

# FLEXIBLE PROTECTION PLAN

## Data Capture Form

For use with our online  
application system



LIVERPOOL VICTORIA

### COMPLETING THE DATA CAPTURE FORM

This Data Capture Form has been developed to assist Financial Advisers to gather the relevant details to submit online business and cannot be accepted as an application form. The questions on this form follow the screens, where possible, to assist entering the details online. Due to the active response of our online system, only relevant questions will be asked online and we may not require the full information that this document will capture.

**Before completing this form please check you can apply online. If you cannot tick both of the boxes below, please apply using a paper application form or contact your Account Manager.**

This Application is for new business only (not to be used for top up applications)

The Applicants are UK residents and do not have any prospect  
or intention of residing outside the UK

**Please do not send this completed data capture form to LV=.**

**This form is for Financial Advisers to gather the relevant details to submit a Flexible Protection Plan online (at [www.LV.com/adviser](http://www.LV.com/adviser)) and should not be returned to LV= as it cannot be accepted as an 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 Data Capture 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.**

### APPLICATION TYPES EXPLAINED:

#### **Short Form – Complete boxed sections only**

To complete a Short Form application we only require basic information such as Personal and Product details including Occupational Risk assessment questions. Once submitted the application will be passed to our Telephone Underwriting team to contact the client to complete the application in full.

#### **Normal Form – Complete full form**

To complete a Normal Form application we require full information to be entered online enabling us to make an instant decision. In many cases immediate acceptance is available. If the application is not accepted immediately it may be referred to our underwriters for individual consideration.

#### **Please note**

When completing a Normal Form application if any of the questions on pages 12 to 15 are answered 'Yes' please complete 'Details of specific medical condition' on pages 16 to 20 for each disclosure. The 'Details of specific medical condition' have been developed to capture as much information as possible to answer the active questions online, which cannot be completely duplicated in a paper format, as they are dependent upon the response.

### HELP US TO HELP YOU...

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 policyowners, 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.

**This Data Capture Form has been developed to assist your Financial Adviser to gather the relevant details to be able to submit on line business and cannot be accepted as an application form.**

### DATA PROTECTION NOTICE

**Please be aware that LV= may not pay a claim and could cancel the policy if you do not answer the questions in this Data Capture Form truthfully and accurately.**

Your Financial Adviser may use information provided in this Data Capture Form to process your application and to manage your 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 period after that.

Your Financial Adviser will hold this information for the online application process. Once the application has been submitted to LV= by your Financial Adviser an application summary will be sent to you for your signature.

## STEP 1 ABOUT YOU

### 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

Maiden Name

Date of Birth   /   /     DD/MM/YYYY

Gender  Male  Female

Telephone number (including area code)

Day

Evening

House number or name

Address Line 1

Address Line 2

Town/City

Postcode

Country

E-mail address

#### 2nd Person Insured (if applicable)

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

First name(s)

Surname

Maiden Name

Date of Birth   /   /     DD/MM/YYYY

Gender  Male  Female

Telephone number (including area code)

Day

Evening

House number or name

Address Line 1

Address Line 2

Town/City

Postcode

Country

E-mail address

#### 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 ?

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?

£

£

Is the cover going to continue?

Yes  No

Yes  No

Are you an existing member of Liverpool Victoria Friendly

Society Limited?

Yes  No

Yes  No

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

Will the Person Insured also be the applicant?

Yes  No

Yes  No

If 'No' please go to the Details of Applicant section on page 4

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

Yes  No

Yes  No

## DETAILS OF APPLICANT(S)

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 sections 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	2nd Applicant (if applicable)
Have you any prospect or intention of residing outside the UK?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have existing life, critical illness or income protection 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 number(s) if known	_____	_____
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
If 'Yes' please supply your existing policy numbers (if known)	_____	_____

## COVER START DATE

**To be completed by the applicant(s).**

If your application is accepted on normal terms do you wish the policy to start immediately?  Yes  No

If 'No', please state the date you would like the policy to start.  DD/MM/YYYY

### 1st Applicant

Insurable Interest in the life/lives to be assured (reason you would lose out financially),

Spouse  Civil Partner  
 Live-in Partner

If Other please give details

### 2nd Applicant (if applicable)

Insurable Interest in the life/lives to be assured (reason you would lose out financially).

