

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	196602195
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"/>

# Skandia

## applying for skandia protect

Financial adviser stamp

Please enter your business postcode

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Are you enclosing a cheque with this application?

Yes

No



To be completed by the financial adviser.

Please confirm if you have given advice to the client in relation to this product. (✓)

Yes

No

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

Notes

### Important information

Please answer all the questions in this form honestly and in full. If you miss any information out, or give us misleading information, we may not be able to pay a claim, and it could result in cancellation of all the cover under your policy. It could also cause a delay in starting your cover. If you are not sure whether a particular fact is relevant, you should include it.

### Changes in your circumstances

You must tell us in writing if anything you tell us in this application changes before the policy starts, such as a change to:

- your personal health
- your family history
- your occupation
- taking part in any hazardous leisure activities
- where you travel to
- where you live.

### Your medical details

We will rely on the information you give us, and you should not assume that we will clarify or confirm with your doctor any facts you have given.

For confidentiality, you may complete the medical questions separately and send them directly to our Chief Medical Officer at Skandia's Head Office. Please tell us on the form if you have done this.

### Completing the form

To complete this form:

- use BLOCK CAPITALS only
- use blue or black ink
- tick boxes as appropriate

If someone else completes the form for you, for example your financial adviser, please check that all the details are correct before you sign the declaration.

If any relevant sections are incomplete, we will write to you and ask you for the missing information, which may delay your application.

Please initial any changes or corrections made to the answers given on the form.

All references to Skandia in this application mean Skandia Life Assurance Company Limited.

Copies of the policy terms and/or this completed application are available on request.

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

A	Cover
---	-------

Please tick the cover(s) you wish to apply for (✓)

Life cover  Combined critical illness and life cover  Critical illness cover

If all benefits are accepted on standard terms, we will start the cover immediately.

If you do not want the cover to start immediately, please tick here (✓)  You will need to tell us when to start the cover.

Quote reference

Date of quote (day/month/year)

B	Details of the life/lives assured
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**First or sole life assured**

Title (✓) Mr  Mrs  Miss  Other

Full forename(s)

Surname

Address   
  
  
 Postcode

E-mail address

Telephone number: Home

Telephone number: Work

Date of birth (day/month/year)

Sex (✓) Male  Female

Marital status (✓) Single  Married  Civil Partner\*  Widowed  Divorced   
Separated  \* as defined by the Civil Partnership Act 2004

Will the life assured also be the policyholder? (✓) Yes  No

Where the life assured is not a policyholder, please state the nature and extent of the insurable interest.

**Second life assured (if applicable)**

Title (✓) Mr  Mrs  Miss  Other

Full forename(s)

Surname





Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

**D Shareholder/Partnership protection**

Complete this section if cover is for shareholder/partnership protection and you want all the policies under one plan. We will address correspondence to a nominated person at the firm.

*Please note: If this section is completed, each policy must be written under a Business Assurance Trust from outset.*

Name of firm	
Name of nominated person	
Address	
	Postcode
Business e-mail address	
Business telephone number	

**E Your mortgage details**

Complete this section if you are using a policy to cover your mortgage.

If you are applying for more than one policy, please state which policy(ies) is/are being used. (✓)

Policy 1  Policy 2  Policy 3  Policy 4  See section F.

Lender's name	
Lender's address	
	Postcode
Lender's reference	

Do you want us to send the policy(ies) to the lender? (✓)  Yes  No

If you are moving house, please state the new address for correspondence.

	Postcode

Moving date (if known)

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

F	Your policy details
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You can use this section to apply for up to four policies. If you require more than four policies, please complete and attach section F from a separate application form.

**Policy 1**

Sum assured £

Sum assured to be paid in instalments\* (✓) Yes  No

Premium £

Trust - please tick if policy will be under trust (✓)

Type of cover - please tick one box for life cover only OR one box for combined critical illness and life cover (✓)

Life cover only 1st life  2nd life  Joint life first death  Joint life last death

OR

Combined critical illness and life cover\*\* 1st life  2nd life  Joint life first death/event

\* For a key person cover policy, you can only include the instalment option at outset, but you can ask us to change it to a cash sum at the time you submit a claim to us, if needed.  
 \*\* If there are reasons why the life cover is not required, we can remove this from the policy on request. The premium will not change and, because of this, you will need to enclose a covering letter with the application form with an explanation as to why the life cover should be removed.

**Term**

Please tick one box to indicate the type of term. (✓)

Minimum fixed term is five years, maximum 35 years for life cover and 25 years for critical illness cover. Key person cover is only available for fixed and rolling term policies. For rolling term and fixed terms longer than 10 years, we will not allow key person cover in excess of £500,000.

Fixed    years

OR

Rolling

OR

Whole life  Only available if life cover only has been selected.

Optional benefits (tick to indicate any optional benefits) (✓)

Total permanent disability benefit+ 1st life  2nd life  Both lives joint life first death/event

Premium protection benefit 1st life  2nd life  Both lives joint life first death/event

Both lives joint life last death

Cover reinstatement option† 1st life  2nd life  Both lives joint life first death/event

+ Only available for fixed and rolling term policies.  
 † Available if critical illness and/or total permanent disability benefit has been selected. Cover reinstatement option is not available in the last five years of a fixed term.

continued

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

F	Your policy details <i>(continued)</i>
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**Policy 2**

Sum assured £

Sum assured to be paid in instalments\* (✓) Yes  No

Premium £

Trust - please tick if policy will be under trust (✓)

Type of cover - please tick one box for life cover only OR one box for combined critical illness and life cover (✓)

Life cover only 1st life  2nd life  Joint life first death  Joint life last death

OR

Combined critical illness and life cover\*\* 1st life  2nd life  Joint life first death/event

\* For a key person cover policy, you can only include the instalment option at outset, but you can ask us to change it to a cash sum at the time you submit a claim to us, if needed.

