

LIFETIME+

Application Form



IMPORTANT INFORMATION

All the information that you provide will be shared with all parties to this application. Please be aware that we may not pay a claim and could cancel the plan if you do not answer the questions in this application form truthfully and accurately.

You can get this and other documents from us in Braille or large print by contacting your financial adviser.

HELP US TO HELP YOU...

We aim to process your application as quickly as possible. However, to avoid unnecessary delay please make sure you read the Important Information shown below:

Fully complete all sections in clear BLOCK CAPITALS and in black ink.

Read, sign and date the Declaration and the Direct Debit Instruction.

If you are applying for this plan with someone else you will both become the plan owners even if you are not the person or people insured.

Where there are two plan owners, all correspondence will be addressed to both of you and sent to the address shown for the first plan owner. Medical correspondence will always be sent to the relevant person insured.

Throughout this form 'applicant' means the person or people applying for the insurance and will be the plan owner(s). 'Person/people insured' means the person or people you are insuring. If you are applying to insure your own life and/or health you need to complete all relevant sections.

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SECTION B – DETAILS OF APPLICANT(S)

This section should be completed only if the Applicant(s) is/are different from the person/people insured.

Please be aware that we may not pay a claim and could cancel the plan you do not answer the following questions truthfully and accurately.

1st Applicant

Title Mr/Mrs/Miss/Ms/Dr/Other _____

First name(s) _____

Surname _____

House number or name _____

Address Line 1 _____

Address Line 2 _____

Town/City _____

Postcode _____

Country _____

2nd Applicant (if applicable)

Title Mr/Mrs/Miss/Ms/Dr/Other _____

First name(s) _____

Surname _____

House number or name _____

Address Line 1 _____

Address Line 2 _____

Town/City _____

Postcode _____

Country _____

1st Applicant

What insurable Interest do you have in the person/people insured (reason you would lose out financially) e.g. Spouse, Partner, Financial Relationship, Business cover?

2nd Applicant

What insurable Interest do you have in the person/people insured (reason you would lose out financially) e.g. Spouse, Partner, Financial Relationship, Business cover?

1st Applicant

2nd Applicant

(if applicable)

Do you have any existing life insurance policies with LV= or Liverpool Victoria? Yes No Yes No

If 'yes' please supply your existing policy number(s) if known

Are you a member of Liverpool Victoria Friendly Society

 Yes

 No

 Yes

 No

Have you any prospect or intention of residing outside the UK?

 Yes

 No

 Yes

 No

If 'Yes' please give full details, including the proposed country of residence, how long you intend to live there and the month and year you intend to return to the UK.

1st Applicant

2nd Applicant (if applicable)

SECTION C – PERSONAL DETAILS OF THE PERSON/PEOPLE INSURED

Please be aware that we may not pay a claim and could cancel the plan if you do not answer the following questions truthfully and accurately.

1st Person Insured

Title Mr/Mrs/Miss/Ms/Dr/Other

First name(s)

Surname

Marital Status

Married
 Civil Partner
 Single
 Widowed
 Divorced/Dissolution
 Separated

Maiden Name (if applicable)

Date of Birth / / -- DD/MM/YYYY

Please send evidence of age, (birth certificate, passport, driving licence, marriage or civil partnership certificate) with this application. If this evidence shows a different name to your current name please also include evidence of your name change.

Gender Male Female

Telephone number (including area code)

Daytime

Evening

E-mail address

House number or name

Address Line 1

Address Line 2

Town/City

Postcode

Country

2nd Person Insured (if applicable)

Title Mr/Mrs/Miss/Ms/Dr/Other

First name(s)

Surname

Marital Status

Married
 Civil Partner
 Single
 Widowed
 Divorced/Dissolution
 Separated

Maiden Name (if applicable)

Date of Birth / / -- DD/MM/YYYY

Gender Male Female

Telephone number (including area code)

Daytime

Evening

E-mail address

House number or name

Address Line 1

Address Line 2

Town/City

Postcode

Country

1st Person Insured

2nd Person Insured (if applicable)

Do you have any existing life insurance policies with LV= or Liverpool Victoria? Yes No Yes No

If 'yes' please supply your existing policy numbers (if known)

How much cover do you have with LV= or Liverpool Victoria? £ £

Will you be cancelling any of these policies? Yes No

Are you a member of Liverpool Victoria Friendly Society? Yes No Yes No

1st Person Insured**2nd Person Insured (if applicable)**

Have you any prospect or intention of residing outside the UK?

