ROYAL LONDON IRELAND

Financial Broker Stamp Here

Protection
Data Capture Form

This Data Capture Form may be used by your Financial Broker when completing an online application on your behalf. It does not form part of your application to Royal London Ireland. It should be returned to your Financial Broker as it is for their use only and will not be reviewed or retained by Royal London Ireland.

Please note that Royal London Ireland's products and the information on this form are provided for residents of the Republic of Ireland only.

1. Important information for Financial Brokers using this form

- This form can be used to capture the information from your client that you will need in order to submit an application using Royal London Ireland's online system.
- The person whose life is to be assured should provide the answers personally.
- You should keep this form for your own records.
- We will send a copy of all the questions and answers entered into the online system to you and your client. Where possible, the default communication preference for clients will be set to paperless/online. If your client wishes to change this preference they should let you know.

2. Which of our products would you like?

This section should be completed by all applicants.

(A) Mortgage Protection Cover

Form of cover: Single Life ☐ Joint Life ☐ Dual Life ☐

Where cover is on a Dual Life basis, cover is provided separately for the two lives and two claims are possible.
Where cover is on a Joint Life basis, only one claim is possible and a claim for one of the lives will end the policy.
Dual Life Mortgage Protection Life cover is provided at the same premium as Joint Life Mortgage Protection cover.
However, if Accelerated Specified Serious Illness Cover is selected, different premium rates will apply for Dual Life and Joint Life cover.

Amount of Life Cover: €

If availing of the Insurance Ireland Code of Practice for Underwriting Mortgage Protection Insurance for Cancer Survivors, the amount of cover applied for should be equal to or less than the mortgage amount, to a maximum of €500,000 per applicant.

Amount of Accelerated Specified Serious Illness Cover: €

A minimum of 10% or €10,000, whichever is the higher amount, and a maximum of 100% of the Life Cover may be selected as Specified Serious Illness Cover. If left blank no Specified Serious Illness Cover is selected.

Term of cover you want: _____ Years

Mortgage interest rate: 6% ☐ 9% ☐ 13% ☐

The amount of cover reduces over the term of your mortgage in line with a capital and interest mortgage at the selected interest rate.
13% is not available if you have Specified Serious Illness Cover.

Do you want a Conversion Option? Yes ☐ No ☐

For Mortgage Protection cover, an application with a Conversion Option will be fully underwritten.

Purpose of Cover:
Applicable for all Joint or Dual Life policies, or for Single Life policies where the Life to be assured will not be the Policy Owner.

Mortgage Protection ☐ Personal Cover ☐
Family Protection ☐ Business Cover ☐ Other ☐

*If **Other**, please give details:* _____

2. Which of our products would you like? continued

(B) Term Assurance and/or Specified Serious Illness Cover

Form of cover: Single Life ☐ Joint Life ☐ Dual Life ☐

Amount of Life Cover: Life 1 € ____ Life 2* € ____

**For Joint Life Cover, the amount of cover for Life 2 must be the same as for Life 1.*

Amount of Specified Serious Illness Cover: Life 1 € ____ Life 2 € ____

A minimum of 10% or €10,000, whichever is the higher, and a maximum of 100% of the Life Cover may be selected as Specified Serious Illness Cover. If left blank no Specified Serious Illness Cover is selected.

Type of Specified Serious Illness Cover: Accelerated ☐ Stand-alone ☐

Stand-alone not available for Joint Life applications.

Term of cover you want: ____ Years

Do you want Indexation? Yes ☐ No ☐

With Indexation, cover will increase at 3% per annum and premiums will increase at 4% per annum. If you select this option, you can opt out later.

Do you want a Conversion Option? Yes ☐ No ☐

Purpose of Cover:
Applicable for all Joint or Dual Life policies, or for Single Life policies where the Life to be assured will not be the Policy Owner.

- Personal Cover ☐
- Family Protection ☐
- Business Cover ☐
- Mortgage Protection ☐
- Other ☐

*If **Other**, please give details:* ____

(C) Pension Term Assurance

Eligibility

1. Are you engaged on your behalf (self-employed) or as an active partner in a trade, profession or occupation? Yes ☐ No ☐
2. Are you an employed person or holder of an office of employment? Yes ☐ No ☐
   *If **YES**, please answer 2.1 also.*

2.1 If you are an employed person, is one or more of your occupations non-pensionable? Yes ☐ No ☐

*If you are a member of an employer's pension scheme from which you expect to receive a retirement benefit, whether in lump sum or pension, you are **not** eligible to effect this policy unless you have another source of non-pensionable earnings.*

Retirement age (Policy expiry): ____
Must be between 60 and 75 years old.

Amount of Life Cover: Life 1 € ____

Do you want Indexation? Yes ☐ No ☐
With Indexation, cover will increase at 3% per annum and premiums will increase at 4% per annum. If you select this option, you can opt out later.