\*\* If there are reasons why the life cover is not required, we can remove this from the policy on request. The premium will not change and, because of this, you will need to enclose a covering letter with the application form with an explanation as to why the life cover should be removed.

**Term**

Please tick one box to indicate the type of term. (✓)

Minimum fixed term is five years, maximum 35 years for life cover and 25 years for critical illness cover. Key person cover is only available for fixed and rolling term policies. For rolling term and fixed terms longer than 10 years, we will not allow key person cover in excess of £500,000.

Fixed   years

OR

Rolling

OR

Whole life  *Only available if life cover only has been selected.*

Optional benefits (tick to indicate any optional benefits) (✓)

Total permanent disability benefit<sup>+</sup> 1st life  2nd life  Both lives joint life first death/event

Premium protection benefit 1st life  2nd life  Both lives joint life first death/event   
Both lives joint life last death

Cover reinstatement option<sup>†</sup> 1st life  2nd life  Both lives joint life first death/event

<sup>+</sup> Only available for fixed and rolling term policies.

<sup>†</sup> Available if critical illness and/or total permanent disability benefit has been selected. Cover reinstatement option is not available in the last five years of a fixed term.

*continued*

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

F	Your policy details <i>(continued)</i>
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**Policy 3**

Sum assured £

Sum assured to be paid in instalments\* (✓) Yes  No

Premium £

Trust - please tick if policy will be under trust (✓)

Type of cover - please tick one box for life cover only OR one box for combined critical illness and life cover (✓)

Life cover only 1st life  2nd life  Joint life first death  Joint life last death

OR

Combined critical illness and life cover\*\* 1st life  2nd life  Joint life first death/event

\* For a key person cover policy, you can only include the instalment option at outset, but you can ask us to change it to a cash sum at the time you submit a claim to us, if needed.

\*\* If there are reasons why the life cover is not required, we can remove this from the policy on request. The premium will not change and, because of this, you will need to enclose a covering letter with the application form with an explanation as to why the life cover should be removed.

**Term**

Please tick one box to indicate the type of term. (✓)

Minimum fixed term is five years, maximum 35 years for life cover and 25 years for critical illness cover. Key person cover is only available for fixed and rolling term policies. For rolling term and fixed terms longer than 10 years, we will not allow key person cover in excess of £500,000.

Fixed    years

OR

Rolling

OR

Whole life  *Only available if life cover only has been selected.*

Optional benefits (tick to indicate any optional benefits) (✓)

Total permanent disability benefit<sup>+</sup> 1st life  2nd life  Both lives joint life first death/event

Premium protection benefit 1st life  2nd life  Both lives joint life first death/event

Both lives joint life last death

Cover reinstatement option<sup>†</sup> 1st life  2nd life  Both lives joint life first death/event

<sup>+</sup> Only available for fixed and rolling term policies.

<sup>†</sup> Available if critical illness and/or total permanent disability benefit has been selected. Cover reinstatement option is not available in the last five years of a fixed term.

*continued*

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

F	Your policy details <i>(continued)</i>
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**Policy 4**

Sum assured £

Sum assured to be paid in instalments\* (✓) Yes  No

Premium £

Trust - please tick if policy will be under trust (✓)

Type of cover - please tick one box for life cover only OR one box for combined critical illness and life cover (✓)

Life cover only 1st life  2nd life  Joint life first death  Joint life last death

OR

Combined critical illness and life cover\*\* 1st life  2nd life  Joint life first death/event

\* For a key person cover policy, you can only include the instalment option at outset, but you can ask us to change it to a cash sum at the time you submit a claim to us, if needed.  
 \*\* If there are reasons why the life cover is not required, we can remove this from the policy on request. The premium will not change and, because of this, you will need to enclose a covering letter with the application form with an explanation as to why the life cover should be removed.

**Term**

Please tick one box to indicate the type of term. (✓)

Minimum fixed term is five years, maximum 35 years for life cover and 25 years for critical illness cover. Key person cover is only available for fixed and rolling term policies. For rolling term and fixed terms longer than 10 years, we will not allow key person cover in excess of £500,000.

Fixed    years

OR

Rolling

OR

Whole life  *Only available if life cover only has been selected.*

Optional benefits (tick to indicate any optional benefits) (✓)

Total permanent disability benefit<sup>+</sup> 1st life  2nd life  Both lives joint life first death/event

Premium protection benefit 1st life  2nd life  Both lives joint life first death/event

Both lives joint life last death

Cover reinstatement option<sup>†</sup> 1st life  2nd life  Both lives joint life first death/event

<sup>+</sup> Only available for fixed and rolling term policies.  
<sup>†</sup> Available if critical illness and/or total permanent disability benefit has been selected. Cover reinstatement option is not available in the last five years of a fixed term.