Yes

No

Yes

No

If 'Yes' please give full details, including the proposed country of residence, how long you intend to live there and the month and year you intend to return to the UK.

1st Person Insured**2nd Person Insured (if applicable)****1st Person Insured****2nd Person Insured (if applicable)**

What is your height?

ft

ins

ft

ins

or

cms

or

cms

What is your weight?

st

lbs

st

lbs

or

kgs

or

kgs

What is your typical consumption of alcohol per week?

units per week

units per week

1 glass of wine (175ml) = 2 units, 1 pint of standard lager/beer = 2 units, 1 measure spirits (25ml) = 1 unit

Have you smoked or used any tobacco or nicotine products in the last 12 months?

Yes

No

Yes

No

Note: If you answer 'No' to this question, you may be asked to undergo a test to verify your answer.

For the following tobacco products,

Cigarettes

Cigarettes

please state your typical consumption per day.

Cigars

Cigars

Pipe tobacco

Pipe tobacco

ounces or

ounces or

grams

grams

Are you currently applying to, or do you have existing policies in force with any other provider for Life cover?

Yes

No

Yes

No

If 'Yes', will the concurrent applications be cancelled on acceptance of this application?

Yes

No

Yes

No

Does the total existing amount of cover and this application and any other application(s) exceed £600,000 (lump sum) Life Cover?

Yes

No

Yes

No

OCCUPATION DETAILS

Please be aware that we may not pay a claim and could cancel the plan if you do not answer the following questions truthfully and accurately.

	1st Person Insured	2nd Person Insured (if applicable)
What is your occupation?	<input type="text"/>	<input type="text"/>

Does your occupation involve working in any of the following:-

Armed forces

Commercial aviation with flying duties

Fishing industry

Oil or gas production industry

Underground

Underwater

With explosives

At heights greater than 12 metres?

 Yes No

 Yes No

If you have answered 'Yes' to the above question, please provide full details in the box provided below.

1st Person Insured

2nd Person Insured (if applicable)

	1st Person Insured	2nd Person Insured (if applicable)
Is your occupation admin/clerical and 100% office based?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Does your job involve any manual work (e.g. carrying, lifting, working with machinery or tools)?

 Yes No

 Yes No

If 'Yes', please give full details relating to your occupation including a description of your duties and percentage of time spent on each activity.

1st Person Insured

2nd Person Insured (if applicable)

	1st Person Insured	2nd Person Insured (if applicable)
If your work involves driving (other than commuting to and from work) what is your annual business mileage?	<input type="text"/> miles	<input type="text"/> miles

Does your job involve any overseas business trips?

 Yes No

 Yes No

If 'Yes', how many business trips do you make per year?

1st Person Insured

2nd Person Insured (if applicable)

If 'Yes', do you only travel to Europe,
North America, Australia or New Zealand?

Yes No

Yes No

If 'No', please give full details, including the countries you will visit, duration of stay and how many trips.

1st Person Insured

2nd Person Insured (if applicable)

1st Person Insured

2nd Person Insured (if applicable)

Do you have more than one occupation?

Yes No

Yes No

If 'Yes' please provide details.

1st Person Insured

2nd Person Insured (if applicable)

LIFESTYLE AND LEISURE PURSUITS OF THE PERSON/PEOPLE INSURED

Please be aware that we may not pay a claim and could cancel the plan if you do not answer the following questions truthfully and accurately.

1st Person Insured **2nd Person Insured**
(if applicable)

Except for holidays of less than 30 days, have you any intention of going abroad? Yes No Yes No
If 'Yes' please give full details relating to this including the countries you will visit, dates and duration of stay and reasons for the trip.

1st Person Insured

2nd Person Insured (if applicable)

1st Person Insured **2nd Person Insured**
(if applicable)

Within the last 5 years have you lived or frequently travelled to an area which has a high incidence of HIV infection? Yes No Yes No
If 'Yes' please give full details

1st Person Insured

2nd Person Insured (if applicable)

1st Person Insured **2nd Person Insured**
(if applicable)

Do you now, or do you intend to, take part in hazardous activities or sports (e.g. motor sport, mountaineering, diving or aviation)? Yes No Yes No
If 'Yes' please give full details

1st Person Insured

2nd Person Insured (if applicable)

MEDICAL DETAILS OF THE PERSON/PEOPLE INSURED

Genetic Test Results

For this application we do not need to know about any genetic test result if the amount of cover is £500,000 or less.

Above these limits, you may need to tell us about certain genetic test results. We will only be interested in genetic test results where the Government's Genetics and Insurance Committee has approved them for insurers to use. If you think this may apply to you, please ask us for details of the current position.