Do you want a Conversion Option? Yes ☐ No ☐

2. Which of our products would you like? continued

(D) Multi-Claim Protection Cover

Form of cover: Single Life ☐ Dual Life ☐

Amount of Core Benefit: Life 1 € _____ Life 2 € _____

Amount of Additional Life Cover benefit: Life 1 € _____ Life 2 € _____

If left blank no Additional Life Cover benefit is selected

Term of cover you want: _____ Years

Do you want Indexation? Yes ☐ No ☐

With Indexation, cover will increase at 3% per annum and premiums will increase at 4% per annum. If you select this option, you can opt out later.

Do you want a Conversion Option? Yes ☐ No ☐

A minimum term of ten years is needed for the Conversion Option to be selected.

Purpose of Cover:
Applicable for all Dual Life policies, or for Single Life policies where the Life to be assured will not be the Policy Owner.

Personal Cover ☐ Family Protection ☐
Business Cover ☐ Other ☐

*If **Other**, please give details:* _____

(E) Whole of Life

Form of cover:

Single Life ☐
Joint Life First Death ☐
Joint Life Second Death ☐
Dual Life ☐

Do you want this policy to be eligible for relief under Section 72 of the Capital Acquisitions Tax Consolidation Act 2003, generally used for inheritance tax planning? Yes ☐ No ☐

If this policy is being used for relief under Section 72 the form of cover must be Single Life or Joint Life Second Death.

Please note, if you intend to use this policy for inheritance tax planning it is strongly recommended that you complete a Section 72 Trust Form or provide for this policy in your Will. Otherwise the policy proceeds may not qualify for relief under Section 72.

Amount of Life Cover: Life 1 € _____ Life 2* € _____

**For Joint Life Cover, the amount of cover for Life 2 must be the same as for Life 1.*

Do you want Indexation? Yes ☐ No ☐

With Indexation, cover will increase at 3% per annum and premiums will increase at 4.5% per annum. If you select this option, you can opt out later.

Do you want the Life Changes Option? Yes ☐ No ☐

Purpose of Cover:
Applicable for all Joint or Dual Life policies, or for Single Life policies where the Life to be assured will not be the Policy Owner.

Capital Acquisitions Tax Provision ☐ Personal Cover ☐
Family Protection ☐ Business Cover ☐
Mortgage Protection ☐ Other ☐

*If **Other**, please give details:* _____

2. Which of our products would you like? continued

(F) Income Protection Cover

Form of cover: Personal ☐ Executive ☐

Annual amount of Income Protection Cover:
The maximum amount of Income Protection Cover is 75% of earnings less the personal rate of state illness benefit.
€

Please select the deferred period (in weeks) before which payments starts. 4 ☐ 8 ☐ 13 ☐ 26 ☐ 52 ☐

If you would like to receive part of your income cover earlier, enter the amount you would like and the period after you wish the payment to commence.
€
4 ☐ 8 ☐ 13 ☐ 26 ☐

At what age should your cover end?
This must be between 55 and 70 years old.

Do you want Indexation? Yes ☐ No ☐
With Indexation, cover will increase at 3% per annum and premiums will increase at 3.5% per annum. If you select this option, you can opt out later.

Do you want Escalation in Benefit during claim? Yes ☐ No ☐

For Executive Income Protection only, specify the annual cover required in respect of employer pension contributions (if any).
The maximum amount of employer pension contributions you can protect is 35% of earnings subject to a monetary maximum of €50,000. Annual pension contributions will always be paid after the longest deferred period selected above.
€

3. Personal details

This section should be completed by all applicants.

All cover types

How do you wish to pay the premiums? Monthly by Direct Debit ☐ Annually ☐

	First person to be covered	Second person to be covered
Date of Birth:	D D M M Y Y Y Y	D D M M Y Y Y Y
Have you smoked or used any tobacco or nicotine replacement products or e-cigarettes in the last 12 months? *We may require you to perform a simple test to confirm this.*	Yes ☐ No ☐	Yes ☐ No ☐

Personal information

	First person to be covered	Second person to be covered
First Name:		
Surname:		
Title:		
Gender:	Male ☐ Female ☐	Male ☐ Female ☐
Marital Status:	Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐	Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

3. Personal details continued

Contact details

	First person to be covered	Second person to be covered
Main Contact Telephone Number: *This must be provided.*		
Other Telephone Number:		
Email: *Email address and mobile phone number provided must be unique to each person.*		

Home address

		(If different to First Person)
Street:		
Area:		
Town:		
County/Area Code:		
Is this to replace an existing Royal London Ireland or Caledonian Life Policy?	Yes ☐ No ☐	Yes ☐ No ☐
*If **YES**, please provide the policy reference (s)*		

Politically Exposed Persons

We are required to identify politically exposed persons (PEPs).

