

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	196606077
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"/>



Elixia 123 Personal Critical Illness Cover Application Form



Please return this form to Unum
PO Box 7733, Redcliffe Way, Bristol, BS99 1PJ.
Cheques should be made payable to Unum.

FOR INTERMEDIARY USE ONLY

A. Intermediary Details

- A1. Full name of firm
- A2. FSA Registration Number
- A3. Unum Agency Number (if known)
- A4. Has the applicant been given financial advice in connection with this application? Yes No
- A5. Please ensure a copy of the quotation is enclosed with this application. Copy quote enclosed (tick box)

B. Customer Identity Verification

Verification of the identity of all parties (i.e. life insured and, if different, the applicant and payer of the premiums) is required before Unum can accept the risk and issue the policy. This requirement can be waived if the premiums payable to Unum for all policies, including this application, total less than £50 a month / £600 a year. If necessary, use a separate form for each party.

Is payment to be drawn from a UK / EU regulated bank or building society?

Yes

No

If Yes, please complete **EITHER** sections B2 and B3 **OR** sections B3, B4 and B5.

If No, please complete sections B3, B4 and B5.

B1. Other Party Details

ONLY complete the name and address details if premiums are to be paid by a party other than the applicant.

Please give the name, date of birth, current address of the third party and their relationship to the applicant. If they have resided at their current address for less than 3 months provide their details in the box overleaf.

Name (please print)

Date of birth

Current address

Relationship to the applicant

B2. Source of Funds Concession

Account name

Account number

Sort code

I have seen verification evidence that the payer of the premiums owns the above account e.g. statement of account, cheque with confirmation of account details added.

Yes

No

If No, you cannot rely on the Source of Funds Concession. You must complete sections B3, B4 and B5.

B3. Signature

Signature of person who has seen the original documentary evidence:

Date

Name (please print)

Position

B. Customer Identity Verification (continued)

B4. Proof of Name

Please tick ONE box from the list and insert the details requested into the details section below.

Current signed passport (Details required: passport number, date of expiry, country of issue)

Current full UK / EU photo-card driving licence (Details required: driver number)

National Insurance card (Details required: name, number)

Inland Revenue tax notification (Details required: date of issue, unique reference number)

Benefit book or original notification letter from the benefits agency confirming the right to benefits
(Details required: type of evidence sighted (e.g. letter / book, type of benefit))

Other (Details required: Please check with Unum Sales Consultant)

Details

B5. Proof of Address

Please tick ONE box from the list and insert the details requested into the details section below.

Home visit (Details required: date of visit)

Recent utility bill or statement for current address e.g. gas, electricity, water (maximum of three months old)
(Details required: utility provider, bill reference number, date of issue)

Recent original mortgage statement from a recognised lender for current address (maximum of three months old)
(Details required: name of lender, date of statement, name(s) of loan holder)

Bank, building society or credit union statement or passbook containing current address
(Details required: name of institution, sort code, account number, and name of account holder(s))

Current local authority council tax bill for current address (Details required: date of issue, bill reference number)

Current full UK driving licence / current UK photo-card driving licence (if not used for proof of name)
(Details required: driver number)

Local council rent card or tenancy agreement for current address
(Details required: name of council / person with whom tenancy held)

Other (Details required: Please check with Unum Sales Consultant)

Details

B6. Additional information

Previous address

Postcode

Elixia 123 Personal Critical Illness Cover Application Form

Application to Unum Limited ("Unum").

Please answer all questions in BLOCK CAPITALS, ticking boxes as appropriate.

Important

The information required on this application form is 'material' to the policy in that it may affect the acceptance of your application or the terms issued. Failure to disclose all the material facts may reduce the amount of benefit payable under the policy or even invalidate the cover entirely. If you are in any doubt as to whether certain facts are material to your application, please state the information in full.

