

Family Income Assurance

Application Form



Please bear in mind that we'll share the information you give us in this application form with the other people involved in 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.



Important information

Data protection notice

Your financial adviser may use information provided in this application 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.

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 complete the Direct Debit in section E if you're paying monthly or if you're applying for inflation-linked cover.

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

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

Throughout this form 'applicant' means the person or people applying for the insurance. 'Person or people insured' means the person or people you are insuring. If you are applying to insure your own life you need to complete all relevant sections.

A summary of how we use your personal information

Liverpool Victoria Friendly Society Limited (LV=) is the data controller of your personal information. We'll keep you informed about how we use your personal information in the document 'How we use your personal information', which is available:

- online at LV.com/dataprotectionlife
- in print from Life Customer Support, LV=, County Gates, Bournemouth, BH1 2NF or LifeCustomerSupport@LV.com

By completing this application I am aware that my data will be used in line with the LV= 'How we use your information' statement', which includes being;

- Used by Liverpool Victoria Friendly Society Limited (LV=) and shared with my intermediary or introductory partner (if applicable) for the purposes of providing me with a quote, processing and administering my insurance contract and assessing any claims.
- Shared with reinsurers, medical professionals and/or healthcare management companies chosen by LV= to enable LV= to process and service my insurance contracts and assess any claims.
- Shared with regulatory bodies (for example, the Financial Conduct Authority and HM Revenue and Customs) to enable LV= to fulfil legal and regulatory obligations.

You have a number of rights concerning your personal information. You can ask for a person to review an automated decision, and in certain circumstances to:

- access the personal information we hold about you
- correct personal information
- have your personal information *deleted*
- restrict us processing your personal information
- receive your personal information in a *portable* format, and
- object to us processing your personal information.

If you want to find out more or exercise these rights, contact Life Customer Support, LV=, County Gates, Bournemouth, BH1 2NF or email us at LifeCustomerSupport@LV.com.

You can contact us about data protection at: Data Protection Officer, LV= County Gates, Bournemouth BH1 2NF or dpo@LV.com.

Please ensure that you advise anyone else whose personal details you are providing in this form where they can find this information. Please let us know if you'd like us to send you a copy, or have any questions.

Quotation reference: (if known)

Contents

You must complete **sections A,C and D** and read the notes and sign the declaration in **section E**. If completing **section B**, please indicate this by placing a tick (✓) in the appropriate box.

Section F must always be completed if you're paying premiums monthly, or if you're applying for inflation linked cover.

		Person or People Insured
Section A – Cover Required	On page 2	<input checked="" type="checkbox"/>
Section B – Details of the person or people applying for this plan (if different from the person or people being insured)	On page 3	<input type="checkbox"/>
Section C – Personal Details of the person or people being insured	On page 4	<input checked="" type="checkbox"/>
Section D – Risk Assessment	On pages 5	<input checked="" type="checkbox"/>
Section E – Important Notes and Declaration	On page 20	<input checked="" type="checkbox"/>
Section F – Payment Details	On page 25	<input type="checkbox"/>

Section A – Cover Required

Level

(cover and premiums remain constant throughout the term)

Amount of cover £ a year Plan term years or terminating age

Inflation-linked

(cover and premiums automatically increase each year in line with the Retail Prices Index (RPI))

Amount of cover £ a year Plan term years or terminating age

Plan start date

If your application is accepted on normal terms, do you wish your plan to start immediately?

(See important notes section E)

Yes No

If 'no', when would you like your plan to start

/

/

(DD/MM/YYYY)

Is Waiver of Premium required?

Yes No

Have you had advice from a financial adviser on this product?

Yes No

Section B – Details of the person or people applying for this plan

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 plan 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 _____

1st applicant - insurable interest in the people being insured (reason you would lose out financially) for example spouse, partner, financial relationship, business cover

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 _____

2nd applicant - insurable interest in the people being insured (reason you would lose out financially) for example spouse, partner, financial relationship, business cover

Do you have any existing Life, Critical Illness, Personal Sick Pay, or Income Protection cover with LV= or Liverpool Victoria?

Yes No

Yes No

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 living outside the UK?

Yes No

Yes No

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

1st applicant

2nd applicant (if applicable)



Section C – Personal details of the person or people being insured

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

1st person insured

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

First name(s)

Surname

Marital Status

Married Civil partner Single
 Widowed Divorced/dissolution
 Separated

Maiden name (if applicable)

Date of birth / / (DD/MM/YYYY)

Gender Male Female

Telephone number (including area code)

Day

Evening

Email address

By giving you an email address, above I agree to you contacting me by email with information about other products and services.