Spouse  Civil Partner  
 Live-in Partner

If Other please give details

## PERSONAL DETAILS OF THE PERSON OR PEOPLE BEING INSURED

continued from page 3

### 1st Person Insured

### 2nd Person Insured (if applicable)

Marital Status

Married   
  Civil Partner   
  Single  
 Widowed   
  Divorced/Dissolution   
  Separated

Marital Status

Married   
  Civil Partner   
  Single  
 Widowed   
  Divorced/Dissolution   
  Separated

### 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 a 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.

Cigarettes

Cigarettes

Cigars

Cigars

Pipe tobacco

Pipe tobacco

ounces or

ounces or

grams

grams

## OCCUPATION DETAILS OF THE PERSON OR PEOPLE BEING INSURED

### 1st Person Insured

### 2nd Person Insured (if applicable)

What is your occupation?

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

### 2nd Person Insured (if applicable)

	<b>1st Person Insured</b>	<b>2nd Person Insured (if applicable)</b>
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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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.		
<b>1st Person Insured</b>	<b>2nd Person Insured (if applicable)</b>	
	<b>1st Person Insured</b>	<b>2nd Person Insured (if applicable)</b>
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
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
If 'No', please give full details, including the countries you will visit, duration of stay and how many trips.		
<b>1st Person Insured</b>	<b>2nd Person Insured (if applicable)</b>	
	<b>1st Person Insured</b>	<b>2nd Person Insured (if applicable)</b>
How many business trips do you make per year?	<input type="text"/>	<input type="text"/>
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.		
<b>1st Person Insured</b>	<b>2nd Person Insured (if applicable)</b>	

## STEP 2 COVER DETAILS

### COVER DETAILS

Is the policy for:  Personal Cover  Business Cover  
 Type of Application  Short Form  Normal Form  
 Commission Type  Standard  Variable  Nil

### 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 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

† **Important notes: You may select one of three types of critical illness cover which will apply to both people being insured for all critical illness policies in this plan.**

**If you select Permanent Total Disability cover only you can apply for this online however you must select it as a separate policy online.**

#### Level amount of cover

Policy Term  years  years  years  
 Amount of cover £  £  £   
 Permanent Total Disability†  
 None  None  None  
 Included  Included  Included  
 Only  Only  Only

#### Decreasing amount of cover

Policy Term  years  years  years  
 Amount of cover £  £  £   
 Permanent Total Disability†  
 None  None  None  
 Included  Included  Included  
 Only  Only  Only

#### Inflation-linked amount of cover

Policy Term  years  years  years  
 Amount of cover £  £  £   
 Permanent Total Disability†  
 None  None  None  
 Included  Included  Included  
 Only  Only  Only



## Income Protection

### 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.

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 any mortgage payment protection policies in this plan. **It is important to check that the amount of cover for this plan (and all other sickness and accident policies) do not exceed 50% of earned income.**

	<input type="checkbox"/> 1st Person Insured	<input type="checkbox"/> 1st Person Insured	<input type="checkbox"/> 2nd Person Insured	<input type="checkbox"/> 2nd Person Insured
Type of cover*	i) <input type="checkbox"/> Full or <input type="checkbox"/> Budget	<input type="checkbox"/> Full or <input type="checkbox"/> Budget	<input type="checkbox"/> Full or <input type="checkbox"/> Budget	<input type="checkbox"/> Full or <input type="checkbox"/> Budget
	ii) <input type="checkbox"/> Level or <input type="checkbox"/> Index-linked	<input type="checkbox"/> Level or <input type="checkbox"/> Index-linked	<input type="checkbox"/> Level or <input type="checkbox"/> Index-linked	<input type="checkbox"/> Level or <input type="checkbox"/> Index-linked
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
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.				
Amount of cover** (a month)	£ <input type="text"/>	£ <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	<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 refer to your Policy Summary or Key Features document for a full explanation of types of cover

\*\* The overall maximum amount of cover 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

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

	1st Person Insured	2nd Person Insured
Salaried employee Salary (not a company director)	£ <input type="text"/> a year	£ <input type="text"/> a year
Salaried employee Salary (company director)	£ <input type="text"/> a year	£ <input type="text"/> a year
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?	<input type="text"/> months	<input type="text"/> months
Would you receive reduced pay?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'Yes', please state the period you would receive reduced pay and the percentage this will be of your full pay.	<input type="text"/> period <input type="text"/> %	<input type="text"/> period <input type="text"/> %

\*\*\* 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.