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

G	Premium details
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Frequency of premiums (✓)

*(Tick monthly or yearly only, as frequency selected will apply to all policies.)*

Monthly	<input type="checkbox"/>
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Yearly	<input type="checkbox"/>
--------	--------------------------

How will you pay your first premium? (✓)

*(Subsequent monthly premiums must be paid by direct debit.)*

Direct debit	<input type="checkbox"/>
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Cheque	<input type="checkbox"/>
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For direct debits, please state preferred collection date between 1st and 28th.

*(If no date is specified, collection will be made on 1st of the month.)*

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

Direct debit collections will be made as detailed here, or as subsequently advised. Please note it will not be possible to change your premium frequency after we have accepted your application. It is therefore important you select a frequency which you can maintain throughout your period of insurance.

H	Automatic inflation option
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Fixed and rolling term policies

Please select the rate you want your benefits to increase by each year. (✓)

5%	<input type="checkbox"/>
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10%	<input type="checkbox"/>
-----	--------------------------

*If the increase in the Retail Prices Index (RPI) is greater than the rate you select, benefits will be increased by the increase in the RPI. The increases are subject to an overall maximum sum assured limit, details are available on request. The increase in premiums will not necessarily be proportionate to the increase in benefits.*

Whole life policy

Would you like your benefits to increase automatically each year? (✓)

Yes	<input type="checkbox"/>
-----	--------------------------

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

*Under the automatic inflation option we will increase your benefits automatically each year by the greater of 5% or the rate of inflation as measured by the Retail Prices Index (RPI). The maximum RPI increase we will allow is 10% each year and the increases are also subject to an overall maximum sum assured limit, details are available on request. The increase in premiums will not necessarily be proportionate to the increase in benefits.*

If you do not select the automatic inflation option, your benefits will NOT be increased automatically. We will write to you each year instead, offering an increase in benefits. You can find full details about our yearly increase offer in the relevant policy terms, which are available on request.

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

I	Health and other information
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In accordance with the Association of British Insurers' (ABI) policy on genetics and insurance, you do not need to tell us about any genetic test result you have had if this application for insurance, taken together with any other insurance policies you already have for this type of insurance, totals to:

- £500,000 or less for life insurance;
- £300,000 or less for critical illness insurance.

Above these limits, you may need to tell us about certain genetic test results when applying for insurance. We will only be interested in genetic test results where the Government's Genetics and Insurance Committee (GAIC) has approved them for insurers to use.

If you think this may apply to you, please ask us for details of the current position. These details are also available from the ABI website at [www.abi.org.uk/consumer2/disclosure.htm](http://www.abi.org.uk/consumer2/disclosure.htm)

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

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

**Insurance history**

**First or sole life assured**

**Second life assured (if applicable)**

1. Have you previously applied to Skandia for a policy? (✓)

Yes		No	
-----	--	----	--

Yes		No	
-----	--	----	--

2. Which, if any, of your existing Skandia policies are to be replaced by this policy?



3. Are you applying, or have you in the last six months applied, to any other life office for life, disability or critical illness cover? (✓)

Yes		No	
-----	--	----	--

Yes		No	
-----	--	----	--

If Yes, please give full details

Company	
Type of cover	
Sum assured	£

Company	
Type of cover	
Sum assured	£

4. Has any application on your life been declined, deferred, or have you been offered special terms? (✓)

Yes		No	
-----	--	----	--

Yes		No	
-----	--	----	--

If Yes, please give full details

--

--

Company	
---------	--

Company	
---------	--

Date of application	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> </tr> </table>										

Date of application	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> <td style="width: 20px; border: 1px solid black;"></td> </tr> </table>										

5. Is there life or critical illness cover already in force on your life (including group policies)? (✓)

Yes		No	
-----	--	----	--

Yes		No	
-----	--	----	--

If Yes, please state the total sum assured.

Life cover	£
Critical illness cover	£

Life cover	£
Critical illness cover	£

*continued*



Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

I	Health and other information <i>(continued)</i>
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**First or sole life assured**

**Second life assured *(if applicable)***

**Residence**

7. Country of permanent residence



In the last five years, have you lived, worked or travelled for more than three consecutive months outside the UK, Channel Islands and Isle of Man other than for a holiday, or do you intend to do so in the future? (✓)

Yes	
-----	--

No	
----	--

Yes	
-----	--

No	
----	--

If Yes, please give full details

Country

Date from

Date to

Reason for visit

**Occupation/Pastimes**

8. Please give full details of your main occupation, for example your primary function or duties and the percentage split between administrative and manual work.



Administrative	%	Manual	%
----------------	---	--------	---

Administrative	%	Manual	%
----------------	---	--------	---

9. Do you work at heights? (✓)

Yes	
-----	--

No	
----	--

Yes	
-----	--

No	
----	--

If Yes, please give the maximum height at which you work

	ft	or		m
--	----	----	--	---

	ft	or		m
--	----	----	--	---

10. Do you work in the armed forces, diving, merchant marine, mining, oil or natural gas industries? (✓)

Yes	
-----	--

No	
----	--

Yes	
-----	--

No	
----	--

If Yes, please state which



11. Do you, or are you likely to, participate in aviation (other than as a fare-paying passenger) or in any hazardous occupation, sport or activity (for example, gliding, motor racing, mountaineering)? (✓)

Yes	
-----	--

No	
----	--

Yes	
-----	--

No	
----	--

If Yes, please give full details



*continued*

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

I	Health and other information <i>(continued)</i>
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For confidentiality, you may send information about your health directly to the Chief Medical Officer at Skandia's Head Office.

