

FLEXIBLE PROTECTION PLAN

Application Form



This application form is for new Flexible Protection Plans only. If you already have a Flexible Protection Plan, and wish to add policies to it, or change the policies in it, please contact us for the appropriate 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 policy if you do not answer the questions in this application form truthfully and accurately.

We are able to provide literature and communications in alternative formats: If you would like this document in Braille or large print, please contact 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 policy owners of every policy in the plan even if you are not the person insured.

Where there are two policy owners, all correspondence will be addressed to both of you and sent to the address shown for the first policy 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 policy owners. 'Person or 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.

WHICH POLICIES WOULD YOU LIKE TO APPLY FOR:

		1st Person Insured	2nd Person Insured	Joint Life
Life Protection	On page 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Critical Illness Protection	On page 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Combined Life & Critical Illness Protection	On pages 8	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Income Protection	On page 8 & 9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mortgage Payment Protection	On pages 9 & 10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver of Premium	On page 10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you adding further policies to an existing plan?
If so, please state the plan number

Does the policy you are applying for replace any policy currently within your existing plan? Yes No

If 'yes', please give details in the box below

SECTION A – DETAILS OF THE PERSON OR PEOPLE APPLYING FOR THIS PLAN (THE PLAN OWNERS)

This section should be completed only if the Applicant(s) is/are different from the Person or People being insured.

Please be aware that we may not pay a claim and could cancel the policy if 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

If you are completing this form on behalf of a Company or other body, please complete the following 2 questions.

Full Name of the Company or other body?

Client Type? – Please circle as appropriate: Trustee / Corporation / Partnership / Creditor / Charity / Estate / Will / Other

1st Applicant

Insurable Interest in the Person or People being insured (reason you would lose out financially) for example: Spouse, Partner, Financial Relationship, Business cover

2nd Applicant (if applicable)

Insurable Interest in the Person or People being insured (reason you would lose out financially) for example: Spouse, Partner, Financial Relationship, Business cover

1st Applicant

2nd Applicant (if applicable)

Do you have any existing life, income protection or critical illness policies with LV= or Liverpool Victoria?

Yes No

Yes No

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

Are you an existing member of Liverpool Victoria Friendly Society Limited?

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 B – PERSONAL DETAILS OF THE PERSON OR PEOPLE BEING INSURED

Please be aware that we may not pay a claim and could cancel the policy if you do not answer the following sections 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

Gender Male Female

Telephone number (including area code)
 Day _____
 Evening _____

Email 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)
 Day _____
 Evening _____

Email 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, income protection, or critical illness policies with LV= or Liverpool Victoria?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'yes' please supply your existing policy numbers (if known)	<input type="text"/>	<input type="text"/>
How much cover and what types of policy do you have with LV= or Liverpool Victoria?	Life <input type="checkbox"/> £ <input type="text"/>	Life <input type="checkbox"/> £ <input type="text"/>
	Critical Illness <input type="checkbox"/> £ <input type="text"/>	Critical Illness <input type="checkbox"/> £ <input type="text"/>
	Income Protection <input type="checkbox"/> £ <input type="text"/> per month	Income Protection <input type="checkbox"/> £ <input type="text"/> per month
Will you be cancelling any of these policies? If 'Yes' please tick the relevant box(es)	Life <input type="checkbox"/> Critical Illness <input type="checkbox"/> Income Protection <input type="checkbox"/>	Life <input type="checkbox"/> Critical Illness <input type="checkbox"/> Income Protection <input type="checkbox"/>
Are you an existing member of Liverpool Victoria Friendly Society Limited?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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

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2nd Person Insured (if applicable)

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

What is your height?

 ft ins
 or cms

 ft ins
 or cms

What is your weight?

 st lbs
 or kgs

 st lbs
 or kgs

What is your typical consumption of alcohol per week?

 units a week units a 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,

please state your typical consumption a day.

 Cigars Cigarettes Cigars Cigarettes

Pipe tobacco

 ounces or
 grams

Pipe tobacco

 ounces or
 grams
OCCUPATION DETAILS**1st Person Insured****2nd Person Insured (if applicable)**

What is your occupation?

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

Armed forces (including reservists or territorial army)

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

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2nd Person Insured (if applicable)

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	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 (for example: carrying, lifting, working with machinery or tools)?

	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
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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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If 'Yes', how many business trips do you make per year?	<input type="text"/>	<input type="text"/>
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If 'Yes', do you only travel to Europe, North America, Australia or New Zealand?

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

If 'Yes' please provide details.

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

POLICY SELECTION

To be completed by the applicant(s) and the Person or People being insured.