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

Section D Risk Assessment

Honest and truthful disclosure

You must answer all questions truthfully and honestly even if this has been provided on a previous application to LV=

If you don't provide complete, accurate and up-to-date information LV= may not be able to pay your claim. Your policy may be cancelled or changed to apply the correct policy terms or you may be asked to pay any additional premiums due.

Whilst LV= often accept applications based on the information you provide, sometimes LV= may need additional information to support your application. LV= will contact you if this happens to let you know what is needed.

LV= will also regularly select a sample of customers to check for false information.

Don't assume LV= will write to your doctor to get information. It's your responsibility to provide correct and accurate information.

Eligibility

You can only apply for LV= cover if you permanently live in the UK. The UK does not include the Channel Islands or the Isle of Man.

Genetic information

You only need to tell LV= about the result of a predictive genetic test you've had, if the test was for Huntington's disease and the total life insurance you are applying for with LV= is over £500,000.

In all cases you must tell LV= if you're experiencing symptoms or having treatment for a genetic condition.

If you have a genetic condition present in your immediate family and have been genetically tested for it, which has come back negative, it'll be worthwhile letting LV= know.

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 plan if you do not answer the following questions truthfully and accurately.

	1st person insured	2nd person insured (if applicable)
Do you have any existing Life, Critical Illness, Personal Sick Pay or Income Protection cover with LV= or Liverpool Victoria?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please supply your existing plan numbers (if known)	_____	_____
How much cover do you have with LV= or Liverpool Victoria?	£ <input style="width: 100px;" type="text"/>	£ <input style="width: 100px;" type="text"/>
Will you be cancelling any of these covers? Life If 'yes' please tick the relevant box(es)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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
Have you any prospect or intention of living outside the UK?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

1st person insured

2nd person insured (if applicable)

	1st person insured	2nd person insured (if applicable)
What is your height?	<input style="width: 40px;" type="text"/> ft <input style="width: 40px;" type="text"/> ins or <input style="width: 60px;" type="text"/> cms	<input style="width: 40px;" type="text"/> ft <input style="width: 40px;" type="text"/> ins or <input style="width: 60px;" type="text"/> cms
What is your weight?	<input style="width: 40px;" type="text"/> st <input style="width: 40px;" type="text"/> lbs or <input style="width: 60px;" type="text"/> kgs	<input style="width: 40px;" type="text"/> st <input style="width: 40px;" type="text"/> lbs or <input style="width: 60px;" type="text"/> kgs
What is your typical consumption of alcohol a week? 1 glass of wine (175ml) = 2 units, 1 pint of standard lager/beer = 2 units, 1 measure spirits (25ml) = 1 unit	<input style="width: 60px;" type="text"/> units a week	<input style="width: 60px;" type="text"/> units a week
Have you smoked or used any tobacco or nicotine products in the last 12 months? Note: If you answer 'no' to this question, you may be asked to undergo a test to verify your answer.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

1st person insured**2nd person insured
(if applicable)**

For the following tobacco products, please state your typical consumption a day.

 Cigarettes

 Cigars

Pipe tobacco

 ounces

 or grams

 Cigarettes

 Cigars

Pipe tobacco

 ounces

 or grams

Including this application, will the total amount of cover on your life exceed £1m life protection? (You can ignore cover that is being cancelled or multiple applications where only one will proceed)

 Yes No

 Yes No

If 'no' go to the next section (occupation details on page 8). If 'yes' please give details of your current cover in the table below, and answer the following questions:

1st or 2nd person insured	Name of company	Type of policy	Amount of cover/term	Reason for cover	Is this cover being cancelled and/or replaced?

Please state your current annual taxable income (if applicable this can include bonuses, regular commission and the value of any benefits)

 £

 £

Please give details of the number and age of dependents and their relationship to you.

Occupation details of the person or people being insured

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

	1st person insured	2nd person insured (if applicable)
What is your occupation?	<hr/>	<hr/>
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 or working at heights or underground)?	<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.		