First or sole life assured

Second life assured *(if applicable)*

Health

12. Do you currently have any symptoms or medical condition for which you have not yet seen your doctor or received treatment? (✓)

Yes	<input type="checkbox"/>
-----	--------------------------

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

Yes	<input type="checkbox"/>
-----	--------------------------

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

13. Have you ever suffered from any of the following:

a Cancer, Hodgkin's disease, lymphoma or leukaemia, brain or spinal tumours whether malignant or benign? (✓)

Yes	<input type="checkbox"/>
-----	--------------------------

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

Yes	<input type="checkbox"/>
-----	--------------------------

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

b Heart disease including cardiomyopathy, heart valve disorder, angina or heart attack? (✓)

Yes	<input type="checkbox"/>
-----	--------------------------

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

Yes	<input type="checkbox"/>
-----	--------------------------

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

c Stroke or transient ischaemic attack (TIA), brain haemorrhage or permanent brain injury through accident? (✓)

Yes	<input type="checkbox"/>
-----	--------------------------

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

Yes	<input type="checkbox"/>
-----	--------------------------

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

d Multiple sclerosis, Parkinson's disease, paralysis, epilepsy, Alzheimer's disease, dementia or cerebral palsy? (✓)

Yes	<input type="checkbox"/>
-----	--------------------------

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

Yes	<input type="checkbox"/>
-----	--------------------------

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

e Any disorder of the central nervous system (the brain, spinal cord and nerves) not already mentioned? (✓)

Yes	<input type="checkbox"/>
-----	--------------------------

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

Yes	<input type="checkbox"/>
-----	--------------------------

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

f Any disease or abnormality of your arteries or veins, including your aorta, or intermittent claudication? (✓)

Yes	<input type="checkbox"/>
-----	--------------------------

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

Yes	<input type="checkbox"/>
-----	--------------------------

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

g Diabetes or sugar in your urine? (✓)

Yes	<input type="checkbox"/>
-----	--------------------------

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

Yes	<input type="checkbox"/>
-----	--------------------------

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

h Mental illness that has required hospital treatment, or have you attempted to commit suicide? (✓)

Yes	<input type="checkbox"/>
-----	--------------------------

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

Yes	<input type="checkbox"/>
-----	--------------------------

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

14. Within the last five years, have you suffered from:

a Any mole or freckle that has bled, become painful, changed colour or size; or any cysts, growths, lumps or lesions, whether or not you have consulted your doctor about them? (✓)

Yes	<input type="checkbox"/>
-----	--------------------------

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

Yes	<input type="checkbox"/>
-----	--------------------------

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

b Raised cholesterol levels, heart murmur or palpitations, chest pain or raised blood pressure? (✓)

Yes	<input type="checkbox"/>
-----	--------------------------

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

Yes	<input type="checkbox"/>
-----	--------------------------

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

c Asthma, bronchitis, pneumonia or any other lung disorder or condition? (✓)

Yes	<input type="checkbox"/>
-----	--------------------------

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

Yes	<input type="checkbox"/>
-----	--------------------------

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

d Numbness, loss of feeling or tingling of the limbs or face, or temporary loss of muscle power? (✓)

Yes	<input type="checkbox"/>
-----	--------------------------

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

Yes	<input type="checkbox"/>
-----	--------------------------

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

e Fits, epilepsy, blackouts, blurred or double vision? (✓)

Yes	<input type="checkbox"/>
-----	--------------------------

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

Yes	<input type="checkbox"/>
-----	--------------------------

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

f Any problems with your speech, hearing, ears or balance, or problems with your eyes or vision which could not be corrected using spectacles/contact lenses? (✓)

Yes	<input type="checkbox"/>
-----	--------------------------

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

Yes	<input type="checkbox"/>
-----	--------------------------

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

*continued*

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

I Health and other information *(continued)*

First or sole life assured

Second life assured *(if applicable)*

g Arthritis, disorder of the spine, neck or any joint, including slipped disc, sciatica, back or neck pain or gout? (✓)

Yes

No

Yes

No

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

Yes

No

Yes

No

i Any blood disorder, anaemia or thyroid problem? (✓)

Yes

No

Yes

No

j Problems with your kidneys, prostate or bladder such as a urinary infection? (✓)

Yes

No

Yes

No

k Any nervous or mental disorder such as anxiety, stress, depression or schizophrenia; chronic fatigue, or have you been referred to a psychiatrist? (✓)

Yes

No

Yes

No

l Any gynaecological disorder; or breast problem such as a lump or cyst, skin discolouration, bleeding, discharge or any other abnormality? (✓)

Yes

No

Yes

No

15. Other than mentioned above:

a Within the last five years, have you had a blood test, medical investigation or counselling at a hospital, clinic or surgery? (✓)

Yes

No

Yes

No

b Within the last five years, have you had any illness, accident or surgery that has resulted in being off work for more than two weeks at one time? (✓)

Yes

No

Yes

No

c Within the last five years, have you used recreational drugs, for example cannabis, ecstasy, cocaine or heroin? (✓)