A PEP can be identified as having held one of the following prominent public functions within the last 12 months. Please note that the below is a non-exhaustive list and if one has held any prominent position in any agency owned or controlled by the State then this should be considered when determining if one is a PEP. In addition, a PEP may be a close relative or business associate of the following:

1. A specified official such as a head of state, head of government, government minister or deputy or assistant government minister.
2. A member of parliament, a similar legislative body or a member of the governing body of a political party.
3. A member of a supreme court, constitutional court or another high-level judicial body whose decisions are not typically subject to appeal.
4. A member of a court of auditors or member of the board of a central bank.
5. An ambassador, chargé d'affaires (a diplomat who heads an embassy in the absence of the ambassador) or high-ranking officer in the armed forces.
6. A member of an administrative, management or supervisory body of a state-owned enterprise.
7. A director, deputy director, member of the board or person performing the equivalent function in an international organisation.

	First person to be covered	Second person to be covered
Are you a Politically Exposed Person (PEP) or related to/associated with a PEP?	Yes ☐ No ☐	Yes ☐ No ☐
*If **YES**, please answer the following:*		
PEP Function:		
PEP Status:	PEP ☐	PEP ☐
	Close relative of a PEP ☐	Close relative of a PEP ☐
	Close associate of a PEP ☐	Close associate of a PEP ☐

Note: If you are a PEP, or a close relative or close associate of a PEP, we must apply enhanced customer due diligence procedures. You will be required to provide evidence of identity as part of your application. Further information and documentation will be requested, if required.

4. Policy Owner (if different to person(s) covered)

Name/Company Name:*

Mobile Number:

Email:

Date of Birth: D D M M Y Y Y Y

Address:

Is the Policy Owner a Politically Exposed Person (PEP) or related to/associated with a PEP? Yes ☐ No ☐

*If **YES**, please answer the following:*

PEP Function:

PEP Status: PEP ☐ Close relative of a PEP ☐ Close associate of a PEP ☐

If there is a second Policy Owner named above, they should answer the following:

PEP Function:

PEP Status: PEP ☐ Close relative of a PEP ☐ Close associate of a PEP ☐

Note: If you are a PEP, or a close relative or close associate of a PEP, we must apply enhanced customer due diligence procedures. You will be required to provide evidence of identity as part of your application. Further information and documentation will be requested, if required.

If you require this policy to be written in trust then select the type of trust and submit a completed trust form.

Directors ☐ Flexible ☐ Married Women's ☐ Section 72 ☐ Partners ☐ Other ☐

Your policy will not be placed in trust until Royal London Ireland has received a fully completed trust deed.

***Executive Income Protection is only available if the Policy Owner is a company registered in Ireland under the Companies Acts.**

5. Doctor details

This section should be completed by all applicants.

	First person to be covered	**Second person to be covered**
Name of your doctor:		
Address of your doctor:		
Telephone Number:		

If you have been attending this doctor for less than one year, please give details of your previous doctor(s):

Name of this doctor:		
Address of this doctor:		
Telephone Number:		

6. Lifestyle and Family history

You must answer these questions honestly and in full. They are material to the underwriting of your policy and the calculation of the premium. The answers you provide to the questions and the associated declarations will be used in the underwriting process to establish material facts about you which influence the assessment and acceptance of cover, the setting of the terms, and the calculation of the premium. You are obliged to respond to all of the questions posed by us in your application honestly and with reasonable care. The height and weight provided must be current and accurate. If you don't answer these questions fully, honestly, to the best of your knowledge and with reasonable care, this may result (depending on the circumstances) in:

- delays in the processing of your claim;
- a reduction in the claim amount or refusal of a claim;
- the policy being treated as if it had been entered into on different terms; or
- the policy being cancelled from the start date (potentially without returning premiums) and with any subsequent claim not being paid.

You must tell us if there's a change to anything that would affect any of the answers to these specific questions or any relevant additional information in relation to this application, in the time after you've applied for your cover, but before your policy commences, such as a change to your health, occupation, or leisure activities. If you don't let us know about any changes affecting any of your answers before policy commencement, then this may also result in the consequences set out in the bullet points in the above paragraph.

	First person to be covered	Second person to be covered
Which of the following describes you?		
a. I've never smoked.	☐	☐
b. I used to smoke but stopped over a year ago. *Please add the date you stopped smoking.*	☐ D D M M Y Y Y Y	☐ D D M M Y Y Y Y
c. I've vaped or used e-cigarettes in the last 12 months.	☐	☐
d. I've use other nicotine replacement products in the last 12 months.	☐	☐
If you have smoked or used any tobacco or nicotine replacement products in the last 12 months, please select which of these you have used:		
a. Cigarettes	Use ☐ Don't use ☐	Use ☐ Don't use ☐
b. Cigars	Use ☐ Don't use ☐	Use ☐ Don't use ☐
c. Other tobacco	Use ☐ Don't use ☐	Use ☐ Don't use ☐
d. Electronic cigarettes	Use ☐ Don't use ☐	Use ☐ Don't use ☐
e. Other nicotine replacement products	Use ☐ Don't use ☐	Use ☐ Don't use ☐
If applicable, please tell us the amount of tobacco or nicotine replacement products you use in a day.		
How tall are you?	☐ feet ☐ inches ☐ or cm	☐ feet ☐ inches ☐ or cm
How much do you weigh? *The weight provided must be current and accurate. If you are currently pregnant, please tell us your weight immediately before your pregnancy.*	☐ st ☐ lbs ☐ or kg	☐ st ☐ lbs ☐ or kg