- **You must tell us** if you have a family history of any medical condition, including any genetically inherited condition, or if you are experiencing symptoms of, or are having treatment for, any such medical condition.
- **You do not need to tell us about any genetic test result you have had.** This statement of our practice is correct at the time of printing this form and remains so while, in the opinion of the Government's Genetics and Insurance Committee, it is inappropriate for any genetic test result to be used in critical illness insurance risk assessment.
- You may like to tell us about a genetic test you have had that shows you are not at risk of developing a particular disease that may run in your family.

C. Personal Details (of the life to be insured)	
C1. Surname	<input type="text"/>
C2. Title (please tick one of these boxes or state another title)	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other <input type="text"/>
C3. Forename(s)	<input type="text"/>
C4. Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>
C5. Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
C6. Marital Status	<input type="text"/>
C7. Home address	<input type="text"/> <input type="text"/> <input type="text"/>
	Postcode
C8. Telephone number	<input type="text"/> (Daytime)
C9. Name and address of usual doctor	
Dr	<input type="text"/>
Address	<input type="text"/> <input type="text"/>
	Postcode
Telephone number	<input type="text"/> (Daytime)

D. Plan Details

D1. Overall maximum amount of critical illness protection

£

Of which % or £ is to be paid under Category 1

% or £ is to be paid under Category 2

% or £ is to be paid under Category 3 (must not exceed Category 1)

Minimum is 10% in each Category

It is important to understand that different forms of cancer, heart attack and stroke are defined in each of Categories 1 and 3, and that Category 1 covers only the most severe levels of these illnesses.

D2. Period of cover?

years

D3. Please choose one of the 3 cover options below (tick one only):

Level Cover

Increasing Cover

Reducing Cover

D4. Premiums are to be paid monthly or yearly?

Monthly

Yearly*

*If yearly, do you wish to pay by direct debit or by cheque?

Direct debit

Cheque

D5. As soon as we accept your application, we will normally issue a plan immediately. This would ensure that you have the full protection of your plan straight away.

If you would prefer to wait until a particular date for cover to start, please tick the box.

Preferred start date (if known)

/ /

D6. We will normally collect your premiums at monthly (or yearly) intervals on or near the same day of the month to coincide with the start date of your plan.

If you would prefer us to collect premiums on a particular day of the month, please tell us what day (between 1st and 28th) you would prefer:

Premium collection date

D7. Have you smoked or otherwise used any tobacco products in the last 12 months or do you intend to in the future?

Yes

No

If **Yes**, please state your daily use (eg number of cigarettes, cigars smoked per day)

per day

D8. Do you want to include Waiver of Premium?

Yes

No

PLEASE NOTE THAT YOUR COVER IS NOT IN FORCE UNTIL WE HAVE ACCEPTED YOUR APPLICATION AND THE FIRST PREMIUM HAS BEEN RECEIVED.

E. Medical Details

E1. Have any of your natural parents, brothers or sisters been diagnosed with, or died from, any of the following before the age of 60:

- Cancer, heart disease, high blood pressure, circulatory disorders or stroke, diabetes or kidney disease, multiple sclerosis, paralysis or any other disorder of the brain or nervous system?

Yes

No

If **Yes**, please tell us below the nature of the illness, their relationship to you and their age at diagnosis. For cancer, please tell us which part of the body was affected.

Details:

E2. Have you consulted any doctor or been advised to have an operation, x-ray, check up or investigation in the past 5 years (other than routine minor conditions or pregnancy without complications)?

Yes

No

If **Yes**, please give us full details below including dates, treatment, medication and indicate whether a full recovery has been made.

Details:

E3. Have you ever had symptoms of, or been diagnosed with, any of the following:

- high blood pressure, chest pain, angina, heart or circulatory disorder or stroke
- lump, growth, tumour or cancer
- diabetes or kidney disease
- liver, stomach, intestinal, bowel or bladder disease
- paralysis (temporary or permanent) or any form of numbness or tingling
- mental or nervous disorder (including depression, anxiety or stress)
- arthritis or other disorder of the bones, joints or spine, including back pain
- asthma, bronchitis or other chest complaint
- any disorder of the ear or eye (that is not corrected by lens)
- any skin disorder?