Yes

No

Yes

No

d Are you currently having treatment, taking any medicine or drugs or on a special diet for any medical condition not mentioned above? (✓)

Yes

No

Yes

No

**IMPORTANT:** If you have answered Yes to any of the questions numbered 12-15, please complete section J.

16. Please state whether your natural parents, brothers or sisters have suffered from:

- heart disease
- stroke
- diabetes
- kidney disease
- cancer
- multiple sclerosis
- raised blood pressure
- Alzheimer's disease
- motor neurone disease
- Parkinson's disease
- any hereditary disorder, including Huntington's disease

before age 60? (✓)

Yes

No

Yes

No

If you have answered Yes, please state:

*(If the condition was cancer, please specify its site.)*

Relationship
Condition/illness
Age at diagnosis

Relationship
Condition/illness
Age at diagnosis

Relationship
Condition/illness
Age at diagnosis

Relationship
Condition/illness
Age at diagnosis

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

I | Health and other information *(continued)*

**First or sole life assured**

**Second life assured** *(if applicable)*

17. Have you ever tested positive for HIV, Hepatitis B or C or are you awaiting the result of such a test? (✓)

Yes

No

Yes

No

If you have answered Yes, please give full details in the box below. Alternatively, for confidentiality, you may send these directly to our Chief Medical Officer at Skandia's Head Office.



*(Please note that 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.)*

18. Within the last five years have you undergone any surgical procedure outside of the UK, or been a recipient of blood products outside of the UK? (✓)

Yes

No

Yes

No

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

Date from

Date to

Country/Countries

Reason

19. Have you ever injected non-prescribed drugs? (✓)

Yes

No

Yes

No

20. Within the last five years have you tested positive or been treated for any disease, which was transmitted sexually? (✓)

Yes

No

Yes

No

21. How many units of alcohol do you regularly consume each week?

*(1 unit is equivalent to 1/2 pint of beer/lager, 1 glass of wine or 1 measure of spirits)*

units a week

units a week

Have you ever had counselling or been advised to reduce your alcohol consumption for medical reasons? (✓)

Yes

No

Yes

No

*continued*

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

I	Health and other information <i>(continued)</i>
---	---

**First or sole life assured**

**Second life assured** *(if applicable)*

22. Have you smoked tobacco or used any other tobacco or nicotine replacement products (such as gum or patches) in the last 12 months? (✓)

Yes <input style="width: 20px;" type="checkbox"/>	No <input style="width: 20px;" type="checkbox"/>
---	--

Yes <input style="width: 20px;" type="checkbox"/>	No <input style="width: 20px;" type="checkbox"/>
---	--

*If you answer No, we may ask you to take a simple test to verify your answer.*

If Yes:

(i) please provide details of what you smoke and what your average DAILY consumption is?

cigarettes  a day

cigarettes  a day

pipes  gm/oz a day

pipes  gm/oz a day

cigars a day  a day

cigars a day  a day

nicotine replacement products  a day

nicotine replacement products  a day

(ii) Have you ever smoked more than this? (✓)

Yes <input style="width: 20px;" type="checkbox"/>	No <input style="width: 20px;" type="checkbox"/>
---	--

Yes <input style="width: 20px;" type="checkbox"/>	No <input style="width: 20px;" type="checkbox"/>
---	--

If Yes, please state:

Tobacco product

Tobacco product

Average consumption  a day

Average consumption  a day

Year

Year

23. What is your:

i) Height  ft  in or  .  m

ft  in or  .  m

ii) Weight  st  lbs or  kg

st  lbs or  kg

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

J	Additional health information
---	-------------------------------

For each Yes answer you have given to any part of questions 12 to 15 in section I, please complete a set of Additional Medical Questions. If you have given more than four Yes answers, please complete and attach our stand-alone Additional Health Information form available from your financial adviser.

### ADDITIONAL MEDICAL QUESTIONS 1

1. Which life assured do these answers refer to? (✓) 

First life assured	<input type="checkbox"/>
--------------------	--------------------------

Second life assured	<input type="checkbox"/>
---------------------	--------------------------
2. Which question do these answers refer to? *For example, 13a or 14e*

--
3. What is the precise diagnosis of your illness? 

4. When was your illness diagnosed, or when did you have the most recent attack or symptoms, if later? 

Month	<input type="checkbox"/>	<input type="checkbox"/>
-------	--------------------------	--------------------------

Year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
------	--------------------------	--------------------------	--------------------------	--------------------------
5. How many days were you absent from work? If none, state NONE. 

--
6. Have you recovered completely, without any recurrent symptoms? (✓) 

Yes	<input type="checkbox"/>
-----	--------------------------

No	<input type="checkbox"/>
----	--------------------------
7. What treatment did you receive? 

8. Are you currently having treatment? (✓) 

Yes	<input type="checkbox"/>
-----	--------------------------

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

Please complete the questions below ONLY if you have answered Yes to question 14c or 14g in section I

9. What is the nature and severity of the symptoms when they are/were present? 

10. Do/did they restrict you in any way? (✓) 

Yes	<input type="checkbox"/>
-----	--------------------------

No	<input type="checkbox"/>
----	--------------------------
- If Yes, please give details of the restriction 

11. Have you seen a specialist for the condition? (✓) 

Yes	<input type="checkbox"/>
-----	--------------------------

No	<input type="checkbox"/>
----	--------------------------
- If Yes, please give:
- |          |  |
|----------|--|
| Name     |  |
| Hospital |  |
|          |  |
|          |  |

continued

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

J Additional health information *(continued)*

12. What medical investigations have been carried out?


What were the results, if you know them?


