen a specialist for the condition? If so, please give their name and hospital.

--	--

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the application.

UNDERWRITING QUESTIONS (CONT'D)

First life **Second life**

What medical investigations have been performed? What were the results if known?

--	--

Have all investigations now been completed? Are you waiting for any follow-ups or reviews?

--	--

When did you last see your GP with this condition?

Month: Year:	Month: Year:
---	---

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

Number of admissions: Month (last ad): Year (last ad):	Number of admissions: Month (last ad): Year (last ad):
--	--

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

Month: Year:	Month: Year:
---	---

What treatment has been prescribed? Is it continuing?

--	--

How much time off work have you had to take and when was this?

--	--

Is any operation planned or being considered? If so, when?

--	--

Question 3

- a) Have you ever tested positive for HIV, hepatitis B or C or are you awaiting the result 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.)
- Yes No Yes No

If you have answered yes, please specify:

Tested positive for HIV or hepatitis

Awaiting an HIV or hepatitis test result

- b) Within the last five years, have you been exposed to the risk of HIV infection? (Note: The risk can arise through unsafe sex, intravenous drug abuse, or blood transfusions or surgery undertaken outside the EU.)
- Yes No Yes No

If yes, please provide details

--	--

- c) Within the last five years, have you tested positive or been treated for any disease that was sexually transmitted?
- Yes No Yes No

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the application.

UNDERWRITING QUESTIONS (CONT'D)

First life

Second life

If yes, please provide details

d) Have you ever injected non-prescription drugs or have you ever taken drugs other than on medical advice?

Yes No

Yes No

If yes, please provide details

Question 4

a) Are you due to have any check-up in the next 12 months in connection with any medical condition, or are you waiting for the result of any medical investigation?

Yes No

Yes No

b) Are you currently taking prescribed drugs, medicines, tablets or any other treatment?

Yes No

Yes No

c) Have you any expectation of seeking medical advice or treatment in the near future?

Yes No

Yes No

If you have answered **NO** to all of the above then please proceed to Underwriting Question 5.

What is the exact diagnosis of the medical condition?

When did symptoms of this condition first occur?

Month: Year:

Month: Year:

When did you last have symptoms?

Month: Year:

Month: Year:

Do you have recurrent symptoms? If so, please state how many episodes or attacks of symptoms you have had since onset of the condition.

Please describe the nature and severity of the symptoms.

Do they restrict you in any way?

Have you seen a specialist for the condition? If so, please give their name and hospital.

What medical investigations have been performed?

What were the results if known?

Have all investigations now been completed?

Yes No

Yes No

You must fill in the form fully and truthfully to the best of your knowledge and belief. If you do not do this, and this affects our assessment of the risk, your insurance may be void and all your cover may be cancelled. If you are in any doubt about whether to provide information when filling in the form, please provide the information. If you are unsure about any information, you may wish to consult your doctor before completing the application.

UNDERWRITING QUESTIONS (CONT'D)

First life

Second life

Are you waiting for any follow-ups or reviews?

--	--

When did you last see your GP with this condition?

Month: _____ Year: _____	Month: _____ Year: _____
--------------------------	--------------------------

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

Number of admissions: _____	Number of admissions: _____
Month (last ad): _____ Year (last ad): _____	Month (last ad): _____ Year (last ad): _____

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

Month: _____ Year: _____	Month: _____ Year: _____
--------------------------	--------------------------

What treatment has been prescribed? Is it continuing?

--	--

How much time off work have you had to take and when was this?

--	--

Is any operation planned or being considered? If so, when?

--	--

Question 5

Have any of your parents, brothers or sisters ever had any of the following medical conditions before they reached age 60?

Heart disease or disorder
Stroke
Diabetes
Cancer

Multiple sclerosis
Bowel disease or disorder
Kidney disease or disorder
Huntington's disease

Alzheimer's disease
Parkinson's disease
Muscular dystrophy
Motor neurone disease

Yes No

Yes No

If yes, please state the diagnosis or cause of death (if cancer, please also state the type or site), the age at diagnosis or the age at death if applicable, for each relative.