Is the policy for:	<input type="checkbox"/> Personal Cover? <input type="checkbox"/> Business Cover?
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Is the policy to be written in trust?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Your Financial Adviser can provide you with a trust form.

If your application is accepted on normal terms do you wish the policy to start immediately?

	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If 'No', please state the date you would like the policy to start.	<input type="text"/> / <input type="text"/> / <input type="text"/> DD/MM/YYYY
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Have you had advice from a Financial Adviser on this product?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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1st Person Insured**2nd Person Insured (if applicable)**

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

Income Protection 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, £300,000 (lump sum) Critical Illness cover or £150,000 (a year) Income Protection cover?

Yes No

Yes No

Life Protection

Who is being insured?

1st Person Insured and/or **2nd Person Insured** and/or **Joint Life**

Single cover

Single cover

both people first event

Level amount of cover

Policy Term years

years

years

Amount of cover

£

£

£

Decreasing amount of cover

Policy Term years

years

years

Amount of cover

£

£

£

Inflation-Linked amount of cover

Policy Term years

years

years

Amount of cover

£

£

£

Critical Illness

Choice of Cover

You may select **one** of three types of critical illness cover; these are outlined below and will apply to both people being insured for **all** critical illness policies in this plan.

Protection Type – please tick **one** only

Critical Illness including Permanent Total Disability

Critical Illness excluding Permanent Total Disability

Permanent Total Disability cover only

Critical Illness Protection

Please make sure you have selected **one** of the above before completing this section.

Who is being insured?

1st Person Insured and/or **2nd Person Insured** and/or **Joint Life**

Single cover

Single cover

both people first event

Level amount of cover

Policy Term years

years

years

Amount of cover

£

£

£

Decreasing amount of cover

Policy Term years

years

years

Amount of cover

£

£

£

Inflation-linked amount of cover

Policy Term years

years

years

Amount of cover

£

£

£

Combined Life and Critical Illness Protection

***If you choose Guaranteed Premiums, the amount of the critical illness cover cannot be more than the amount of life cover.**

Who is being insured? **1st Person Insured** and/or **2nd Person Insured** and/or **Joint Life**
 Single cover Single cover both people first event

Level amount of cover

Type of Premium* Guaranteed Guaranteed Guaranteed
 or Reviewable or Reviewable or Reviewable
 Policy Term years years years
 Amount of life cover £ £ £
 Amount of critical illness cover £ £ £

Do you require the option to buyback life cover following a critical illness claim? (This only applies to single cover policies).

1st Person Insured Yes No **2nd Person Insured** Yes No

Decreasing amount of cover

Type of Premium* Guaranteed Guaranteed Guaranteed
 or Reviewable or Reviewable or Reviewable
 Policy Term years years years
 Amount of life cover £ £ £
 Amount of critical illness cover £ £ £

Do you require the option to buyback life cover following a critical illness claim? (This only applies to single cover policies).

1st Person Insured Yes No **2nd Person Insured** Yes No

Who is being insured? **1st Person Insured** and/or **2nd Person Insured** and/or **Joint Life**
 Single cover Single cover both people first event

Inflation-linked amount of cover

Type of Premium* Guaranteed Guaranteed Guaranteed
 or Reviewable or Reviewable or Reviewable
 Policy Term years years years
 Amount of life cover £ £ £
 Amount of critical illness cover £ £ £

Do you require the option to buyback life cover following a critical illness claim? (This only applies to single cover policies).

1st Person Insured Yes No **2nd Person Insured** Yes No

Income Protection

This policy is designed to pay a regular monthly income if you are unable to work because of sickness or accident. The payments from this policy are limited to 50% of income. When calculating this figure, all other sickness and accident insurances will be taken into account including the amount of cover for any mortgage payment protection policies in this plan. **It is important to check that the amount of cover for this policy (and all other sickness and accident policies) do not exceed 50% of earned income.**

Annual taxable earned income* on which the Income Protection policy will be based:

		1st Person Insured	2nd Person Insured
Salaried employee	Salary	£ <input type="text"/> a year	£ <input type="text"/> a year
(not a company director)			
Salaried employee	Salary	£ <input type="text"/> a year	£ <input type="text"/> a year
(company director)	Dividends	£ <input type="text"/> a year	£ <input type="text"/> a year
Self-employed		£ <input type="text"/> a year	£ <input type="text"/> a year
(Please indicate if your income arises from different sources. Separate policies will be issued to cover each source.)			