In all cases you must tell us if you are experiencing symptoms of, or having treatment for a genetic condition.

However, for a genetic condition present in the immediate family, it will be to the applicant's benefit to tell us of a negative test for the same condition.

Details of the Association of British Insurer's Code of Practice in relation to genetic testing and insurance are available on request.

Please be aware that we may not pay a claim and could cancel the plan if you do not answer the following questions truthfully and accurately.

If any of the following questions are answered 'Yes' you will need to complete the additional medical questions on pages 15 to 20.

	1st Person Insured	2nd Person Insured (if applicable)
1a)i) Have you ever tested positive for HIV, Hepatitis B or C? If 'Yes', which? 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
ii) Are you awaiting an HIV or Hepatitis B or C test result?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
1b) Have you ever injected non-prescription drugs or used recreational drugs (e.g. cannabis, cocaine, heroin) or taken prescribed drugs other than on the advice of your doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
1c) Within the last 5 years have you ever been exposed to the risk of HIV infection (this can be caught through unsafe sex, intravenous drug abuse or blood transfusions or surgery undertaken outside of the EU)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
1d) Within the last 5 years have you tested positive or been treated for any disease which was transmitted sexually?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Do you currently have or have you ever had any of the following:		
2a) Cancer, tumour, 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
2b) Heart disease or disorder, including heart attack, angina, cardiomyopathy, heart valve disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2c) Stroke, Transient Ischaemic Attack (TIA), brain haemorrhage, permanent brain damage through accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2d) Multiple sclerosis, Parkinson's disease, epilepsy, paralysis, Alzheimer's disease, dementia or cerebral palsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2e) Any other disease of the central nervous system (the brain, spinal cord and nerves) not already mentioned?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2f) Any disease or disorder of the arteries, including disease in the legs or of the aorta?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2g) Diabetes or sugar in the urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2h) 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

3) In the last 5 years have you had any of the following:

- 3a) A lump, growth of any kind or any mole or freckle that has bled, become painful, changed colour or increased in size, whether or not you have consulted a doctor about them? Yes No Yes No
- 3b) Any blood circulatory problem, chest pain, irregular heart beat, raised blood pressure or raised cholesterol? Yes No Yes No
- 3c) Asthma, Bronchitis or any other respiratory disorder? Yes No Yes No
- 3d) Numbness, loss of feeling or tingling in the limbs or face, or temporary loss of muscle power? Yes No Yes No
- 3e) Seizure, fits, epilepsy, fainting, dizziness or blackouts? Yes No Yes No
- 3f) Disorder of the eyes, including blurred or double vision or optic neuritis?
(Sight problems corrected by glasses or contact lenses can be ignored.) Yes No Yes No
- 3g) Disorder of the ears, hearing or balance? Yes No Yes No
- 3h) Arthritis, rheumatoid arthritis, spine, neck or joint disorder, including slipped disc, sciatica, back, neck, shoulder or knee pain or gout? Yes No Yes No
- 3i) 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
- 3j) Blood disorder or anaemia? Yes No Yes No
- 3k) Thyroid disorder? Yes No Yes No
- 3l) Kidney, bladder or any other disease of the genito-urinary system, including blood or protein in the urine and urinary tract infection? Yes No Yes No
- 3m) Any cervical smear needing treatment, investigation or advice or any other gynaecological disorder? Yes No Yes No
- 3n) Prostate enlargement or abnormal PSA? Yes No Yes No
- 3o) Skin disease? Yes No Yes No
- 3p) Mental illness including depression, anxiety, stress, nervous breakdown, insomnia, or eating disorders? Yes No Yes No
- 3q) Chronic Fatigue Syndrome (CFS), ME, or fibromyalgia? Yes No Yes No

4) When answering the following questions numbered 4(a) to 4(d) you need not tell us again if you have already told us in response to an earlier question or questions on this application.