First life

Relationship	Diagnosis or cause of death	Age at diagnosis	Age at death (if applicable)

Second life

Relationship	Diagnosis or cause of death	Age at diagnosis	Age at death (if applicable)

IMPORTANT NOTES

Scottish Provident is a division of the Royal London Group which consists of The Royal London Mutual Insurance Society Ltd and its subsidiaries.

If you are applying for insurance with other companies at the same time as this, by signing the declaration you are consenting to copies of medical reports being sent to these other companies if they ask. However, if another company asks us to provide copies of highly sensitive information (for example HIV test results), we will ask for your written permission before we do so. The plan will not start until we have assessed and accepted your application, and we have received a cheque or Direct Debit.

In most instances your premium will be as originally quoted. However, if you have passed a birthday or it becomes less than 6 months until your birthday while your application is being processed, the premium may increase from that originally quoted. We may also offer you revised terms and occasionally we may not be able to offer any terms.

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

If we ask you to come for a medical examination, we will need to share the application information with another company who we have authorised to arrange for the examination to take place.

You can ask us for a copy of the Policy Provisions, the Policy Benefit Cover Sheet, the Policy Benefit Schedule or your Application Form at any time.

You can ask us for details of general reassurance principles or details of any company we use to assess your application, by writing to us at: New Business Dept, Scottish Provident, 301 St Vincent Street, Glasgow G2 5PB.

Any telephone calls made to us may be monitored and recorded by us to ensure consistent service.

DATA PROTECTION STATEMENT

Whether or not you become a customer, all the information you or your Intermediary give to us (The Royal London Mutual Insurance Society Ltd), or we hold on you including transactional data, may be shared with and used by us, our associated companies, service providers or agents who may be located in other countries. We will ensure that your information is only used in accordance with our instructions and our own strict internal confidentiality policies. If we transfer your information to another country, we will also ensure that it is given the same levels of protection as required under the UK Data Protection Act 1998. Your information may be used in this way for administration, reassurance, underwriting and claims purposes, and to:

- provide and run the product you have applied for and develop and improve our products and services
- identify and advise you by post, telephone or electronic media of products or services, which we and associated companies think may interest you. (If you are aged over 18, when deciding whether to provide you with details of a credit product we may search the files of credit reference agencies. A record of this search will not be made available to other lenders who search your file)
- invite you to take part in market research surveys.

If you do not want to receive up to date information on other products and services, or be included in market research, you can tick this box

Before we can open your product, we may check your details (this can include the applicant(s) and/or the third party payer) with fraud prevention agencies, and may make searches at credit reference agencies, who will supply us with information including information from the electoral register, for the purposes of verifying your identity. Scoring methods may be used to verify your identity. The credit reference agencies will record details of the search whether or not your application proceeds but this is not a credit check and will not be seen or used by lenders to assess your ability to obtain credit. If you give us false or inaccurate information and we suspect fraud, we will record this.

We and other organisations may use and search these records to:

- help make decisions about credit and credit related services and insurance including motor, household, credit, life and other insurance proposals and claims for you and members of your household
- trace debtors, recover debt, prevent money laundering and fraud, manage accounts and for statistical purposes.

Further information on the fraud prevention agencies and credit reference agencies that we use is available by telephoning 0845 0020 360.

We may also give information about this application and your plan to your Intermediary and to others if necessary for administration and regulatory purposes. Information about you will be kept after your product is closed.

Under the terms of the Data Protection Act 1998 you have the right to ask for a copy of the information that we hold on you, for which we charge a small fee. Please write to: New Business Dept, Scottish Provident, 301 St Vincent Street, Glasgow G2 5PB.

ACCESS TO MEDICAL REPORTS

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 and the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. Your rights 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
 - musculoskeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles
 - anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue
 - suicidal thoughts or attempts at suicide; **or**
 - conditions related to drug or alcohol misuse or smoking or chewing tobacco.
- details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations
- any blood pressure readings in the last three years
- any history of disease among your parents or brothers or sisters that you have told your doctor about.