1st person insured

2nd person insured (if applicable)

If your job involves driving (other than commuting to and from work) what is your annual business mileage?	<input type="text"/> miles	<input type="text"/> miles
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)

Does your job involve the following: armed forces (including reservists/territorial army), heights over 12 metres, overseas travel, oil/gas industry (offshore), aviation with flying duties, fishing, explosives, underwater work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If you have answered 'yes' to the above question, please provide full details below. If your job involves overseas travel please give full details of the countries, regions and cities you will visit, duration of stay, how many trips you make, and your duties while you are overseas.

1st person insured

2nd person insured (if applicable)

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 plan if you do not answer the following questions truthfully and accurately.

	1st person insured	2nd person insured (if applicable)
Do you have any intention of going abroad for longer than 30 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'yes' will you only travel to Europe, North America, Australia, New Zealand, Singapore, Hong Kong, Japan, United Arab Emirates or China?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'no' please give full details of the countries, regions and cities you will visit, duration of stay, how many trips you make, and the reasons for the trip(s).		

1st person insured

2nd person insured (if applicable)

	1st person insured	2nd person insured (if applicable)
Within the last 5 years have you lived or frequently travelled to an area which has a high incidence of HIV infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'yes' please give full details of countries visited, dates, duration and any future plans		

1st person insured

2nd person insured (if applicable)

	1st person insured	2nd person insured (if applicable)
Do you intend to take part in any physical hobby or sport (for example 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)

1st person insured

**2nd person insured
(if applicable)**

Do you ride a motorbike, scooter or moped on the road?

Yes No

Yes No

If you answered 'yes', please provide details

1st person insured

2nd person insured (if applicable)

1st person insured

**2nd person insured
(if applicable)**

Have you been banned from driving or convicted of dangerous or careless driving in the last 5 years?

(You do not need to tell us about: Speeding offences that did not result in a ban, or any spent convictions)

Yes No

Yes No

If you answered 'yes', please provide 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 plan if you do not answer the following questions truthfully and accurately. If any of the following questions are answered 'yes', you will need to complete the additional medical questions on pages 16 to 19.

	1st person insured	2nd person insured (if applicable)
1a) Have you ever tested positive for HIV, Hepatitis B or C?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
1b) Have you ever used recreational drugs (e.g. cannabis, cocaine, heroin)	<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) Diabetes or sugar in the urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2b) Heart condition including heart attack, angina, heart valve disorder or heart enlargement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2c) A vascular or circulatory condition including stroke, Transient Ischaemic Attack (TIA), brain haemorrhage or narrowing or obstruction in the arteries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2d) Cancer, tumour, leukaemia, Hodgkin's disease or lymphoma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2e) Any condition of the central nervous system (the brain, spinal cord and nerves) including multiple sclerosis, optic neuritis, Parkinson's disease, paralysis, Alzheimer's disease, dementia or cerebral palsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2f) Mental health issue that has resulted in referral to a psychiatrist, required hospital treatment or any episode of suicide attempt, suicidal thoughts or self harm?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

	1st person insured	2nd person insured (if applicable)
3) In the last 5 years have you had any of the following: (This is regardless of whether or not you have seen your doctor or required treatment.)		
3a) Raised blood pressure, raised cholesterol, chest pain or irregular heart beat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3b) A mole or freckle that has bled, become painful, changed appearance or any lump or growth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3c) Asthma, bronchitis or any other respiratory condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



	1st person insured	2nd person insured (if applicable)
3d) Any joint, bone or muscle pain, fracture, gout or arthritis? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3e) Any back or neck condition, including pain, sciatica or whiplash? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3f) Mental health issue including depression, anxiety, stress, nervous breakdown, insomnia, or eating disorders? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3g) Chronic Fatigue Syndrome (CFS), ME, or fibromyalgia? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3h) Any digestive, liver, stomach, pancreas or bowel condition including ulcer, hepatitis, colitis or Crohn's disease? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3i) Kidney, bladder or urinary condition including blood or protein in the urine and urinary tract infection? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3j) Seizure, fits, epilepsy, fainting, dizziness, tremor, blackouts, facial pain or migraines? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3k) Numbness, change in skin sensation, lack of coordination, difficulty walking or temporary loss of muscle power? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3l) Any eye condition including eye pain, blurred or double vision? (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
3m) Any ear, hearing or balance condition? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3n) Any cervical smear or other gynaecological condition needing treatment, investigation or advice? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3o) Prostate enlargement or abnormalities? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3p) Blood disorder or anaemia? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4a) In the last 5 years have you had any medical attention at a hospital or required any investigations, scans or tests (including blood tests), in connection with any medical condition which you haven't told us about already in this application form? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

1st person insured

**2nd person insured
(if applicable)**

4b) Do you have another medical condition, which you haven't told us about already in this application, for which you are taking prescribed drugs, medicines, tablets or any other treatment? (Please ignore contraceptives, HRT, hayfever treatments, cold/flu remedies)

Yes No

Yes No

4c) Are you awaiting the results of, or have you been advised to have, any medical investigations, tests or scans or have you any expectation of seeking medical advice or treatment in the near future?