6. Lifestyle and Family history continued

Have your birth parents, brothers or sisters had any of these before they were 60?	**First person to be covered**	**Second person to be covered**
a. Heart attack, coronary artery disease or stroke.	Yes ☐ No ☐	Yes ☐ No ☐
b. Cardiomyopathy.	Yes ☐ No ☐	Yes ☐ No ☐
c. Diabetes.	Yes ☐ No ☐	Yes ☐ No ☐
d. Bowel cancer or bowel polyps.	Yes ☐ No ☐	Yes ☐ No ☐
e. Breast or ovarian cancer.	Yes ☐ No ☐	Yes ☐ No ☐
f. Any other cancer (including leukaemia or lymphoma).	Yes ☐ No ☐	Yes ☐ No ☐
g. Muscular dystrophy, Huntington's disease, or motor neurone disease.	Yes ☐ No ☐	Yes ☐ No ☐
h. Multiple sclerosis, Parkinson's disease, or Alzheimer's disease.	Yes ☐ No ☐	Yes ☐ No ☐
i. Polycystic kidney disease.	Yes ☐ No ☐	Yes ☐ No ☐
j. None of these	Yes ☐	Yes ☐
k. Don't know	Yes ☐	Yes ☐

If **YES**, then please provide details. If the condition is cancer, please be specific as to the type of cancer:

First person to be covered

Relative	Medical Condition	Age at Diagnosis

Second person to be covered

Relative	Medical Condition	Age at Diagnosis

If any tests, investigations or check-ups have been recommended or undertaken as a result of a relative's medical condition, please provide details:

How many alcoholic drinks do you consume in a week?

(One alcoholic drink is a pint of beer, a glass of wine or one measure of spirits.)

None ☐	None ☐
Up to 10 ☐	Up to 10 ☐
11–20 ☐	11–20 ☐
21–40 ☐	21–40 ☐
41–60 ☐	41–60 ☐
61 and over ☐	61 and over ☐

Have any of these applied to you?		
a. I've been advised by a medical professional to cut down or stop drinking alcohol.	Yes ☐ No ☐	Yes ☐ No ☐
b. I've attended, or been referred for, alcohol or drug specialist support such as Alcoholics Anonymous or Narcotics Anonymous.	Yes ☐ No ☐	Yes ☐ No ☐
c. I've used recreational drugs, or received treatment regarding the use of recreational drugs, in the last 10 years.	Yes ☐ No ☐	Yes ☐ No ☐
d. I've been addicted to, misused or overused medication, prescribed or not, in the last 10 years.	Yes ☐ No ☐	Yes ☐ No ☐

7. Employment

	First person to be covered	Second person to be covered
What is your job?		

Only answer the rest of the employment questions if you are applying for Income Protection

Are you involved in any of the following industries?

a. Defence Forces or reservist for Defence Forces — Yes ☐ No ☐

b. Oil or gas platform work — Yes ☐ No ☐

c. Working with explosives or any other hazardous materials — Yes ☐ No ☐

d. Tunnelling or underground work — Yes ☐ No ☐

e. Working at sea or commercial diving — Yes ☐ No ☐

Are you:

a. Employed? — Yes ☐

b. Self-Employed? — Yes ☐

c. A Shareholding Director? — Yes ☐

If you are Self-Employed or a Shareholding Director, how many employees (including sub-contractors) work for you?

How much did you earn (pre-tax) over the last 12 months?
Including overtime, commission and bonuses but not including investment income or income from other sources.

Do you have another job? Yes ☐ No ☐

*If **YES**, what is that job?*

Does your job involve manual work, driving or working at heights? Yes ☐ No ☐
*If **YES**, please provide details.*

a. Manual work (% of time):

b. Driving (business km per year, excluding commuting):

c. Working at heights (% of time):

Typical height (feet):

If you perform any manual work, please record typical manual duties.

Do any of the following apply?

I'm currently off work due to sickness or injury. Yes ☐ No ☐

I'm working reduced hours due to sickness or injury. Yes ☐ No ☐

I've altered my duties due to sickness or injury. Yes ☐ No ☐

*If **YES**, give details of all periods of absence, applicable dates and reasons.*

8. Health

You must answer these questions honestly and in full. They are material to the underwriting of your policy and the calculation of the premium. The answers you provide to the questions and the associated declarations will be used in the underwriting process to establish material facts about you which influence the assessment and acceptance of cover, the setting of the terms, and the calculation of the premium. You are obliged to respond to all of the questions posed by us in your application honestly and with reasonable care. If you don't answer these questions fully, honestly, to the best of your knowledge and with reasonable care, this may result (depending on the circumstances) in:

- delays in the processing of your claim;
- a reduction in the claim amount or refusal of a claim;
- the policy being treated as if it had been entered into on different terms; or
- the policy being cancelled from the start date (potentially without returning premiums) and with any subsequent claim not being paid.