We have asked your doctor not to reveal information about:

- negative tests for Human Immunodeficiency Virus (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 or questions relating to the process of getting, assessing or storing medical information, please write to us at: New Business Dept, Scottish Provident, 301 St Vincent Street, Glasgow G2 5PB.

DECLARATION

Scottish Provident is a division of the Royal London Group which consists of The Royal London Mutual Insurance Society Ltd and its subsidiaries.

Please sign this declaration once you have read and agree to it, together with the important notes, data protection statement and notes on the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991.

I have read the answers to all the questions in this application and I declare that the statements made in, or in connection with, this application, whether in my handwriting or not, are true and complete as far as I know. I understand that they will be considered to form part of the contract of insurance.

I understand that if I leave out any relevant information, or give incorrect information, it may lead to the contract being declared void. If my circumstances change in any way before the plan starts, I will tell you. I understand that if I do not do this, the contract may be declared void.

I agree to you or your agents asking any doctor I have consulted about my physical or mental health to provide medical information so you may assess my application. 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 have applied for. I authorise those asked to provide medical information when they see a copy of this consent form. This form allows you or your agents to gather medical reports within six months of the start of the plan, or after my death, to support any claim made under the plan. This information can also be used to maintain management information for business analysis.

I understand that if I am habitually resident in:

- the UK my plan will be governed by the law of Scotland, except for unemployment benefit which is governed by the law of England;
- the Channel Islands or Isle of Man my plan will be governed by the law of England and held under Seal;

unless otherwise agreed with Scottish Provident.

I understand that my Intermediary acts as my agent and can contact Scottish Provident to carry out any action about the plan on my behalf.

By signing this declaration I am allowing you to process my application using the information that I have given. You may also use this information to process any claim made on this plan.

Unemployment benefit

I understand that my contract for unemployment benefit and premium payment benefit (unemployment) is underwritten by a General Insurer, Primary Insurance Company Ltd, for whom Scottish Provident acts as agent.

I have read the declaration, important notes, data protection statement and information relating to my rights under the Access to Medical Reports Act 1988 and Access to Personal Files and Medical Reports (Northern Ireland) Order 1991.

I do **not** want to see the medical report before it is sent to Scottish Provident. Please tick the box if you want to see any report before it is sent to us. First Life Second Life

Please note, if you have not completed the application form yourself, **before you sign the declaration** please read all of the answers and agree that they are accurate and complete. If you did not complete the form, who completed it on your behalf and what is their relationship to you (e.g. Intermediary, Daughter, Son etc)?

(Print name and relationship)

First Applicant

Second Applicant

Signature of applicant

Date

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

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

Please state full name and capacity if signing on behalf of a corporate body

First life (if different from applicant)

Second life (if different from applicant)

Signature of life assured

Date

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

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

Name

MONEY LAUNDERING

Scottish Provident has a statutory requirement to verify identity (in line with UK Money Laundering Legislation and FSA Regulations). We may therefore need confirmation of the applicant's identity and address. Please ensure you follow the instructions below where appropriate. Failure to provide the necessary requirements will result in a delay to processing of this application.

FOR INTERMEDIARY USE

If the premium for the plan is over £50 per month or £600 per year, and the Source of Funds Concession is not applicable, you will need to complete an Introduction Verification Certificate for each applicant/third party payer in line with the "Direct Debit & Cheque" Section (see page 8) to enable us to process the application. The form (Individual or Corporate) is available on our website at www.ifawebcentre.com.

Please also note that further verification of identity may be required during the lifetime of the plan or at claim.