- 4a) In the last 5 years have you received any investigations, scans or blood tests (including liver function tests) in connection with any medical condition which you have not told us about already in this application form? Yes No Yes No
- 4b) In the last 5 years have you received any form of medical attention at a hospital as an inpatient or outpatient in connection with any medical condition which you have not told us about already in this application form? Yes No Yes No
- 4c) Are you currently taking any prescribed drugs, medicines, tablets or any other treatment for any medical condition which you have not told us about already in this application form?
(Please ignore contraceptives, hayfever treatments, cold/flu remedies) Yes No Yes No
- 4d) Have you ever been advised to reduce or stop drinking alcohol for medical or health reasons of which you have not told us about already in this application form? Yes No Yes No

1st Person Insured **2nd Person Insured**
(if applicable)

5) In the last 5 years have you drunk more than 30 units of alcohol per week on a regular basis? Yes No Yes No
1 glass of wine (175ml) = 2 units, 1 pint of standard lager/beer = 2 units, 1 measure spirits (25ml) = 1 unit

6) Are you awaiting the results of, or have been advised to have, any medical investigations, tests or scans (including smear, PSA test or mammogram)? Yes No Yes No

7) Have you any expectation of seeking medical advice or treatment or undergoing a check or routine scan in the near future? Yes No Yes No

8) Have you ever been declined or accepted at other than normal terms for Life, Critical Illness, Accident and Sickness insurance or Income Protection with any provider? Yes No Yes No
If 'Yes', was this due to a medical condition, occupation or hobby/activity already disclosed on this application? Yes No Yes No

If 'No', please provide full details

1st Person Insured

2nd Person Insured (if applicable)

1st Person Insured **2nd Person Insured**
(if applicable)

9) Are you currently off work due to sickness or injury? Yes No Yes No

If 'Yes', please provide full details

1st Person Insured

2nd Person Insured (if applicable)

If any of the above questions are answered 'Yes' you will need to complete the additional medical questions on pages 15 to 20. A new page should be completed for each medical condition.

FAMILY HISTORY OF THE PERSON/PEOPLE INSURED

Please be aware that we may not pay a claim and could cancel the plan if you do not answer the following questions truthfully and accurately.

1st Person Insured **2nd Person Insured**
(if applicable)

Have any of your natural parents, brothers or sisters been diagnosed with or died from any of the following hereditary disorders before the age of 65? Yes No Yes No

	1st or 2nd person insured	Relation	Age at onset	Current age or age at Death
a) Heart disease? Raised blood pressure? Stroke? Diabetes?				
b) Cardiomyopathy?				
c) Cancer? (please specify area affected)				
d) Multiple Sclerosis?				
e) Huntington's disease?				
f) Polycystic kidney disease?				
g) Polyposis of the colon?				
h) Motor neurone disease?				
i) Parkinson's disease?				
j) Alzheimers disease?				
k) Other hereditary disorders?				

DOCTOR/CLINIC DETAILS OF THE PERSON/PEOPLE INSURED

Please be aware that we may not pay a claim and could cancel the plan if you do not answer the following questions truthfully and accurately.

You should not assume that we will write to your doctor for a report, although we may do so.

1st Person Insured	2nd Person Insured (if applicable)
Name of Doctor/Clinic	Name of Doctor/Clinic
Building Number or name	Building Number or name
Address Line 1	Address Line 1
Address Line 2	Address Line 2
Town/City	Town/City
Postcode	Postcode
Country	Country
Telephone number (inc area code)	Telephone number (inc area code)
Have you been with your doctor/clinic for less than 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been with your doctor/clinic for less than 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No

If 'Yes' please give details of your previous doctor/clinic below:

1st Person Insured	2nd Person Insured (if applicable)
Name of Doctor/Clinic	Name of Doctor/Clinic
Building Number or name	Building Number or name
Address Line 1	Address Line 1
Address Line 2	Address Line 2
Town/City	Town/City
Postcode	Postcode
Country	Country
Telephone number (inc area code)	Telephone number (inc area code)

TELEPHONE APPOINTMENT FOR THE PERSON/PEOPLE INSURED

We may need to contact you by telephone to gather some additional information. Please select the most convenient time and telephone number for us to call you. Every effort will be made to contact you during the selected time period.

1st Person Insured	2nd Person Insured (if applicable)
Time <input type="checkbox"/> 9am – 12 noon <input type="checkbox"/> 12 noon – 6pm <input type="checkbox"/> 6pm – 9pm	Time <input type="checkbox"/> 9am – 12 noon <input type="checkbox"/> 12 noon – 6pm <input type="checkbox"/> 6pm – 9pm
Telephone Number (inc area code)	Telephone Number (inc area code)

Do you know of any dates in the near future when you will be unavailable for a telephone appointment?

If 'Yes', please provide details below

1st Person Insured	2nd Person Insured (if applicable)
<div style="border: 1px solid black; height: 100px;"></div>	<div style="border: 1px solid black; height: 100px;"></div>

DETAILS OF SPECIFIC MEDICAL CONDITION 1

This page is provided so that you can give us further information about any medical conditions that you have told us about in pages 10-13. Please complete a separate page for each medical condition and continue on a blank page if necessary.