Yes No

Yes No

5) Have you ever been advised to reduce or stop drinking alcohol for a medical or health reason which you haven't told us about already in this application form?

Yes No

Yes No

6) In the last 5 years have you drunk more than 30 units of alcohol a week on a regular basis? 1 glass of wine (175ml) = 2 units, 1 pint of standard lager/beer = 2 units, 1 measure spirits (25ml) = 1 unit

Yes No

Yes No

If 'yes' please provide full details

1st person insured

2nd person insured (if applicable)

7) Are you currently off work, working reduced hours or have you altered your duties 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 19. 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 plan if you do not answer the following questions truthfully and accurately.

<p>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 60?</p>	<p>1st person insured</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>2nd person insured (if applicable)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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	1st or 2nd person insured?	Relation	Age at onset	Current age or age at death
a) Heart disease, including heart attack, angina, by-pass or heart enlargement/cardiomyopathy? (please circle which condition was diagnosed)				
b) Stroke?				
c) Diabetes?				
d) Cancer? (please state the area affected)				
e) Multiple Sclerosis?				
f) Huntington's disease?				
g) Polycystic kidney disease?				
h) Polyposis of the colon?				
i) Motor neurone disease?				
j) Parkinson's disease?				
k) Alzheimers disease?				
l) Other hereditary disorders?				

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

Name of doctor/clinic

Building number or name

Address line 1

Address line 2

Town/city

Postcode

Country

Telephone number (including area code)

2nd person insured (if applicable)

Name of doctor/clinic

Building number or name

Address line 1

Address line 2

Town/city

Postcode

Country

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

Time 9am - 12 noon 12 noon - 6pm
 6pm - 9pm

Telephone number

2nd person insured (if applicable)

Time 9am - 12 noon 12 noon - 6pm
 6pm - 9pm

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

1st person insured

2nd applicant (if applicable)

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 you have told us about in pages 11-13. 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 plan if you do not answer the following questions truthfully and accurately. (Please be as specific as possible, if relevant please give specific details of the limb/part of the body involved. For example arthritis – right knee; breast cyst)

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

Which question do the following answers relate to on pages 11-13?

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 medication, specialist appointments? Yes No

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

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

Have you had any tests or investigations? Yes No

If 'yes', what were they?

What were the results?

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

If 'yes', how many times? when?

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

If 'yes', please provide details.

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

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

Are you fully recovered? Yes No

Details of specific medical condition 2

This page is provided so that you can give us further information about any medical conditions that you have you have told us about in pages 11-13. 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 plan if you do not answer the following questions truthfully and accurately. (Please be as specific as possible, if relevant please give specific details of the limb/part of the body involved. For example arthritis – right knee; breast cyst)

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

Which question do the following answers relate to on pages 11-13?

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 medication, specialist appointments? Yes No

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

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

Have you had any tests or investigations? Yes No

If 'yes', what were they?

What were the results?

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

If 'yes', how many times? 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 you have told us about in pages 11-13. 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 plan if you do not answer the following questions truthfully and accurately. (Please be as specific as possible, if relevant please give specific details of the limb/part of the body involved. For example arthritis – right knee; breast cyst)

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

Which question do the following answers relate to on pages 11-13?

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 medication, specialist appointments? Yes No

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

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

Have you had any tests or investigations? Yes No

If 'yes', what were they?

What were the results?

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

If 'yes', how many times? when?

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

If 'yes', please provide details.

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

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

Are you fully recovered? Yes No

Details of specific medical condition 4

This page is provided so that you can give us further information about any medical conditions that you have you have told us about in pages 11-13. 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 plan if you do not answer the following questions truthfully and accurately. (Please be as specific as possible, if relevant please give specific details of the limb/part of the body involved. For example arthritis – right knee; breast cyst)

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

Which question do the following answers relate to on pages 11-13?

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 medication, specialist appointments? Yes No

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

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

Have you had any tests or investigations? Yes No

If 'yes', what were they?