For how long will you receive full pay if you are off work because of sickness or accident? months months

Would you receive reduced pay? Yes No Yes No

If 'Yes', please state the period you period period
 would receive reduced pay and the % %
 percentage this will be of your full pay.

*** By earned income, we mean the income earned before tax, less any expenses that are allowable against income tax. Normally, if employed this will be your salary before tax, but for company directors, earned income may include earnings received as dividends provided these are paid from current profits. For self-employed individuals, earned income is taken to be their share of the profits, i.e. gross profit less expenses. In the event of a claim we must see evidence of earnings such as most recent P60 and payslips for an employee, or the most recent accounts and HM Revenue & Customs notice of assessment for the self-employed. We must see this evidence to confirm the level of income before the claim, because it is this amount that we use to work out how much we'll pay out. If the evidence we receive doesn't support the amount of cover applied for, then the amount we'll pay out for a claim will be less than the amount covered. More information on how we work out how much we can pay out is explained in the policy conditions.**

Who is being insured?

Depending on your circumstances you may need more than one Income Protection policy within your plan. Should you wish to effect two policies at the same time, you can do this by completing both columns for the person insured below.

	<input type="checkbox"/> 1st Person Insured	<input type="checkbox"/> 1st Person Insured	<input type="checkbox"/> 2nd Person Insured	<input type="checkbox"/> 2nd Person Insured
Amount of cover** (a month)	£ <input type="text"/>	£ <input type="text"/>	£ <input type="text"/>	£ <input type="text"/>
Type of Premium	<input type="checkbox"/> Guaranteed or <input type="checkbox"/> Reviewable	<input type="checkbox"/> Guaranteed or <input type="checkbox"/> Reviewable	<input type="checkbox"/> Guaranteed or <input type="checkbox"/> Reviewable	<input type="checkbox"/> Guaranteed or <input type="checkbox"/> Reviewable
Waiting period (months)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 12 <input type="checkbox"/> 24	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 12 <input type="checkbox"/> 24	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 12 <input type="checkbox"/> 24	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 12 <input type="checkbox"/> 24
Age at which policy ends	<input type="text"/> years	<input type="text"/> years	<input type="text"/> years	<input type="text"/> years
This must be from age 50 to 65 inclusive.				
Type of cover***	i) <input type="checkbox"/> Full or <input type="checkbox"/> Budget ii) <input type="checkbox"/> Level or <input type="checkbox"/> Inflation-linked	<input type="checkbox"/> Full or <input type="checkbox"/> Budget <input type="checkbox"/> Level or <input type="checkbox"/> Inflation-linked	<input type="checkbox"/> Full or <input type="checkbox"/> Budget <input type="checkbox"/> Level or <input type="checkbox"/> Inflation-linked	<input type="checkbox"/> Full or <input type="checkbox"/> Budget <input type="checkbox"/> Level or <input type="checkbox"/> Inflation-linked

**** The overall maximum amount of cover payable will be 50% of earned income
 LESS any payments from other sickness or accident insurance policies (including mortgage payment protection policies under this plan)
 LESS 60% of any ill-health or retirement benefits
 LESS 60% of any continuing earnings from employment
 PLUS if the person insured is not eligible to receive Employment and Support Allowance, the Basic and Work Related Activity Components of Employment and Support Allowance**

***** Please refer to your Policy Summary or Key Features document for a full explanation of types of cover**

Mortgage Payment Protection

Mortgage Payment Protection is designed to pay your selected monthly mortgage payment if you (or the person you are insuring, if this is someone else) are unable to work due to sickness or accident.

Mortgage Details

Amount of mortgage £ Term years
 Monthly mortgage payment £ Date of move (if applicable) //
D D M M Y Y Y Y

We will be unable to process the application for this cover without this information

Salary Details

Annual taxable earned income* on which the policy will be based:

If you have already given your salary details because you are applying for Income Protection, you do not need to provide the information again.

		1st Person Insured	2nd Person Insured
Salaried employee (not a company director)	Salary	£ <input type="text"/> a year	£ <input type="text"/> a year
Salaried employee (company director)	Salary	£ <input type="text"/> a year	£ <input type="text"/> a year
	Dividends	£ <input type="text"/> a year	£ <input type="text"/> a year

Self-employed

£ a year

£ a year

* **By earned income, we mean the income earned before tax, less any expenses that are allowable against income tax. Normally, if employed this will be your salary before tax, but for company directors, earned income may include earnings received as dividends provided these are paid from current profits. For self-employed individuals, earned income is taken to be their share of the profits, i.e. gross profit less expenses. In the event of a claim we must see evidence of earnings such as most recent P60 and payslips for an employee, or the most recent accounts and HM Revenue & Customs notice of assessment for the self-employed. We must see this evidence to confirm the level of income before the claim, because it is this amount that we use to work out how much we'll pay out. If the evidence we receive doesn't support the amount of cover applied for, then the amount we'll pay out for a claim will be less than the amount covered. More information on how we work out how much we can pay out is explained in the policy conditions.**