## 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) / /   
 DD/MM/YYYY

**We will be unable to process the application for this policy 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	Salary	<input type="text" value="£"/>	a year	<input type="text" value="£"/>	a year
(not a company director)					
Salaried employee	Salary	<input type="text" value="£"/>	a year	<input type="text" value="£"/>	a year
(company director)	Dividends	<input type="text" value="£"/>	a year	<input type="text" value="£"/>	a year
Self-employed		<input type="text" value="£"/>	a year	<input type="text" value="£"/>	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
<b>Mortgage Payment Protection – Integrated Health</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.			
<b>Mortgage Payment Protection – Health</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Mortgage Payment Protection – Budget Health</b>	<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

	<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		<input type="checkbox"/> Guaranteed		<input type="checkbox"/> Guaranteed
	or <input type="checkbox"/> Reviewable		or <input type="checkbox"/> Reviewable		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" value="£"/>		<input type="text" value="£"/>		<input type="text" value="£"/>
Waiting period (months)	<input type="checkbox"/> 1 <input type="checkbox"/> 2		<input type="checkbox"/> 1 <input type="checkbox"/> 2		<input type="checkbox"/> 1 <input type="checkbox"/> 2
	<input type="checkbox"/> 3 <input type="checkbox"/> 6		<input type="checkbox"/> 3 <input type="checkbox"/> 6		<input type="checkbox"/> 3 <input type="checkbox"/> 6
	<input type="checkbox"/> 12 <input type="checkbox"/> 24		<input type="checkbox"/> 12 <input type="checkbox"/> 24		<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

Do you require Waiver of Premium? **1st Person Insured**  Yes  No **2nd Person Insured (if applicable)**  Yes  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)  1  2  3  6  1  2  3  6

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? **1st Person Insured**  Yes  No **2nd Person Insured (if applicable)**  Yes  No

If you are completing a short form application please continue on page 21.

For a normal application, please complete the following sections in full.

## STEP 3 RISK ASSESSMENT

### 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.

Except for holidays of less than 30 days, have you any intention of going abroad? **1st Person Insured**  Yes  No **2nd Person Insured (if applicable)**  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)

Within the last 5 years have you lived or frequently travelled to an area which has a high incidence of HIV infection? **1st Person Insured**  Yes  No **2nd Person Insured (if applicable)**  Yes  No  
 If 'Yes' please give full details

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

**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

If '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

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 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.**

**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?       Yes     No       Yes     No

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.



ii) Are you awaiting an HIV or Hepatitis B or C test result?       Yes     No       Yes     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?       Yes     No       Yes     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)?       Yes     No       Yes     No

1d) Within the last 5 years have you tested positive or been treated for any disease which was transmitted sexually?       Yes     No       Yes     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?       Yes     No       Yes     No

2b) Heart disease or disorder, including heart attack, angina, cardiomyopathy, heart valve disorder?       Yes     No       Yes     No

2c) Stroke, Transient Ischaemic Attack (TIA), brain haemorrhage, permanent brain damage through accident?       Yes     No       Yes     No

2d) Multiple sclerosis, Parkinson's disease, epilepsy, paralysis, Alzheimer's disease, dementia or cerebral palsy?       Yes     No       Yes     No

2e) Any other disease of the central nervous system (the brain, spinal cord and nerves) not already mentioned?       Yes     No       Yes     No

2f) Any disease or disorder of the arteries, including disease in the legs or of the aorta?       Yes     No       Yes     No

2g) Diabetes or sugar in the urine?       Yes     No       Yes     No

2h) Mental illness that has required hospital treatment or referral to a psychiatrist?  Yes  No  Yes  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

**You only need to answer question 3m) if you are female, and you only need to answer question 3n) if you are male**

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 in this Data Capture Form.**

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 Data Capture 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 Data Capture 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 Data Capture 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 Data Capture 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 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?				