Detailed answers to these questions may help to speed up the processing of your application.

Please be aware that we may not pay a claim and could cancel the plan if you do not answer the following questions truthfully and accurately.

(Please be as specific as possible, if relevant please give specific details of the limb/part of the body involved. For example arthritis – right knee; Breast cyst)

To which person insured does the following information apply? 1st Person Insured 2nd Person Insured

Which question do the following answers relate to on pages 10-13?

What condition has been diagnosed?

When did this condition first occur? Month/year / / DD/MM/YYYY

When did you last have symptoms? Month/year / / DD/MM/YYYY

Have symptoms been continuous? Yes No

If 'No', how many episodes have you suffered?

Please confirm what symptoms you are suffering or have suffered and the severity

Have you been told that this condition is due to another medical condition? Yes No

If 'Yes', please provide full details.

Are you currently having treatment, for example any medication, specialist appointments? Yes No

If 'Yes', please confirm the type of treatment being received and the frequency

If you have had previous treatment, please confirm the type and the frequency

Have you had any tests or investigations? Yes No

If 'Yes', what were they?

What were the results?

Have you been admitted to hospital with this condition? Yes No

If 'Yes', how many times? and when?

Are you awaiting any investigations, operation or the results of tests or investigations? Yes No

If 'Yes', please provide details.

How much time off work have you taken in relation to this condition and when was this?

If you've had time off work have you now fully returned to work? Yes No

Are you fully recovered? Yes No

DETAILS OF SPECIFIC MEDICAL CONDITION 2

This page is provided so that you can give us further information about any medical conditions that you have told us about in pages 10-13. Please complete a separate page for each medical condition and continue on a blank page if necessary.

Detailed answers to these questions may help to speed up the processing of your application.

Please be aware that we may not pay a claim and could cancel the plan if you do not answer the following questions truthfully and accurately.

(Please be as specific as possible, if relevant please give specific details of the limb/part of the body involved. For example arthritis – right knee; Breast cyst)

To which person insured does the following information apply? 1st Person Insured 2nd Person Insured

Which question do the following answers relate to on pages 10-13?

What condition has been diagnosed?

When did this condition first occur? Month/year / / DD/MM/YYYY

When did you last have symptoms? Month/year / / DD/MM/YYYY

Have symptoms been continuous? Yes No

If 'No', how many episodes have you suffered?

Please confirm what symptoms you are suffering or have suffered and the severity

Have you been told that this condition is due to another medical condition? Yes No

If 'Yes', please provide full details.

Are you currently having treatment, for example any medication, specialist appointments? Yes No

If 'Yes', please confirm the type of treatment being received and the frequency

If you have had previous treatment, please confirm the type and the frequency

Have you had any tests or investigations? Yes No

If 'Yes', what were they?

What were the results?

Have you been admitted to hospital with this condition? Yes No

If 'Yes', how many times? and when?

Are you awaiting any investigations, operation or the results of tests or investigations? Yes No

If 'Yes', please provide details.

How much time off work have you taken in relation to this condition and when was this?

If you've had time off work have you now fully returned to work? Yes No

Are you fully recovered? Yes No

DETAILS OF SPECIFIC MEDICAL CONDITION 3

This page is provided so that you can give us further information about any medical conditions that you have told us about in pages 10-13. Please complete a separate page for each medical condition and continue on a blank page if necessary.

Detailed answers to these questions may help to speed up the processing of your application.

Please be aware that we may not pay a claim and could cancel the plan if you do not answer the following questions truthfully and accurately.

(Please be as specific as possible, if relevant please give specific details of the limb/part of the body involved. For example arthritis – right knee; Breast cyst)

To which person insured does the following information apply? 1st Person Insured 2nd Person Insured

Which question do the following answers relate to on pages 10-13?

What condition has been diagnosed?

When did this condition first occur? Month/year / / DD/MM/YYYY

When did you last have symptoms? Month/year / / DD/MM/YYYY

Have symptoms been continuous? Yes No

If 'No', how many episodes have you suffered?

Please confirm what symptoms you are suffering or have suffered and the severity

Have you been told that this condition is due to another medical condition? Yes No

If 'Yes', please provide full details.

Are you currently having treatment, for example any medication, specialist appointments? Yes No

If 'Yes', please confirm the type of treatment being received and the frequency

If you have had previous treatment, please confirm the type and the frequency

Have you had any tests or investigations? Yes No

If 'Yes', what were they?

What were the results?

Have you been admitted to hospital with this condition? Yes No

If 'Yes', how many times? and when?