Policy Type

Please indicate which type of mortgage protection policy you require by ticking the appropriate box(es) below:

	1st Person Insured	2nd Person Insured	Joint Life
Mortgage Payment Protection – Integrated Health You can only choose this policy if you are also applying for a Critical Illness Protection policy for the same person insured. The amount of cover for Critical Illness Protection must be at least equal to the mortgage amount and in the event that a Critical Illness Protection claim is paid, the Integrated Health policy will end. The term of the Integrated Health policy may not exceed the term of the Critical Illness Protection policy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mortgage Payment Protection – Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mortgage Payment Protection – Budget Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please complete the sections that are relevant to the types of policy you have selected:

Mortgage Payment Protection – Integrated Health, Health and Budget Health

Who will this cover apply to?	<input type="checkbox"/> 1st Person Insured, and/or	<input type="checkbox"/> 2nd Person Insured, and/or	<input type="checkbox"/> Joint Life
Type of Premium	<input type="checkbox"/> Guaranteed or <input type="checkbox"/> Reviewable or	<input type="checkbox"/> Guaranteed <input type="checkbox"/> Reviewable	<input type="checkbox"/> Guaranteed or <input type="checkbox"/> Reviewable
Policy term	<input type="text"/> years	<input type="text"/> years	<input type="text"/> years
Amount of cover (a month)	£ <input type="text"/>	£ <input type="text"/>	£ <input type="text"/>
Waiting period (months)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 12 <input type="checkbox"/> 24	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 12 <input type="checkbox"/> 24	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 12 <input type="checkbox"/> 24

Please note: the total amount of cover for all people insured must not exceed 140% of the initial monthly mortgage payment.

Waiver of Premium

	1st Person Insured	2nd Person Insured (if applicable)
Do you require Waiver of Premium?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If 'Yes' please complete the following.

This policy will cover the premiums for all of the policies in your plan in the event of sickness, accident or disability.

1st Person Insured	2nd Person Insured
Waiting period (months) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 6	Waiting period (months) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 6
	1st Person Insured 2nd Person Insured (if applicable)

If you have chosen policies in this plan to continue beyond age 65,

would you also like waiver of premium to extend beyond age 65? Yes No Yes No

LIFESTYLE AND LEISURE PURSUITS OF THE PERSON OR PEOPLE BEING INSURED

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

	1st Person Insured	2nd Person Insured (if applicable)		
<hr/>				
Except for holidays of less than 30 days, have you any intention of going abroad?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> 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)		
<hr/>				
Within the last 5 years have you lived or frequently travelled to an area which has a high incidence of HIV infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If 'Yes' please give full details				
1st Person Insured	2nd Person Insured (if applicable)			

	1st Person Insured	2nd Person Insured (if applicable)		
<hr/>				
Do you now, or do you intend to, take part in hazardous activities or sports (e.g. motor sport, mountaineering, diving or aviation)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If 'Yes' please give full details				
1st Person Insured	2nd Person Insured (if applicable)			

MEDICAL DETAILS OF THE PERSON OR PEOPLE BEING INSURED

Genetic Test Results

- For this application we do not need to know about any genetic test result subject to the amount of cover being within:
 - £500,000 or less for Life Protection
 - £300,000 or less for Critical Illness
 - £30,000 or less for Income Protection.
- 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 policy 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 16 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 style="width: 100px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input style="width: 100px;" 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3b) Any blood circulatory problem, chest pain, irregular heart beat, raised blood pressure or raised cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3c) Asthma, Bronchitis or any other respiratory disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3d) Numbness, loss of feeling or tingling in the limbs or face, or temporary loss of muscle power?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3e) Seizure, fits, epilepsy, fainting, dizziness or blackouts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3g) Disorder of the ears, hearing or balance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3h) Arthritis, rheumatoid arthritis, spine, neck or joint disorder, including slipped disc, sciatica, back, neck, shoulder or knee pain or gout?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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
- 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 16 to 20. A new page should be completed for each medical condition.