You must tell us if there's a change to anything that would affect any of the answers to these specific questions or any relevant additional information in relation to this application, in the time after you've applied for your cover, but before your policy commences, such as a change to your health, occupation, or leisure activities. If you don't let us know about any changes affecting any of your answers before policy commencement, then this may also result in the consequences set out in the bullet points in the above paragraph.

The Disability Act 2005 prohibits processing of genetic data in relation to insurance. Therefore you should not disclose any genetic test or the results of any genetic test you may have had. You must however, tell us if you are having treatment or have had treatment for, or are experiencing symptoms of a genetic condition. You will also be asked to give us full information about your family history, including all genetic conditions.

Have you ever had any of the following:	**First person to be covered**	**Second person to be covered**
a. Cancer, cancer-in-situ, leukaemia, Hodgkin's disease or any other tumour? *If **YES** and you are applying for Mortgage Protection, please also complete the questions in Section 13 on page 19.*	Yes ☐ No ☐	Yes ☐ No ☐
b. Heart attack, irregular heart beat, cardiomyopathy, valve disorder or any other heart condition or heart surgery?	Yes ☐ No ☐	Yes ☐ No ☐
c. A stroke, TIA, brain haemorrhage or damage or surgery to your brain?	Yes ☐ No ☐	Yes ☐ No ☐
d. Bipolar disorder, manic depression, schizophrenia, psychosis or eating disorder? *If **YES**, please also complete the questions in Section 12 on pages 17 and 18.*	Yes ☐ No ☐	Yes ☐ No ☐
e. Tried to take your own life, intentionally harmed yourself, or had thoughts of either?	Yes ☐ No ☐	Yes ☐ No ☐
f. **(Under 55s only)** Multiple sclerosis, epilepsy, Parkinson's or any other disorder of the brain or nervous system?	Yes ☐ No ☐	Yes ☐ No ☐
g. **(Over 55s only)** Alzheimer's or any other form of dementia?	Yes ☐ No ☐	Yes ☐ No ☐
h. A positive test, or are you waiting on the results of a test for, HIV, AIDS or Hepatitis B or C? *If the result of a test you're waiting on turns out to be negative, the fact you had a test won't affect the terms we offer you.*	Yes ☐ No ☐	Yes ☐ No ☐
i. Hospitalisation due to COVID-19?	Yes ☐ No ☐	Yes ☐ No ☐

*If **YES** is answered to any question, please record details or answer the additional questions as directed above.*

First person to be covered

Second person to be covered

8. Health continued

In the last 5 years, have you had any of the following:	First person to be covered	Second person to be covered
a. Raised blood pressure, high cholesterol, or chest pain? *If you have raised blood pressure please also complete the questions on page 15.* *If you have raised cholesterol please also complete the questions on pages 16 and 17.*	Yes ☐ No ☐	Yes ☐ No ☐
b. Depression, anxiety, or stress? *If **YES**, please also complete the questions in Section 12 on pages 17 and 18.*	Yes ☐ No ☐	Yes ☐ No ☐
c. Diabetes or raised blood sugar?	Yes ☐ No ☐	Yes ☐ No ☐
d. Anaemia, blood clot or anything else affecting your blood?	Yes ☐ No ☐	Yes ☐ No ☐
e. A growth, lump or cyst? *Please answer **YES** whether seen by a doctor or not.*	Yes ☐ No ☐	Yes ☐ No ☐
f. Asthma, sleep apnoea or anything else affecting your lungs or breathing?	Yes ☐ No ☐	Yes ☐ No ☐
g. Crohn's, colitis, IBS, or anything else affecting your stomach, bowel or digestive system?	Yes ☐ No ☐	Yes ☐ No ☐
h. **(Males only)** Kidney stones, urinary infection or anything else affecting your kidneys, prostate, bladder or urine?	Yes ☐ No ☐	Yes ☐ No ☐
i. **(Females only)** Kidney stones, urinary infection or anything else affecting your kidneys, bladder or urine?	Yes ☐ No ☐	Yes ☐ No ☐
j. **(Females only)** An abnormal cervical smear or any other gynaecological disorder that has required regular follow-up?	Yes ☐ No ☐	Yes ☐ No ☐
k. Anything affecting your liver or pancreas?	Yes ☐ No ☐	Yes ☐ No ☐

*If **YES** is answered to any question, please record details or answer the additional questions as directed above.*