What were the results?

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

If 'yes', how many times? when?

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

If 'yes', please provide details.

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

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

Are you fully recovered? Yes No



Section E – Important Notes and Declaration

Important Notes

The plan will start on the start date shown in your policy schedule. If you have a birthday while your application is being processed, the terms may differ from those originally quoted to you. Also after we've processed your application we may have to offer you revised terms, and occasionally we may not be able to offer any terms. We may ask you to contact your doctor if we're waiting for reports which we've asked for. If we ask you to come for a medical examination, we'll need to share the application information with another company we've 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 reinsurers 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 policies in your plan. If you'd like more details of the companies we use for your application, please contact us.

Access to medical reports

Your permission for LV= to request a medical report:

To help us assess your application for insurance, or to assess any claim made under your insurance policy, we may need to get a medical report from your doctor. To do this we will need your consent under the Access to Medical Reports Act 1988 or (if you live in Northern Ireland) the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991.

Your legal rights

- You don't need to give your consent, but LV= aren't able to request a medical report without it. If you don't give your consent LV= won't be able to proceed with your application for insurance, and if your policy has already started it may be cancelled, or may impact LV= ability to assess a claim.
- You can ask your doctor to show you the medical report before they return it to LV= (you can make this choice below). You then have 21 days from the date LV= request the report to arrange an appointment with your doctor to see it.
- Your doctor is allowed to keep the report from you if they feel that it would cause physical or mental harm to you or others.
- You can ask your doctor to let you see a copy of the medical report at any time within 6 months of them sending it to LV=.
- If you think that any part of the medical report is incorrect or misleading, you can ask your doctor to amend it or to include an accompanying statement describing that changes have been made.

What we'll ask

LV= will only ask your doctor to provide information from your medical records about your current and past health that is relevant to your application and / or claim.

LV= won't ask your doctor to reveal any information about:

- Negative tests for HIV, Hepatitis B or C;
- Any sexually-transmitted diseases unless there could be long-term effects on your health;
- Predictive genetic test results unless it is for Huntington's disease, and you have applied for life insurance cover of £500,000 or over, OR unless there is a favourable test result that shows that you have not inherited a condition your family suffers from.

Do you want to see a copy of the medical report before it's sent to LV=? (please tick one box only)

1st Person insured

No I do not want to see the report before it is sent to LV=

Yes I do want to see the report before it is sent to LV=

2nd person insured

No I do not want to see the report before it is sent to LV=

Yes I do want to see the report before it is sent to LV=

Your Consent

- I agree to LV= asking any doctor I have consulted about my physical or mental health to provide medical information so you may assess my application, or any claim made under my insurance policy.
- I authorise those asked to provide medical information when they see a copy of this consent form.
- I agree this consent is valid from the date I have signed and dated below
- I agree this consent can continue as valid for an undefined timescale unless I choose to withdraw this at any point by contacting LV=.

Print name here

Print name here

1st person insured signature

2nd person insured (if applicable) signature

Date / / (DD/MM/YYYY)

Date / / (DD/MM/YYYY)

If you have any questions about your legal rights or questions relating to the process of getting, assessing or storing medical information, please email us at LifeCustomerSupport@LV.com

Declaration

Honest and truthful disclosure

By completing this application form, I confirm that;

- I have answered all questions truthfully and honestly even if this has been provided on a previous application to LV=
- All information provided in connection with this application is honest and accurate
- I will let LV= know if anything is incorrect or changes before my policy starts

If you don't provide complete, accurate and up-to-date information LV= may not be able to pay your claim. Your policy may be cancelled or changed to apply the correct policy terms or you may be asked to pay any additional premiums due.

LV= will also regularly select a sample of customers to check for false information.

You must give LV= your doctor's details and your consent to obtain information from them if requested. If you don't then LV= will be unable to process your application for insurance, and if your policy has already started it will be cancelled.

If LV= cancel your policy you won't be entitled to any refund of premiums or payment from it.

Financial Crime

The personal information LV= have collected from you will be shared with crime prevention agencies who will use it to prevent financial crime and money-laundering and to verify your identity. If financial crime is detected, you could be refused certain services, finance or employment. Further details of how your information will be used by LV= and these fraud prevention agencies, and your data protection rights, can be found by contacting us at GFC LV=, County Gates, Bournemouth BH1 2NF.