Are all investigations now complete? (✓)  Yes  No

Are you waiting for any follow-ups or reviews? (✓)  Yes  No

If Yes, please give details


13. When did you last see your GP about this condition?  Month     Year

14. Have you been admitted to hospital for this condition? (✓)  Yes  No

If Yes, how many times?

When was the last time?  Month     Year

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

16. Is any operation planned or being considered? (✓)  Yes  No

If Yes, when?  Month     Year

Please give details of the operation


*continued*

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

J	Additional health information <i>(continued)</i>
---	--

For each Yes answer you have given to any part of questions 12 to 15 in section I, please complete a set of Additional Medical Questions. If you have given more than four Yes answers, please complete and attach our stand-alone Additional Health Information form available from your financial adviser.

### ADDITIONAL MEDICAL QUESTIONS 2

1. Which life assured do these answers refer to? (✓) 

First life assured	
--------------------	--

Second life assured	
---------------------	--
2. Which question do these answers refer to? *For example, 13a or 14e*

--
3. What is the precise diagnosis of your illness? 

4. When was your illness diagnosed, or when did you have the most recent attack or symptoms, if later? 

Month		
-------	--	--

Year				
------	--	--	--	--
5. How many days were you absent from work? If none, state NONE. 

--
6. Have you recovered completely, without any recurrent symptoms? (✓) 

Yes	
-----	--

No	
----	--
7. What treatment did you receive? 

8. Are you currently having treatment? (✓) 

Yes	
-----	--

No	
----	--

**Please complete the questions below ONLY if you have answered Yes to question 14c or 14g in section I**

9. What is the nature and severity of the symptoms when they are/were present? 

10. Do/did they restrict you in any way? (✓) 

Yes	
-----	--

No	
----	--

If Yes, please give details of the restriction

11. Have you seen a specialist for the condition? (✓) 

Yes	
-----	--

No	
----	--

If Yes, please give:

Name	
Hospital	

*continued*

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

J Additional health information *(continued)*

12. What medical investigations have been carried out?

What were the results, if you know them?

Are all investigations now complete? (✓)  Yes  No

Are you waiting for any follow-ups or reviews? (✓)  Yes  No

If Yes, please give details

13. When did you last see your GP about this condition?  Month     Year

14. Have you been admitted to hospital for this condition? (✓)  Yes  No

If Yes, how many times?

When was the last time?  Month     Year

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

16. Is any operation planned or being considered? (✓)  Yes  No

If Yes, when?  Month     Year

Please give details of the operation

*continued*

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

J Additional health information *(continued)*

For each Yes answer you have given to any part of questions 12 to 15 in section I, please complete a set of Additional Medical Questions. If you have given more than four Yes answers, please complete and attach our stand-alone Additional Health Information form available from your financial adviser.

**ADDITIONAL MEDICAL QUESTIONS 3**

1. Which life assured do these answers refer to? (✓)
2. Which question do these answers refer to? *For example, 13a or 14e*
3. What is the precise diagnosis of your illness?
4. When was your illness diagnosed, or when did you have the most recent attack or symptoms, if later?
5. How many days were you absent from work? If none, state NONE.
6. Have you recovered completely, without any recurrent symptoms? (✓)
7. What treatment did you receive?
8. Are you currently having treatment? (✓)

Please complete the questions below ONLY if you have answered Yes to question 14c or 14g in section I

9. What is the nature and severity of the symptoms when they are/were present?
10. Do/did they restrict you in any way? (✓)      
If Yes, please give details of the restriction
11. Have you seen a specialist for the condition? (✓)      
If Yes, please give: Name   
Hospital

*continued*

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

J | Additional health information *(continued)*

12. What medical investigations have been carried out?


What were the results, if you know them?


Are all investigations now complete? (✓)  Yes  No

Are you waiting for any follow-ups or reviews? (✓)  Yes  No

If Yes, please give details


13. When did you last see your GP about this condition?  Month     Year

14. Have you been admitted to hospital for this condition? (✓)  Yes  No

If Yes, how many times?

--

When was the last time?  Month     Year

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

16. Is any operation planned or being considered? (✓)  Yes  No

If Yes, when?  Month     Year

Please give details of the operation


*continued*



Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

J Additional health information *(continued)*

12. What medical investigations have been carried out?

What were the results, if you know them?

Are all investigations now complete? (✓)  Yes  No

Are you waiting for any follow-ups or reviews? (✓)  Yes  No

If Yes, please give details

13. When did you last see your GP about this condition?  Month     Year

14. Have you been admitted to hospital for this condition? (✓)  Yes  No

If Yes, how many times?

When was the last time?  Month     Year

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

16. Is any operation planned or being considered? (✓)  Yes  No

If Yes, when?  Month     Year

Please give details of the operation

Important notes

Your policy will not start until we have assessed and accepted your application, and the first premium has been paid. 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 will 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 have a medical examination, we 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 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.

You can ask for a copy of our standard Terms and Conditions and a copy of your application form at any time.

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

K	Your rights of 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. 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;
  - 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 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;
- setting premiums at standard rates;
- excluding certain medical conditions and/or increase options from your cover.