**1st Person Insured      2nd Person Insured**

(if applicable)

9) 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' what was the reason the special terms were imposed on your policy?

<input type="checkbox"/> Medical	<input type="checkbox"/> Medical
<input type="checkbox"/> Occupational	<input type="checkbox"/> Occupational
<input type="checkbox"/> Hobbies	<input type="checkbox"/> Hobbies
<input type="checkbox"/> Other	<input type="checkbox"/> Other

Please provide full details

**1st Person Insured**

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

**1st Person Insured**      **2nd Person Insured**

(if applicable)

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

If 'Yes' is this due to a medical condition already disclosed in this Data Capture form?       Yes     No       Yes     No

If 'No' please give details of why you are currently not working including symptoms, diagnosis, treatment, dates etc

**1st Person Insured**

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

11) Do you have any other information that you wish to add at this time?       Yes     No       Yes     No

If 'Yes', please give full details

**1st Person Insured**

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

**N.B. Please ensure you answer the additional medical questions on pages 16 to 20 where required.**

## DOCTOR/CLINIC DETAILS OF THE PERSON OR PEOPLE BEING INSURED

**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?       Yes     No

Have you been with your doctor/clinic  
for less than 12 months?       Yes     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)

# DETAILS OF SPECIFIC MEDICAL CONDITION 1

The following page is provided so that you can give us further information about any medical conditions that you have told us about in pages 12-15. Please complete a separate page for each medical condition.

The additional medical questions are designed to help answer questions asked by our underwriting rules system for the conditions you have disclosed. 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 12-15?

What condition has been diagnosed?

When did this condition first occur? Month/year /

When did you last have symptoms? Month/year /

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 2

The following page is provided so that you can give us further information about any medical conditions that you have told us about in pages 12-15. Please complete a separate page for each medical condition.

The additional medical questions are designed to help answer questions asked by our underwriting rules system for the conditions you have disclosed. 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 12-15?

What condition has been diagnosed?

When did this condition first occur? Month/year /

When did you last have symptoms? Month/year /

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

The following page is provided so that you can give us further information about any medical conditions that you have told us about in pages 12-15. Please complete a separate page for each medical condition.

The additional medical questions are designed to help answer questions asked by our underwriting rules system for the conditions you have disclosed. 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 12-15?

What condition has been diagnosed?

When did this condition first occur? Month/year /

When did you last have symptoms? Month/year /

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 4

The following page is provided so that you can give us further information about any medical conditions that you have told us about in pages 12-15. Please complete a separate page for each medical condition.

The additional medical questions are designed to help answer questions asked by our underwriting rules system for the conditions you have disclosed. 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 12-15?

What condition has been diagnosed?

When did this condition first occur? Month/year /

When did you last have symptoms? Month/year /

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

The following page is provided so that you can give us further information about any medical conditions that you have told us about in pages 12-15. Please complete a separate page for each medical condition.

The additional medical questions are designed to help answer questions asked by our underwriting rules system for the conditions you have disclosed. 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 12-15?

What condition has been diagnosed?

When did this condition first occur? Month/year /

When did you last have symptoms? Month/year /

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

The following notes are duplicated from the Plan Application which will be sent to you for your signature(s) once your application has been submitted by your Financial Adviser.

### Important Notes

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 policy. You can get details of general reinsurance 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.

### Genetic Test Results

- For this application we do not need to know about any genetic test result subject to the sum insured being within the following limits:
  - £500,000 or less for life assurance
  - £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 Governments 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.
- For a genetic condition present in the immediate family, it will be to the applicants benefit to tell us of a negative test for the same condition.

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

### 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 incorrect or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him or her to attach a statement outlining your views, which will then accompany the report. Your doctor can withhold access to the report if he or she feels that it would cause physical or mental harm to you or others.

The medical report your doctor fills in asks about the following:

- Your current health.
  - any care, medication or treatment you are currently receiving.
  - the results of referrals or tests you are waiting for.
- Any time off work in the last three years.
- Your past health.
  - details of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your GP or any other medical adviser, therapist or counsellor, in particular whether you have a history of:
    - malignancy (cancer), cardiovascular (heart) disease, diabetes, and degenerative (gradually worsening) diseases;
    - musculoskeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles;
    - anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue;
    - suicidal thoughts or attempts at suicide; or
    - conditions related to drug or alcohol misuse or smoking or chewing tobacco.