FOR EXECUTION ONLY BUSINESS (meaning no professional advice has been provided)

If the premium amount is over £50 per month or £600 per year, and payment is not being received from a bank account in your name, we will need two different forms of identification from the list below for each applicant and third party payer in line with the "Direct Debit & Cheque" Section (see page 8) as evidence of their identity. Please select one item from each of the following lists and enclose copies of them with the Application Form:

LIST 1

- Unexpired UK/EEA passport
- Unexpired UK/non-EEA passport
- Unexpired UK photocard driving licence
- Firearms certificate of shotgun licence
- EEA or Switzerland national identity card
- Northern Ireland voter's card
- Evidence of entitlement to state/local authority benefit (less than 12 months old)
- Unexpired UK (old style) driving licence (not provisional)
- Evidence of entitlement to tax credit (less than 12 months old)
- Evidence of entitlement to pension from the DWP (less than 12 months old)
- Evidence of entitlement to educational loan/grant
- HMRC (IR) coding/assessment/statement/tax credit (less than 12 months old)
- Entitlement to other government/local authority loan/grant (less than 12 months old)

LIST 2

- Unexpired UK/EEA passport
- Unexpired UK/non-EEA passport
- Unexpired UK photocard driving licence
- Firearms certificate of shotgun licence
- EEA or Switzerland national identity card
- Northern Ireland voter's card
- Evidence of entitlement to state/local authority benefit (less than 12 months old)
- Unexpired UK (old style) driving licence (not provisional)
- Evidence of entitlement to tax credit (less than 12 months old)
- Evidence of entitlement to pension from the DWP (less than 12 months old)
- Evidence of entitlement to educational loan/grant
- HMRC (IR) coding/assessment/statement/tax credit (less than 12 months old)
- Entitlement to other government/local authority loan/grant (less than 12 months old)
- Council tax bill/demand letter (less than 12 months old)
- Utility Bill (not mobile phone/satellite TV/internet printed)
- HMRC (IR) correspondence (including name/address/NI No)
- Bank statement (not internet printed)
- Local council rent card or tenancy agreement (less than 12 months old)
- Pension benefit correspondence from DWP
- UCAS letter (students only) (less than 12 months old)
- Instrument of court appointment (probate/registered POA)
- Confirmation from work/school/college/university/care institution (Student Only) (less than 12 months old)

Please also note that further verification of identity may be required during the lifetime of the plan or at claim.

FOR INTERMEDIARY USE ONLY

I, or my company, have all the appropriate authorisations from the Financial Services Authority for this application. If the application arises as a result of the activities of another person, then that person is also appropriately authorised by the Financial Services Authority or is exempt from authorisation.

Company name	_____	Company stamp:
Address and postcode	_____ _____ _____	
Telephone/Fax no.	_____	
E-mail	_____	
Scottish Provident agency no.	_____	
Consultant	_____	
National network (if applicable)	_____	
Portfolio Member Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	
The Intermediaries' case reference	_____	
The Intermediaries' contact name	_____	

Scottish Provident is unable to cancel a live Direct Debit mandate on your behalf.

Note to third party payer (if applicable) – please complete and sign this Direct Debit mandate once you have read and agreed to our Data Protection and Money Laundering notes.

**Scottish Provident, 301 St Vincent Street, Glasgow G2 5PB.
Instruction to your bank or building society to pay by Direct Debit.**



Name(s) of account holders

Originator's identification number

6	7	0	3	6	8
---	---	---	---	---	---

Bank/building society account number

Branch sort code

Reference number

Name and postal address of your bank or building society

To: The Manager

bank/building society

Address

Instruction to your bank or building society

Please pay Scottish Provident Direct Debits from the account detailed in this instruction subject to the safeguards assured by the Direct Debit guarantee. I understand that this instruction may remain with Scottish Provident and, if so, details will be passed electronically to my bank/building society.

Banks may decline to accept instructions to pay Direct Debits from some types of accounts.

Postcode

Signature(s) Date

**THIS GUARANTEE SHOULD BE DETACHED AND RETAINED BY THE PAYER
THE DIRECT DEBIT GUARANTEE**



- This guarantee is offered by all banks/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 Scottish Provident will notify you at least 10 working days in advance of your account being debited or as otherwise agreed.
- If an error is made by Scottish Provident 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 Scottish Provident.

Scottish Provident is a division of the Royal London Group which consists of The Royal London Mutual Insurance Society Ltd and its subsidiaries. The Royal London Mutual Insurance Society Ltd is authorised and regulated by the Financial Services Authority No.117672 and is registered in England and Wales No.99064. The registered office is 55 Gracechurch Street, London, United Kingdom EC3V 0RL.

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