Are you awaiting any investigations, operation or the results of tests or investigations? Yes No

If 'Yes', please provide details.

How much time off work have you taken in relation to this condition and when was this?

If you've had time off work have you now fully returned to work? Yes No

Are you fully recovered? Yes No

DETAILS OF SPECIFIC MEDICAL CONDITION 4

This page is provided so that you can give us further information about any medical conditions that you have told us about in pages 10-13. Please complete a separate page for each medical condition and continue on a blank page if necessary.

Detailed answers to these questions may help to speed up the processing of your application.

Please be aware that we may not pay a claim and could cancel the plan if you do not answer the following questions truthfully and accurately.

(Please be as specific as possible, if relevant please give specific details of the limb/part of the body involved. For example arthritis – right knee; Breast cyst)

To which person insured does the following information apply? 1st Person Insured 2nd Person Insured

Which question do the following answers relate to on pages 10-13?

What condition has been diagnosed?

When did this condition first occur? Month/year / / DD/MM/YYYY

When did you last have symptoms? Month/year / / DD/MM/YYYY

Have symptoms been continuous? Yes No

If 'No', how many episodes have you suffered?

Please confirm what symptoms you are suffering or have suffered and the severity

Have you been told that this condition is due to another medical condition? Yes No

If 'Yes', please provide full details.

Are you currently having treatment, for example any medication, specialist appointments? Yes No

If 'Yes', please confirm the type of treatment being received and the frequency

If you have had previous treatment, please confirm the type and the frequency

Have you had any tests or investigations? Yes No

If 'Yes', what were they?

What were the results?

Have you been admitted to hospital with this condition? Yes No

If 'Yes', how many times? and when?

Are you awaiting any investigations, operation or the results of tests or investigations? Yes No

If 'Yes', please provide details.

How much time off work have you taken in relation to this condition and when was this?

If you've had time off work have you now fully returned to work? Yes No

Are you fully recovered? Yes No

DETAILS OF SPECIFIC MEDICAL CONDITION 5

This page is provided so that you can give us further information about any medical conditions that you have told us about in pages 10-13. Please complete a separate page for each medical condition and continue on a blank page if necessary.

Detailed answers to these questions may help to speed up the processing of your application.

Please be aware that we may not pay a claim and could cancel the plan if you do not answer the following questions truthfully and accurately.

(Please be as specific as possible, if relevant please give specific details of the limb/part of the body involved. For example arthritis – right knee; Breast cyst)

To which person insured does the following information apply? 1st Person Insured 2nd Person Insured

Which question do the following answers relate to on pages 10-13?

What condition has been diagnosed?

When did this condition first occur? Month/year / / DD/MM/YYYY

When did you last have symptoms? Month/year / / DD/MM/YYYY

Have symptoms been continuous? Yes No

If 'No', how many episodes have you suffered?

Please confirm what symptoms you are suffering or have suffered and the severity

Have you been told that this condition is due to another medical condition? Yes No

If 'Yes', please provide full details.

Are you currently having treatment, for example any medication, specialist appointments? Yes No

If 'Yes', please confirm the type of treatment being received and the frequency

If you have had previous treatment, please confirm the type and the frequency

Have you had any tests or investigations? Yes No

If 'Yes', what were they?

What were the results?

Have you been admitted to hospital with this condition? Yes No

If 'Yes', how many times? and when?

Are you awaiting any investigations, operation or the results of tests or investigations? Yes No

If 'Yes', please provide details.

How much time off work have you taken in relation to this condition and when was this?

If you've had time off work have you now fully returned to work? Yes No

Are you fully recovered? Yes No

DETAILS OF SPECIFIC MEDICAL CONDITION 6

This page is provided so that you can give us further information about any medical conditions that you have told us about in pages 10-13. Please complete a separate page for each medical condition and continue on a blank page if necessary.

Detailed answers to these questions may help to speed up the processing of your application.

Please be aware that we may not pay a claim and could cancel the plan if you do not answer the following questions truthfully and accurately.

(Please be as specific as possible, if relevant please give specific details of the limb/part of the body involved. For example arthritis – right knee; Breast cyst)

To which person insured does the following information apply? 1st Person Insured 2nd Person Insured

Which question do the following answers relate to on pages 10-13?

What condition has been diagnosed?

When did this condition first occur? Month/year / / DD/MM/YYYY

When did you last have symptoms? Month/year / / DD/MM/YYYY

Have symptoms been continuous? Yes No

If 'No', how many episodes have you suffered?

Please confirm what symptoms you are suffering or have suffered and the severity

Have you been told that this condition is due to another medical condition? Yes No

If 'Yes', please provide full details.