Yes

No

Yes

No

Yes

No

Yes

No

Yes

No

Yes

No

Yes

No

Yes

No

Yes

No

Yes

No

If **Yes**, please give us full details below including dates, treatment, medication and indicate whether a full recovery has been made.

Details:

E. Medical Details (continued)

E4. Are you currently experiencing any symptoms of, or suffering from, or expecting to seek medical advice about, any illness, impairment or disability not already mentioned above or are you taking any medication?

Yes

No

Details:

E5. Please state your average WEEKLY alcohol intake (in units)

NB: One unit = 1/2 pint of beer, one glass of wine or one measure of spirits.

 units

E6. What is your height?

*delete as appropriate

 ft/m* **ins/cm***

E7. What is your weight?

*delete as appropriate

 st/kg* **lbs/g***

Access to Medical Report Act 1988/Access to Personal Files and Medical Reports (Northern Ireland) Order 1991/Access to Health Records and Reports Act 1993 (Isle of Man) ("the Acts")

To enable us to assess your application for cover, it may be necessary to obtain medical evidence. Any reports which are requested from your doctors are subject to the Acts. (Please note that reports requested from doctors appointed by Unum are not subject to the Acts.) In summary, your statutory rights are as follows:

1. A Medical Report cannot be requested from any doctor who has attended you, without your written authority.
2. You do not have to give your consent. If you do consent, you can say whether you wish to see the report before it is sent to the Company's Chief Medical Officer. If you do not give consent we may be unable to proceed with your application for cover.
3. If you say you wish to see the report, we will write to your doctor and tell them, and advise you that we have done so. You will then have 21 days to contact the doctor to make arrangements to see the report. Of course, the quicker you act the quicker your application for insurance can be considered.
4. If you say you do not wish to see the report, we do not have to notify you if we apply for one. However, you may write to your doctor and request to see such a report before it is sent to us. You will then have 21 days to contact the doctor to make arrangements to see the report.
5. Whether or not you say you wish to see the report before it is sent to us, you may ask your doctor to show you a copy of the report for up to 6 months after it is supplied.
6. If you ask the doctor for a copy of the report, the doctor can charge you a reasonable fee to cover costs.
7. If you see a report before it is sent to us, the doctor cannot submit it until you give your consent. You can write to the doctor, asking that any part of the report which you consider to be incorrect or misleading be amended, and to have attached to the report a statement of your views on any part where you and the doctor are not in agreement.
8. The doctor is not obliged to let you see any part of a report if,
 - in his/her opinion it would be likely to cause serious harm to your physical or mental health, or that of others,
 - it would indicate the doctor's intentions towards you,
 - disclosure would be likely to reveal information relating to, or the identity of, someone else who has supplied information about you, unless that person has consented,
 - the information relates to, or has been supplied by, a health professional involved in caring for you.

In such cases, the doctor must notify you and you will be limited to seeing any remaining part of the report. If it is the whole report which is affected, the doctor must not send it to us unless you give your consent.

Data Protection Act 1998

Information about you will be put on our database and used by Unum Limited (trading as Unum) who is the data controller, in making decisions about the provision of cover and servicing your relationship with us and for the purposes of identity verification, fraud prevention, audit and debt collection, and claim verification.

We may conduct, or have conducted on our behalf, checks with external agents in connection with this application when dealing with the policy applied for or to validate a claim. We or our agent may ask you for more information, or carry out further checks and searches when assessing your application, or at any time during the life of your policy for the purposes of fraud prevention and claim verification.