First person to be covered

Second person to be covered

If you are applying for Specified Serious Illness or Income Protection cover, please tell us if, in the last 5 years, you have had any of the following:	**First person to be covered**		**Second person to be covered**	
a. Back pain, sciatica, whiplash or anything else affecting your back or neck?	Yes ☐	No ☐	Yes ☐	No ☐
b. Arthritis, gout or anything else affecting your bones, joints, ligaments, tendons or muscles?	Yes ☐	No ☐	Yes ☐	No ☐
c. Numbness, pins and needles, muscle weakness, tremor or difficulty with co-ordination?	Yes ☐	No ☐	Yes ☐	No ☐
d. Tinnitus, labyrinthitis, or anything else affecting your ears, hearing or balance?	Yes ☐	No ☐	Yes ☐	No ☐
e. Impaired, blurred or double vision, optic neuritis or anything else affecting your eyes?	Yes ☐	No ☐	Yes ☐	No ☐
f. Chronic fatigue syndrome, ME, fibromyalgia or persistent tiredness?	Yes ☐	No ☐	Yes ☐	No ☐

*If **YES** is answered to any question, please record details:*

First person to be covered

Second person to be covered

Regardless of the type of cover you are applying for, please tell us if, in the last 3 years, you have:	**First person to be covered**		**Second person to be covered**	
a. Taken or been prescribed treatment for 4 weeks or more? *You do not need to tell us about contraception, fertility, dental treatment or reviews purely in relation to pregnancy.*	Yes ☐	No ☐	Yes ☐	No ☐
b. Been asked to attend a follow-up or regular reviews with a GP, hospital, or clinic? *For example: Abnormal smear or mammogram, biopsy, colonoscopy, scans or blood tests. You do not need to tell us about investigations which were purely for pregnancy, infertility or simple fractures.*	Yes ☐	No ☐	Yes ☐	No ☐
c. Been advised to see a specialist or to have any tests, scans, investigations, or counselling? *For example: Bleeding from the bowels or change in bowel habit, persistent cough, weight loss, onset of fits or seizures, dizziness, blackouts or fainting.*	Yes ☐	No ☐	Yes ☐	No ☐

*If **YES** is answered to any question, please record details:*

First person to be covered

Second person to be covered

8. Health continued

In the last 3 months, have you had any of the following, even if you haven't seen a doctor? *You don't need to include things you've already told us about.*	**First person to be covered**		**Second person to be covered**	
a. **(Female only)** Any lump, growth or hardening affecting either breast?	Yes ☐	No ☐	Yes ☐	No ☐
b. **(Male only)** Any lump, growth or hardening affecting either testicle?	Yes ☐	No ☐	Yes ☐	No ☐
c. Bleeding from the bowel or a change in bowel habit?	Yes ☐	No ☐	Yes ☐	No ☐
d. Unexplained weight loss of 10lbs/4kg or more?	Yes ☐	No ☐	Yes ☐	No ☐
e. A cough lasting more than 3 weeks?	Yes ☐	No ☐	Yes ☐	No ☐
f. A fit or seizure?	Yes ☐	No ☐	Yes ☐	No ☐
g. A mole or skin blemish which has bled, become painful, or changed in appearance?	Yes ☐	No ☐	Yes ☐	No ☐

*If **YES** is answered to any question, please record details:*

First person to be covered

Second person to be covered

9. Hobbies, Travel and Other cover

Are you involved in any of these?	**First person to be covered**		**Second person to be covered**	
a. Defence forces (including reserves)	Yes ☐	No ☐	Yes ☐	No ☐
b. Scuba diving	Yes ☐	No ☐	Yes ☐	No ☐
c. Private flying, gliding or parachuting	Yes ☐	No ☐	Yes ☐	No ☐
d. Motor car or motorcycle sport	Yes ☐	No ☐	Yes ☐	No ☐
e. Mountaineering or rock climbing	Yes ☐	No ☐	Yes ☐	No ☐
f. Professional or semi-professional sports	Yes ☐	No ☐	Yes ☐	No ☐
g. Martial arts or combat sports	Yes ☐	No ☐	Yes ☐	No ☐
h. Off-piste snow sports	Yes ☐	No ☐	Yes ☐	No ☐
i. Sailing at sea or powerboat racing	Yes ☐	No ☐	Yes ☐	No ☐
j. Competitive horse riding	Yes ☐	No ☐	Yes ☐	No ☐

You do not need to disclose non-hazardous team sports such as amateur or recreational football, rugby or hurling.

Have you lived, worked, or travelled outside of the European Union, United Kingdom, North America, Australia, New Zealand or Japan in the last 2 years, or do you have any plans to do so in the next 2 years? *You do not need to tell us about business trips of less than a week or holidays less than 30 days.*	Yes ☐	No ☐	Yes ☐	No ☐

9. Hobbies, Travel and Other cover continued

	First person to be covered	Second person to be covered
If you are currently applying for Specified Serious Illness Cover, and/or Multi Claim Protection Cover, do you have existing Specified Serious Illness Cover and/or Multi-Claim Protection Cover or are you applying for any other Specified Serious Illness Cover and/or Multi-Claim Protection Cover, where the total cover held would exceed €500,000?	Yes ☐ No ☐	Yes ☐ No ☐
If you are currently applying for Income Protection Cover, do you have existing Income Protection Cover or are you applying for any other Income Protection Cover?	Yes ☐ No ☐	Yes ☐ No ☐
If you have existing Income Protection Cover in force, is it being replaced by this application?	Yes ☐ No ☐	Yes ☐ No ☐
If you are currently applying for Life Cover, do you have existing Life Cover or are you applying for any other Life Cover where the total cover held would exceed €5,000,000?	Yes ☐ No ☐	Yes ☐ No ☐

*If **YES**, please provide details of type and amount of cover and name of current insurer.*

First person to be covered

Second person to be covered

10. Health – Blood pressure

Only complete this section if you have had raised blood pressure in the last 5 years.