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 Skandia's Head Office.

*Each life assured should tick one box only.*

First or sole life assured

Second life assured *(if applicable)*

I wish to see the report before it is sent to Skandia (✓)

I do not wish to see the report before it is sent to Skandia (✓)

If you do not complete this section, we shall assume that you do not wish to see your medical report.

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

L	Declaration and application
---	-----------------------------

Any omission or misstatement of a material fact in this application form could affect the payment of benefits under the policy(ies). A material fact is one which is likely to influence the assessment and acceptance of this application.

You must inform us in writing of any material fact occurring before the policy starts; such as a change of health or an actual or intended change of occupation or activities.

If you are uncertain whether a fact is material, you should give full details so that we can assess its possible significance. If you become aware of such a fact while we are considering your application, you should notify us immediately.

#### **Declaration - by the life assured/each life assured**

- a) I declare that to the best of my knowledge and belief the statements made in this application and any related documents are true and complete and that I have not concealed any material fact.
- b) I undertake to inform you in writing of any material fact occurring before the cover starts, and I understand that failure to do so may result in a proposed policy being rendered void so that no sum assured or other benefits will be payable.
- c) I have been informed of my statutory rights under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (N.I.) Order 1991, as explained in section K. In connection with the insurance currently applied for, I consent to you seeking medical information from any doctor who at any time has attended me concerning anything which affects my physical or mental health within six months of the start of the plan or, after my death, to support any claim made on the policy. I agree that a copy of this consent will have the validity of the original.
- d) I consent to you seeking medical information from any life office to which a proposal for life and/or critical illness assurance has been made on my life and I authorise the giving of such information. I agree that a copy of this authorisation will have the validity of the original.
- e) I understand that where I am not a policyholder for Skandia Protect, I complete this form solely as a life assured.

#### **Application - by the applicant/each applicant**

I apply for Skandia Protect policy(ies) securing the benefits shown in section F and request that the policy(ies) be issued in my name as policyholder and legal owner (jointly with the other policyholder, if any).

#### **For shareholder/partnership protection plans**

I agree to you writing to the nominated person in respect of my policy(ies).

#### **PERSONAL DATA STATEMENT - consent of each life assured and each policyholder**

**To: SKANDIA LIFE ASSURANCE COMPANY LIMITED**

I/We agree that you may use my personal data including any sensitive personal data ('my data') to process my application and to service my plan.

I/We confirm if each life assured has not signed this application, that I/we have obtained the consent of each life assured to this personal data statement and are signing the application as his/her agent as well as applicant.

I understand that:

- You may provide my data, by electronic or other means, to:
  - other companies within the Skandia and Old Mutual groups of companies if you regard this as necessary to service my plan
  - my adviser
  - my employer
  - a third party to verify my identity in line with money laundering or other requirements which may involve carrying out checks with credit reference databases
  - third parties who perform tasks for you to help you service my plan. These third parties may be based in countries outside the EEA. I understand that these countries may not have laws to protect my data equivalent to those of the UK. However, I understand that you will ensure that any such third parties agree to treat my data with the same level of protection as if you were dealing with it.
- To prevent and detect fraud you may:
  - share my data with other organisations, including the police
  - check and/or file my data with fraud prevention agencies and databases, and if I give you false or inaccurate information and you suspect fraud, you will record this.
- You and other companies within the Skandia and Old Mutual groups of companies may use my data for assessment and statistical analysis purposes.
- My data may be made available to third parties where required by law, court order or regulation.
- On payment of a small fee, I am entitled to receive a copy of my data which is subject to the Data Protection Act 1998.
- I also have the right to require you to correct any inaccuracies in my data. In such circumstances I can contact you at Skandia Life Assurance Company Limited, PO Box 37, Southampton, SO14 7AY.

*continued*

Failure to disclose relevant information may result in non-payment of your claim, and we may cancel all cover under your policy.

**L Declaration and application** *(continued)*

**Signatures**

Signature of the first life assured	<input type="text"/>	Date	<input type="text"/>
Signature of the first applicant <i>(if different)</i>	<input type="text"/>	Date	<input type="text"/>
Signature of the second life assured <i>(if any)</i>	<input type="text"/>	Date	<input type="text"/>
Signature of the second applicant <i>(if different)</i>	<input type="text"/>	Date	<input type="text"/>

If the application was NOT signed in the UK, in which country was it signed?

Capacity *(for employer/trustee applications only)*

  


*for example 'As Managing Director' (of the employer company) or 'As trustee of the John Smith Will Trust'*

**Before you send your application form to Skandia, please refer to the checklist on page 29 to make sure you have completed all relevant sections.**

**M Confirmation of verification of identity**

To be completed by your financial adviser.

Please complete this section to verify the identity of all lives assured referred to in section B, if also the policyholder, plus all applicants in section C, upon which Skandia will place reliance.

Once completed, you do not need to send us any additional information documentation or identity verification.

You do not need to complete this section to verify applicant(s):

- (i) who are exempt from verification under the Money Laundering Regulations; or
- (ii) who are exempt from verification as an existing client of the introducing firm prior to the introduction of the requirement for identity verification;
- (iii) whose identity has been verified using the source of funds as evidence.