- details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations.
- any blood pressure readings in the last three years.
- Any history of disease among your parents or brothers or sisters that you have told your doctor about.

We have asked your doctor not to reveal information about:

- negative tests for HIV, hepatitis B or C;
- any sexually-transmitted diseases unless there could be long-term effects on your health; or
- predictive genetic test results unless there is a favourable test result which shows that you have not inherited a condition your family suffers from.

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

- refusing to provide insurance;
- increasing premiums above standard rates; 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

### 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.

**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.**

**The Society MUST be informed of any changes in your health, occupation duties or other information provided in this application which take place before your policy starts. For example you must tell us if you have had any medical consultations, advice, treatment, or investigations, or if you have changed job, or 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.**

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

### Declaration

- I/We understand that all parties to this application must sign this application. For the Person or 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.
- 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. Failure to comply with these requirements may invalidate the policy. 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.
- 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 and are true and complete. This disclosure will form the basis of the contract.
- I/We agree to the Society seeking medical information from any doctor who at any time has attended me/us concerning anything which affects my/our physical or mental health, in order to assess my/our application. You may also seek relevant information from other insurers about previous or concurrent applications for life, critical illness or income protection insurance that I/we have applied for. I/We authorise those asked for such information to provide it on the production of a copy of this consent. This consent allows the Society to obtain medical reports at any time during the life of the policy or after my/our death to support any claim made on the policy proceeds.

- 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 disclosed only for the purposes of processing my/our application and for the ongoing administration of my/our policy 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 doctors 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.
- In the event of a claim I/we understand that my/our names, dates 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.
- LV= may use information provided in relation to this application to process my application and for the ongoing management of my 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.
- LV= may use information held about me/us and/or supply it to carefully selected organisations, to keep my records up to date and for research purposes.

**To be completed by the Person or People Insured**

	<b>1st Person Insured</b>		<b>2nd Person Insured</b>	
<b>I want to see the medical report before it is sent to the Society</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>I agree to allow copies of the medical report to be faxed</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>I confirm that I have been advised to read the Important Notes and Declaration and information relating to my rights under the Access to Medical Reports Act</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>1st Person Insured</b> Dated <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> / <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> / <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> DD/MM/YYYY <b>Signed</b>				

**2nd Person Insured** Dated   /   /      DD/MM/YYYY **Signed**

**To be completed by applicants if different from Person or people Insured**

	<b>1st Applicant</b>		<b>2nd Applicant</b>	
<b>I confirm that I have read Important Notes and Declaration above</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Have you had advice from a Financial Adviser on this product?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

**TELEPHONE APPOINTMENT FOR THE PERSON OR 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.

<b>1st Person Insured</b>	<b>2nd Person Insured (if applicable)</b>
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	Telephone Number

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

<b>1st Person Insured</b>	<b>2nd Person Insured (if applicable)</b>

## STEP 4 PAYMENT DETAILS

### DIRECT DEBIT DETAILS

Direct Debit payments can be set up online to pay the plan premium please note below the account details of where the premiums should be collected from. A paper Direct Debit form can be created at the application print summary stage for completion if this information is not known at this stage.

#### The Direct Debit Guarantee

- 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.

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



Originator's Identification Number

9 9 0 2 6 2

Name(s) of Account Holder(s):

Bank/Building Society Account Number:

Branch Sort Code:

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

#### Instruction to your Bank or Building Society

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

#### Do you agree to the Direct Debit Authority as specified above?

I agree to the Direct Debit Authority  Yes  No

You will be sent a confirmation by post 14 days before the first debit.

### FOR ADVISER USE ONLY

Will you (the agent) be obtaining all necessary signatures from the client(s)?

Yes  No

Is this application to be written in trust

Yes  No

**If 'Yes' once the application has been submitted please forward the trust document clearly marked with the application reference number to LV=, Pynes Hill House, Rydon Lane Exeter, EX2 5BF**

Once the application has been submitted, an Application Reference number and Interview number will be provided. Please enter them below and if you contact us regarding this application please quote the reference numbers.

Application Reference number

Interview number

**Please check all the boxed sections have been completed for a Short Form Application.**