FAMILY HISTORY OF THE PERSON OR PEOPLE BEING INSURED

Please be aware that we may not pay a claim and could cancel the policy 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? 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 OR PEOPLE BEING INSURED

Please be aware that we may not pay a claim and could cancel the policy if you do not answer the following sections 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 (including area code)	Telephone number (including 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 (including area code)	Telephone number (including area code)

TELEPHONE APPOINTMENT FOR THE PERSON OR PEOPLE BEING 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 (including area code)	Telephone number (including 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 12-14. Please complete a separate page for each medical condition, and continue on a blank sheet of paper 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 policy 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 12-14?

What condition has been diagnosed?

When did this condition first occur? / MM/YYYY

When did you last have symptoms? / 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, or 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 of 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 12-14. Please complete a separate page for each medical condition, and continue on a blank sheet of paper 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 policy 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 12-14?

What condition has been diagnosed?

When did this condition first occur?

/ MM/YYYY

When did you last have symptoms?

/ 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, or 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 12-14. Please complete a separate page for each medical condition, and continue on a blank sheet of paper 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 policy 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 12-14?

What condition has been diagnosed?

When did this condition first occur? / MM/YYYY

When did you last have symptoms? / 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, or 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 of 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 12-14. Please complete a separate page for each medical condition, and continue on a blank sheet of paper 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 policy 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 12-14?

What condition has been diagnosed?

When did this condition first occur?

/ MM/YYYY

When did you last have symptoms?

/ 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, or 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 12-14. Please complete a separate page for each medical condition, and continue on a blank sheet of paper 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 policy 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 12-14?

What condition has been diagnosed?

When did this condition first occur?

/ MM/YYYY

When did you last have symptoms?

/ 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, or 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

IMPORTANT NOTES AND DECLARATION

Your 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 policy. 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 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 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/We have read the declaration, Important Notes and information relating to my rights under the Access to Medical Reports Act.

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

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

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

I/We understand that all parties to this application must sign this application. For the person/people insured, this requirement extends to them signing the summary of any interviews that may be required for the purposes of underwriting the policy. 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 policies start. For example you must tell us if you have had any medical consultations, advice, treatment, or investigations, or 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 policy.

I/We 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/We hereby declare that my/our answers in this application are true and complete and that I/we have not withheld or concealed any circumstances on which information is required. I/we acknowledge that any policy which the Society may issue to me/us is so issued in reliance on the contents of this application, the answers in my/our medical report(s), if any, and this declaration. Failure to comply with these requirements may invalidate the policy.

I/We will inform you immediately of any changes in my/our health, occupational duties or other information provided to the Society that occur before the Society assumes risk under the policy. I/We 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/our knowledge and belief all the statements made, which includes anything I/we 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/We agree that any sensitive information which I/we give the Society, including sensitive personal data such as health and medical information, may be used only for the purposes of processing my/our application and for the ongoing administration of my/our policy and may be disclosed to: my/our general practitioner; medical practitioners acting for the Society; reinsurers or any other insurer to whom I/We have applied and given consent; my/our Financial Adviser; and any associated company of the Society.

I/We agree to the Society accepting medical reports faxed directly to the Society from my/our doctor's surgery. I/We 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/we understand that my/our name(s), date(s) 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 provided in relation to this application to make searches about me/us at credit reference agencies that supply you with information, including information from the Electoral Roll, for the purposes of verifying my/our identity. The agencies will record details of the search whether or not this application proceeds, I/we understand that you may use scoring methods for the sole purpose of verifying my/our identity and that you reserve the right to request documentary evidence if required.

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

I/We confirm that I am/we are UK resident (excluding Channel Islands and Isle of Man).

LV= may use information provided in relation to this application to process my/our application and for the ongoing management of my/our account. Information may be held on computer, paper file or other appropriate medium for as long as the application is being considered, for as long as the policy remains in force and for an appropriate period thereafter.

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

i Your information will be held by the Liverpool Victoria group of companies and added to our customer databases. It may be used to keep your records up to date, for business analysis and market research purposes. We will not include you in direct marketing campaigns in relation to LV= business conducted through a financial intermediary. We may pass your details to other carefully selected organisations but only for the purposes mentioned above.

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

Signed 1st Person Insured DD/MM/YYYY

Signed 2nd Person Insured (if applicable) DD/MM/YYYY

Signed 1st Applicant if different from Person Insured DD/MM/YYYY

Signed 2nd Applicant (if applicable) if different from Person Insured DD/MM/YYYY

Subject to payment of a fee, you can ask for a copy of the personal information we hold about you by writing to the CCA Department, LV=, County Gates, Bournemouth BH1 2NF. For details of the Liverpool Victoria group of companies please refer 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.

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

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

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

 - -

Originator's Identification Number

 9 9 0 2 6 2

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 X

Date X

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.



LVMIMI