Are you currently having treatment, for example any medication, specialist appointments? Yes No

If 'Yes', please confirm the type of treatment being received and the frequency

If you have had previous treatment, please confirm the type and the frequency

Have you had any tests or investigations? Yes No

If 'Yes', what were they?

What were the results?

Have you been admitted to hospital with this condition? Yes No

If 'Yes', how many times? and when?

Are you awaiting any investigations, operation or the results of tests or investigations? Yes No

If 'Yes', please provide details.

How much time off work have you taken in relation to this condition and when was this?

If you've had time off work have you now fully returned to work? Yes No

Are you fully recovered? Yes No

SECTION D – IMPORTANT NOTES AND DECLARATION

The plan 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 may not be able to offer any terms. We may ask you to contact your doctor if we are waiting for reports which we have asked for. If we ask you to come for a medical examination, we will need to share the application information with another company we have authorised. They will make the arrangements for the examination to take place.

We may need to send your application and relevant medical reports to our reassurers for their opinion or agreement of the terms offered. Or, we may need to send them at a later stage for purposes relating to managing the plan. You can get details of general reassurance principles and details of any company we use to assess your application, from our head office. We have a confidentiality policy in place which means we hold your medical information securely and access is limited to authorised individuals who need to see it. You are entitled to ask for a copy of our standard terms and conditions and a copy of your application form at any time.

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 you've had 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 test), height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations.
- any blood pressure readings in the last three years.

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

We have asked your doctor not to reveal information about:

negative tests for HIV, Hepatitis B or C;

any sexually-transmitted diseases unless there could be long-term effects on your health; or

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

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

refusing to provide insurance;

increasing premiums above standard rates; or

setting premiums at standard rates.

If you have any questions about your rights under the act or questions relating to the process of getting, assessing or storing medical information, please write to: LV=, Pynes Hill House, Rydon Lane, Exeter EX2 5SP

I have read the Important Notes and information relating to my rights under the Access to Medical Reports Act.

I **do not want** to see the report before it is sent to the society (please tick) **1st Person Insured** **2nd Person Insured** (if applicable)

I **do want** to see the report before it is sent to the society (please tick) **1st Person Insured** **2nd Person Insured** (if applicable)

Declaration

I agree to you asking any doctor I have consulted about my physical or mental health to provide medical information so you may assess my proposal. You may gather relevant information from other insurers about any other applications for life, critical illness, sickness, disability, accident or private medical insurance that I have applied for. I authorise those asked to provide medical information when they see a copy of this consent form. This form allows you to gather medical reports within six months of the start of the plan, or after my death, to support any claim made on the plan proceeds.

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

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.

I understand that all parties to this application must sign this application. For the person insured, this requirement extends to them signing the summary of any interviews that may be required for the purposes of underwriting the plan. If all signatures are not received within 60 days from the start of the plan, Liverpool Victoria Friendly Society Limited will cancel the plan and no premiums will be refunded.

You should not assume that we will write to your doctor for a report, although we may do so. Please ensure that you have answered all the questions truthfully and accurately.

You MUST tell us about any changes in your health, occupation duties or other information you have provided in this application, which take place before the plan starts. For example you must tell us if you have had any medical consultations, advice, treatment, or investigations, of if you have changed job, or if the main duties that you carry out as part of your job have changed. If you don't tell us, we may not pay a claim, and could cancel your plan.

I wish to enter into a contract for the benefit stated in this application on Liverpool Victoria Friendly Society Limited ('the Society') normal terms and conditions. I hereby declare that my answers in this application are true and complete and that I have not withheld or concealed any circumstances on which information is required. I acknowledge that any plan which the Society may issue to me is so issued in reliance on the contents of this application, the answers in my medical report(s), if any, and this declaration. Failure to comply with these requirements may invalidate the plan.

I will inform you immediately of any changes in my health, occupational duties or other information provided to the Society that occur before the Society assumes risk under the plan. I understand that the Society must be informed of such changes and failure to do so may result in the contract being declared void, and that a claim for the proceeds may not be paid.

To the best of my knowledge and belief all the statements made, which includes anything I may have said, have been recorded accurately in this application or are attached in a sealed private and confidential envelope, and are true and complete.

This disclosure will form the basis of the contract. (Please tick if you have attached a private and confidential envelope.)

I agree that the Society can use any sensitive information I provide, such as health and medical information, to process my application and for the ongoing management of my plan. This information may be passed on to:

- my GP
- the medical practitioner acting for the Society
- reinsurers or any other insurer I've applied and given consent to
- my financial adviser
- any associated company of the Society.