	First person to be covered	Second person to be covered
Are you awaiting hospital referral, tests or investigations or the results of any tests or investigations for your blood pressure?	Yes ☐ No ☐	Yes ☐ No ☐
Have you had any of the following?		
a. Kidney problems or protein in your urine	Yes ☐ No ☐	Yes ☐ No ☐
b. Angina, a heart attack or stroke, a TIA or blocked or narrow arteries in your legs	Yes ☐ No ☐	Yes ☐ No ☐
c. An ECG or heart test that was abnormal or needed further investigation	Yes ☐ No ☐	Yes ☐ No ☐
d. Chest pain that required attendance at an Accident and Emergency department or any clinic or hospital	Yes ☐ No ☐	Yes ☐ No ☐
e. Eye problems as a result of your condition	Yes ☐ No ☐	Yes ☐ No ☐
Are you currently on prescribed treatment to control your blood pressure?	Yes ☐ No ☐	Yes ☐ No ☐
*If **NO**, have you ever not taken or stopped treatment without your doctor's approval?*	Yes ☐ No ☐	Yes ☐ No ☐
When was your blood pressure first noticed to be raised? *If you are not sure about the exact date please try to be as accurate as possible.*	D D M M Y Y Y Y	D D M M Y Y Y Y
If you know the result of your last blood pressure reading:		
What was the first or top number?		
What was the second or bottom number?		
If you do not know the result of your last blood pressure, did your doctor or nurse tell you whether your last blood pressure reading was? *(select one)*		
a. High and needs to be reduced	☐	☐
b. Satisfactory but slightly raised	☐	☐
c. Normal	☐	☐
d. Low	☐	☐
e. Don't know	☐	☐
What was the outcome of your last review of your blood pressure? *(select all that apply)*		
a. Advised to start or increase treatment	☐	☐
b. Advised to attend a review within 6 months	☐	☐
c. Treatment remained the same or has been decreased	☐	☐
d. Treatment was stopped	☐	☐
e. Advised to attend a review in 6 months time or later	☐	☐
f. Referred to a specialist	☐	☐

11. Health – Cholesterol

Only complete this section if you have had raised cholesterol in the last 5 years.

	First person to be covered	Second person to be covered
Are you awaiting hospital referral, tests or investigations or the results of any tests or investigations for your cholesterol? *You do not need to tell us about routine cholesterol tests.*	Yes ☐ No ☐	Yes ☐ No ☐
Have you had any of the following?		
a. Kidney problems or protein in your urine	Yes ☐ No ☐	Yes ☐ No ☐
b. Angina, a heart attack or stroke, a TIA or blocked or narrow arteries in your legs	Yes ☐ No ☐	Yes ☐ No ☐
c. An ECG or heart test that was abnormal or needed further investigation	Yes ☐ No ☐	Yes ☐ No ☐
d. Chest pain that required attendance at an Accident and Emergency department or any clinic or hospital	Yes ☐ No ☐	Yes ☐ No ☐
e. Eye problems as a result of your condition	Yes ☐ No ☐	Yes ☐ No ☐
When was your cholesterol first noticed to be raised? *If you are not sure about the exact date please try to be as accurate as possible.*	D D M M Y Y Y Y	D D M M Y Y Y Y
If your cholesterol was diagnosed before the age of 31 please confirm if any of your first degree relatives (mother, father, sister or brother) were diagnosed with high cholesterol or had heart disease below the age of 40?	Yes ☐ No ☐	Yes ☐ No ☐
Are you currently on prescribed treatment to control your cholesterol?	Yes ☐ No ☐	Yes ☐ No ☐
*If **YES**, please confirm how many different medications do you take for your raised cholesterol? This does not include aspirin or medication for other conditions.*		
*If **NO**, have you stopped taking any cholesterol lowering medication without being advised to do so by your doctor?*	Yes ☐ No ☐	Yes ☐ No ☐
If you know the result of your last cholesterol test, what was it? *The reading should be given as a number with one decimal place in the format 6.5*		

If you do not know the result of your last cholesterol reading, did your doctor or nurse tell you whether your last cholesterol reading was *(select one)*

	First person to be covered	Second person to be covered
a. High and needs to be reduced	☐	☐
b. Satisfactory but slightly raised	☐	☐
c. Normal	☐	☐
d. Low	☐	☐
e. Don't know	☐	☐