We may share information about you with:

- your nominated GP,
- third parties – including but not limited to the Association of British Insurers, Trustees in Bankruptcy, reassurers, underwriters and medical agencies (in the UK and abroad) and sub-contractors and agents in order to provide you with the service applied for, for fraud prevention or so that services may be processed on our behalf,
- insurance reference agencies – this information will be used by other agency users in assessing insurance risk and for fraud prevention,
- government regulators and or the Ombudsman – to help resolve a complaint or for audit purposes,
- other insurance companies who require the information for lawful purposes.

To help improve our service and in the interests of security we may monitor and/or record your telephone calls with us.

continued overleaf

Declarations and Consents

Declaration to be completed by the life to be insured

1. I declare that to the best of my knowledge and belief the statements made in this application are true and complete. I live and am actively at work in the United Kingdom. I agree to inform the company immediately in writing of any change to any information provided on this application form prior to the policy coming into force. I understand that failure to do so may affect the subsequent payment of benefits under the policy.
2. I have read and I understand my statutory rights under the Access to Medical Reports Act 1988/Access to Personal Files and Medical Reports (Northern Ireland) Order 1991/Access to Health Records and Reports Act 1993 (Isle of Man) as outlined above and I consent to Unum seeking medical information, including copies of my medical records, from any doctor who at any time has attended me, concerning anything which affects my physical or mental health. I consent to Unum confirming the underwriting decision, including any special terms which may be applied, to my financial advisers or (if applicable) to the Applicant for this policy and the Applicant's financial advisers. I consent to Unum seeking information from any insurance office to which an application has been made for insurance on my life and authorise the giving of such information. I have read and I understand the exclusion clauses described in the Key Features booklet.

Do you wish to see the report before it is sent to Unum?

Yes

No

3. I have read and understood the section on the Data Protection Act 1998 and

I consent to Unum being provided with confidential information concerning this application, including but not limited to information concerning my physical and/or mental health or condition from any third party; and

I authorise the release of confidential information, including but not limited to information concerning my physical and/or mental health or condition obtained by Unum, to my doctors or any doctors or specialists appointed by Unum in relation to the application and to any third party who requires such information for lawful purposes.

Signature

Date

Full name

Declaration to be completed by the Applicant (if other than the life to be insured)

Full name

What is the relationship to the life to be insured?

Address

I/we agree that this application shall form the basis of the contract.

Applicant's Signature

Date



Instruction to your Bank or Building Society to pay by Direct Debit

Please fill in the whole form using a black ball point pen and send it to:



Unum
PO Box 7733
Redcliffe Way
Bristol
BS99 1PJ

Name(s) of Account Holder(s)

Bank/Building Society account number

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

Branch Sort Code

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

Reference Number

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

Originator's Identification Number

9	3	0	9	8	4
---	---	---	---	---	---

FOR UNUM OFFICIAL USE ONLY
This is not part of the instruction to your Bank or Building Society

Instruction to your Bank or Building Society

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

Name and full postal address of your Bank or Building Society

To: The Manager	Bank/Building Society
Address	
Postcode	

Signature(s):
Date:

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

This guarantee should be detached and retained by the Payer.

The Direct Debit Guarantee



- 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 Unum will notify you 14 working days in advance of your account being debited or as otherwise agreed.
- If an error is made by Unum 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.

For Policy Enquiries:

For policy enquiries, please contact us at the following address:

Unum,
PO Box 7733,
Redcliffe Way,
Bristol, BS99 1PJ.

Telephone: 0117 910 7733
Facsimile: 0117 910 7734
E-mail: individual@unum.co.uk

For Genetic Information:

If you require further information about what you need to tell us about genetic conditions or you wish to give us information in confidence, please contact:

The Chief Medical Officer
Unum,
Milton Court,
Dorking, RH4 3LZ.

unum.co.uk

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We monitor telephone conversations and e-mail communications from time to time for the purposes of training and in the interests of continually improving the quality of service we provide.

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Surrey RH4 3LZ.
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01306 881394 FAX
01306 887784 TXT TEL

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