Where a third party is involved, who is different from the applicant, the identity of that person must also be verified using a separate 'confirmation of verification of identity' form, available from your local Skandia office, or on the literature library on the Skandia Adviser Extranet. Go to [www.skandia.co.uk](http://www.skandia.co.uk) to log on or register.

I/We confirm that:

- (a) the information in section C was obtained by me/us in relation to the applicant
- (b) the evidence I/we have obtained to verify the identity of the applicant meets the standard evidence set out within the guidance for the UK Financial Sector issued by the Joint Money Laundering Steering Group (JMLSG).

Signed*	<input type="text"/>	Date	<input type="text"/>
Name	<input type="text"/>		
Position	<input type="text"/>		
Full name of regulated firm (or sole trader)	<input type="text"/>		
FSA reference number	<input type="text"/>		

*\*This must be signed by the person who has seen the original documentary evidence, which may include an electronic identity check.*

Checklist - all applicants

(✓)

Have you completed all relevant sections (see guide below) and signed section L?

Type of Policy	A	B	C	D	E	F	G	H	I	J	L
Personal Protection	✓	✓				✓	✓	✓	✓	✓	✓
Life of another/Key person protection	✓	✓	✓			✓	✓	✓	✓	✓	✓
Shareholder/Partnership protection	✓	✓		✓		✓	✓	✓	✓	✓	✓
Mortgage protection	✓	✓			✓	✓	✓	✓	✓	✓	✓

Section H only applies if the automatic inflation option is required.

Section J only applies if you have answered Yes to any of the questions numbered 12 - 15 in section I.

If you are paying monthly, have you completed and signed the attached direct debit instruction?

Where applicable, have you attached a cheque for the first premium?

If the Plan is to be written under trust, have you completed and attached a declaration of trust deed?

Checklist - financial adviser

(✓)

Have you answered the question regarding the advice at the start of this form?

Have you completed the confirmation of verification of identity in section M?

Failure to provide evidence of your client's identity may delay any future withdrawal or surrender request.

Please remember to enclose a copy of the quote.

Calls may be monitored and recorded for training purposes and to avoid misunderstandings.

Skandia Life Assurance Company Limited (an incorporated company limited by shares) Registered number: 1363932 England  
Registered Office: Skandia House, Portland Terrace, Southampton, SO14 7EJ, United Kingdom. Authorised and regulated by the Financial Services Authority  
FSA Register number 110462

SK376/26-1601

00000

Please complete the form and send to:

Skandia, PO Box 37, Skandia House, Portland Terrace, Southampton SO14 7AY.

Originator's Identification Number

7	6	8	2	4	2
---	---	---	---	---	---

Name and full postal address of bank or building society branch

Reference number

Skandia will complete this box

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

To: The Manager
<b>bank or building society</b>
Address
Postcode

### Instruction to your bank or building society

Please pay Skandia Life Assurance Company Limited 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 Skandia Life Assurance Company Limited and, if so, details will be passed electronically to my bank or building society.

Signature(s)

Date

	/	/
	/	/

Name(s) of accountholder(s)

--

Bank or building society account number

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

Building society reference number

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

Branch sort code 

--	--	--

 - 

--	--	--

 - 

--	--	--

*Banks and building societies may not accept direct debit instructions for some types of account.*

### Third party payer details – FOR SKANDIA OFFICIAL USE ONLY – This is not part of the instruction to your bank or building society

Where the payer is not the policyholder, please provide the full name, date of birth, address and telephone number of the bank/building society accountholder. Where a company is paying on behalf of the policyholder, please provide: the company name, name of contact person, address and telephone number of the company. The accountholder's personal data may be made available to a third party by electronic or other means for the purpose of verifying identity in accordance with Money Laundering Regulations. *In some circumstances the policyholder may be the only person permitted to pay premiums. Please contact Skandia if you have any queries with this.*

Full forename(s) 

--

Address

--

Surname 

--

Date of birth 

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

Company name (if applicable) 

--

Postcode

--

Name of contact person (if applicable) 

--

Telephone number

--

- This Guarantee is offered by all banks and building societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by your own bank or building society.
- If the amounts to be paid or the payment dates change Skandia will notify you five working days in advance of your account being debited or as otherwise agreed.
- If an error is made by Skandia or your bank or building society, you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a direct debit at any time by writing to your bank or building society. Please also send a copy of your letter to us.

**Skandia**

Head Office  
PO Box 37  
Skandia House  
Portland Terrace  
Southampton  
SO14 7AY  
**T:** 023 8033 4411  
**F:** 023 8022 0464

Calls may be monitored and recorded for training purposes and to avoid misunderstandings.

Skandia Life Assurance Company Limited (an incorporated company limited by shares) Registered number: 1363932 England  
Registered Office: Skandia House, Portland Terrace, Southampton, SO14 7EJ, United Kingdom. Authorised and regulated by the Financial Services Authority  
FSA Register number 110462

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**Skandia**

Head Office  
PO Box 37  
Skandia House  
Portland Terrace  
Southampton  
SO14 7AY  
**T:** 023 8033 4411  
**F:** 023 8022 0464

Calls may be monitored and recorded for training purposes and to avoid misunderstandings.

Skandia Life Assurance Company Limited (an incorporated company limited by shares) Registered number: 1363932 England  
Registered Office: Skandia House, Portland Terrace, Southampton, SO14 7EJ, United Kingdom. Authorised and regulated by the Financial Services Authority  
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