11. Health – Cholesterol continued

What was the outcome of your last review of your cholesterol? *(select all that apply)*	**First person to be covered**	**Second person to be covered**
a. Advised to start or increase treatment	☐	☐
b. Advised to attend a review within 6 months	☐	☐
c. Treatment remained the same or has been decreased	☐	☐
d. Treatment was stopped	☐	☐
e. Advised to attend a review in 6 months time or later	☐	☐
f. Referred to a specialist	☐	☐

How regularly is your doctor or nurse checking your cholesterol? *(select one)*		
a. Less often than yearly	☐	☐
b. Yearly	☐	☐
c. More often than yearly	☐	☐

12. Mental illness

Only complete this section if, in section 8, you have disclosed a mental illness, and/or you have disclosed attending a health professional, or are taking medication, for a mental illness.

Have you ever had any of the following?	**First person to be covered**	**Second person to be covered**
a. Bipolar disorder	☐	☐
b. Manic depression	☐	☐
c. Schizophrenia	☐	☐
d. Psychosis	☐	☐
e. Eating disorders	☐	☐
f. Hospital treatment or a referral to a psychiatrist or psychologist as a result of any mental illness	☐	☐
g. None of the above	☐	☐

In the last 5 years have you had any of the following?		
a. Depression	☐	☐
b. Anxiety	☐	☐
c. Stress	☐	☐
d. Continuous or chronic fatigue	☐	☐
e. Insomnia	☐	☐
f. Any other mental illness	☐	☐

Are you awaiting hospital or specialist referral for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

12. Mental illness continued

Have you ever?	**First person to be covered**	**Second person to be covered**
a. Tried to take your own life	☐	☐
b. Had thoughts about taking your own life	☐	☐
c. Intentionally harmed yourself	☐	☐
d. Had thoughts about harming yourself	☐	☐
e. None of the above	☐	☐
When did you last experience symptoms of this condition?	D D M M Y Y Y Y	D D M M Y Y Y Y

Which of the following have you visited regarding this condition in the last 5 years? *(select all that apply)*

a. GP/GP Surgery nurse	☐	☐
b. Community Psychiatric Nurse	☐	☐
c. Cognitive behavioural therapy (CBT) or counselling	☐	☐
d. Hospital specialist or psychiatrist	☐	☐
e. Inpatient treatment at hospital/clinic	☐	☐
f. Support for alcohol or drug abuse/rehabilitation	☐	☐
g. None of the above	☐	☐
When did you last take time off work because of this?	D D M M Y Y Y Y	D D M M Y Y Y Y

How many separate episodes of symptoms have you had? *(select one)*

a. Once only	☐	☐
b. Two or three times	☐	☐
c. Recurrent	☐	☐
Are you currently prescribed medication for this condition or receiving counselling or cognitive behavioural therapy (CBT)?	Yes ☐ No ☐	Yes ☐ No ☐

13. Cancer

Only complete this section if, in Section 8, you have disclosed any form of cancer and are applying for Mortgage Protection.

	First person to be covered	Second person to be covered
Which condition(s) have you had?		
When were you diagnosed with cancer?	D D M M Y Y Y Y	D D M M Y Y Y Y
When did you last have treatment for cancer? *Treatment means surgery, radiation therapy, chemotherapy, biological agents, immunotherapy, bone marrow transplant or any evidence-based medical treatments to cure a cancer. It excludes anti-hormonal medications, such as Tamoxifen, or any form of preventative therapy or medicine designed to reduce recurrence risk following complete remission.*	D D M M Y Y Y Y	D D M M Y Y Y Y
Has your treating oncologist confirmed that you are in complete remission? *Complete remission means the absence of signs and symptoms related to a cancer diagnosis which may be determined by, but not limited to, physical examination, radiological investigation and serum biomarkers.*	Yes ☐ No ☐	Yes ☐ No ☐
Is this application being made in relation to a mortgage on your principal private residence? *A principal private residence is where you live most or all of the time. This includes first time buyers, home movers and re-mortgages but not second homes or buy to let mortgages.*	Yes ☐ No ☐	Yes ☐ No ☐
Do you currently have cover in respect of your principal private residence?	Yes ☐ No ☐	Yes ☐ No ☐
*If **YES**, will this existing policy be cancelled on issue of this policy?*	Yes ☐ No ☐	Yes ☐ No ☐
Is this application the only Mortgage Protection application being made in relation to this loan?	Yes ☐ No ☐	Yes ☐ No ☐

*If **NO** is the answer to the above two questions, in order to assess the eligibility under the Code of Practice, please provide details of cover held or being applied for in the market, including name of provider, sum assured and whether it is to be cancelled on acceptance of this policy.*

First person to be covered	Second person to be covered

	First person to be covered	Second person to be covered
Is the amount of cover that you are applying for greater than your mortgage amount?	Yes ☐ No ☐	Yes ☐ No ☐

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