If you or anyone representing you;

- provides LV= with misleading or incorrect information to any of the questions asked when applying for or amending this insurance;
- deliberately misleads LV= to obtain cover, gain a cheaper premium or more favourable terms;
- provides LV= with false documents;
- makes a fraudulent payment by bank account and/or card;

LV= may;

- reject your policy application
- amend your policy to record the correct information, apply any relevant policy terms and conditions and collect any additional premium due including any administration charges
- reject a claim or reduce the amount of payment we make
- cancel or void your policy including all other policies which you have with LV= and apply a cancellation charge
- recover from you any costs incurred and not return any premium paid by you

LV= also have the right to stop processing your application, cancel your policy and pass details to crime prevention and law enforcement agencies if;

- LV= identify financial crime or any attempt to gain an advantage, in connection with this application for insurance, to which you're not entitled.
- LV= identify your involvement or association with insurance fraud or financial crime.

Terrorist Financing

LV= use your information to make sure we comply with any financial sanctions that apply in the UK and overseas. This includes;

- checking your information against sanctions lists
- Sharing your information with HM Treasury and international regulators if required.

LV= will contact you if more information is needed to comply with any financial sanctions.

A summary of how we use your personal information

Liverpool Victoria Friendly Society Limited (LV=) is the data controller of your personal information. We'll keep you informed about how we use your personal information in the document 'How we use your personal information', which is available:

- online at LV.com/dataprotectionlife
- in print from Life Customer Support, LV=, County Gates, Bournemouth, BH1 2NF or LifeCustomerSupport@LV.com

By completing this application I am aware that my data will be used in line with the LV= 'How we use your information 'statement', which includes being;

- Used by Liverpool Victoria Friendly Society Limited (LV=) and shared with my intermediary or introductory partner (if applicable) for the purposes of providing me with a quote, processing and administering my insurance contract and assessing any claims.
- Shared with reinsurers, medical professionals and/or healthcare management companies chosen by LV= to enable LV= to process and service my insurance contracts and assess any claims.
- Shared with regulatory bodies (for example, the Financial Conduct Authority and HM Revenue and Customs) to enable LV= to fulfil legal and regulatory obligations.

1st person insured signature

Date / / (DD/MM/YYYY)

2nd person insured (if applicable) signature

Date / / (DD/MM/YYYY)

1st applicant if different from person insured signature

Date / / (DD/MM/YYYY)

2nd applicant (if applicable) if different from person insured signature

Date / / (DD/MM/YYYY)

You have a number of rights concerning your personal information. You can ask for a person to review an automated decision, and in certain circumstances to:

- access the personal information we hold about you.
- correct personal information.
- have your personal information deleted.
- restrict us processing your personal information
- receive your personal information in a portable format, and
- object to us processing your personal information.

If you want to find out more or exercise these rights, contact Life Customer Support, LV=, County Gates, Bournemouth, BH1 2NF or email us at LifeCustomerSupport@LV.com.

You can contact us about data protection at: Data Protection Officer, LV= County Gates, Bournemouth BH1 2NF or dpo@LV.com.

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Section F - Payment Details



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 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 if you're paying monthly, or if you're applying for inflation-linked cover. 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 once we have assessed and accepted your application. 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=, Emperor House, Grenadier Road, Exeter Business Park, Exeter EX1 3LH. Please ensure you complete all details



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

Form with fields: To: The Manager, Bank or Building Society, Address, Postcode

Service user 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.

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

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

Signature X

Date X [] [] / [] [] / [] [] [] [] (DD/MM/YYYY)

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

This page is intentionally blank - your financial adviser will complete their details on the next page.

For financial adviser use only

For paper applications

Address for applications

LV=, Emperor House, Grenadier Road, Exeter Business Park, Exeter EX1 3LH.

Please tick the relevant boxes.

- | | |
|--|---|
| <input type="checkbox"/> 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? |

Commission options (please tick your preferred option)

- | |
|--|
| <input type="checkbox"/> Full initial commission (<input type="checkbox"/> indemnified <input type="checkbox"/> non-indemnified) and renewal commission |
| <input type="checkbox"/> Initial commission sacrifice of: (<input type="checkbox"/> indemnified <input type="checkbox"/> non-indemnified) |
| <input type="checkbox"/> Nil commission |

Source code _____

financial adviser stamp and/or agency no.

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



Liverpool Victoria Friendly Society Limited: County Gates Bournemouth BH1 2NF.

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