I agree to the Society accepting medical reports faxed directly to the Society from my doctor's surgery. I also do not* object to copies of the report being faxed to any of those parties to whom the Society may disclose personal data, as stated above, at their request. (*Delete the word 'not' if you do not wish us to fax information.)

In the event of a claim I understand that my name, date of birth and post code will be provided to the Association of British Insurers (ABI) Health Claims database which has been set up to deter/prevent fraud.


LV= may use information given to make searches about me at credit reference agencies that hold my information (such as from the electoral roll). The agencies check my identity and will keep records of these searches, even if my application doesn't go ahead. I understand that LV= may use scoring methods to check my identity and may ask me for supporting documents.

I may be contacted by telephone, post or other electronic methods.

I confirm that I am UK resident.

LV= may use information provided to process my application and manage my plan. The information may be kept electronically or on paper file for as long as the application is being considered, while the plan is active and for an appropriate length of time after that.

Please be aware that we may not pay a claim and could cancel the plan if you do not answer the questions in this application truthfully and accurately.

 We'll keep your information and add it to our customer databases even if your application doesn't go ahead. We may use it to keep our records up to date, for business analysis and market research. We won't include you in direct marketing campaigns and we may pass your details to other carefully selected organisations, but only for the purposes listed here.

I confirm that the Society advised me to read the Declaration, Important Notes, and information relating to my rights under the Access to Medical Reports Act. I agree that by signing below I am bound by these sections.

Signed _____ / / / DD/MM/YYYY

1st Person Insured

Signed _____ / / / DD/MM/YYYY

2nd Person Insured (if applicable)

Signed Applicant A _____ / / / DD/MM/YYYY

If different from Person Insured

Signed Applicant B _____ / / / DD/MM/YYYY

(If applicable) if different from Person Insured

Subject to payment of a fee, if you'd like us to send you a copy of the personal information we hold about you, please write to CCA Department, LV=, County Gates, Bournemouth BH1 2NF.

For more information about the LV= group of companies please go to www.lv.com

THE DIRECT DEBIT GUARANTEE To be retained by the Applicant(s)

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits.
- If there are any changes to the amount, date or frequency of your Direct Debit LV= will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request LV= to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your Direct Debit, by LV= or your bank or building society, you are entitled to a full and immediate refund of the amount paid from your bank or building society.
- If you receive a refund you are not entitled to, you must pay it back when LV= asks you to.
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.

SECTION E - DIRECT DEBIT INSTRUCTION

Direct Debit is a simple method of payment and is required in all cases. The instruction conforms to the strict requirements of the clearing banks and you are fully protected by the safeguards under the Direct Debit guarantee. We will give you advance notice of the payments and details of the guarantee when the risk has been accepted by the underwriter. The Direct Debit instruction below should be completed but not detached.

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

Please fill in the whole form and send it to: LV=, Pynes Hill House, Rydon Lane, Exeter, EX2 5SP

Please ensure you complete all details



1. Name and full postal address of your Bank or Building Society

To: The Manager
Bank or Building Society
Address
Postcode

Originator's Identification Number

4. Bank or Building Society account No.

5. For completion by LV=

6. Instruction to your Bank or Building Society

Please pay Liverpool Victoria Friendly Society Limited Direct Debits from the account detailed on this instruction subject to the safeguards assured by The Direct Debit Guarantee. I understand that this instruction may remain with Liverpool Victoria Friendly Society Limited, and, if so, details will be passed electronically to my Bank/Building Society.

Signature

Date

2. Name(s) of account holder(s)

3. Branch sort code (from the top right hand corner of your cheque)

 - -

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

FOR FINANCIAL ADVISER USE ONLY

Address for applications

LV=, Pynes Hill House, Rydon Lane, Exeter EX2 5BF.

Please tick the relevant boxes.

- | | | | |
|---|--------------------------|--|--------------------------|
| All relevant sections filled in? | <input type="checkbox"/> | Is a Trust Form included? | <input type="checkbox"/> |
| Has the declaration been signed? | <input type="checkbox"/> | Have you provided your Agency details? | <input type="checkbox"/> |
| Have the doctor's details been fully completed? | <input type="checkbox"/> | Have you attached the relevant illustration? | <input type="checkbox"/> |

Commission options (please tick your preferred option)

- Full initial commission (indemnified non-indemnified) and renewal commission
- Initial commission sacrifice of: % (indemnified non-indemnified)
- Nil commission

Source code

Financial Adviser stamp and/or agency no.