

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:		Joint Life	Duai Lite 🗆
Where cover is on a Dual Life basis, cover is provided separately for the two lives a	nd two claims are pos	ssible.	
Where cover is on a Joint Life basis, only one claim is possible and a claim for one of	f the lives will end the	policy.	
Dual Life Mortgage Protection Life cover is provided at the same premium as Joint	Life Mortgage Protec	ction cover.	
However, if Accelerated Specified Serious Illness Cover is selected, different premi	um rates will apply fo	r Dual Life and Jo	int 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:

Mortgage interest rate:

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.

6%

Vec

9%

No

Do you want a Conversion Option?

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	

1

Years

13%

If **Other**, please give details:

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

Form of cover:	Single Life Joint Life Dual Life
Amount of Life Cover:	Life1
*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 Indovation?	Yes No
Do you want Indexation? 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
	Personal
Purpose of Cover:	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.	Family Protection
5	Business
	Mortgage Protection
	Other
	Other
If Other , please give details:	
J	
(C) Pension Term Assurance	
Eligibility	
 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?	
If YES , please answer 2.1 also.	Yes No
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:	Life1
Amount of Life Cover:	
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
De you want a Conversion Option:	

(D) Multi-Claim Protection Cover

Form of cover:

Amount of Core Benefit:

Amount of Additional Life Cover benefit: If left blank no Additional Life Cover benefit is selected

Term of cover you want:

Do you want Indexation?

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?

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.

If **Other**, please give details:

(E) Whole of Life

Form of cover:

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? 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:

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

Do you want Indexation?

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?

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.

Single Life Dua	l Life
Life 1	Life 2
Life1	Life 2
Yes No	Years
Yes No	
Personal Far Cover Pro	nily

Other

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

Yes	No	

Cover

Yes No
Yes No
Capital Acquisitions Personal Tax Provision Cover
Family Business Protection 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:		€
	an io 75%	
The maximum amount of Income Protection Cove of earnings less the personal rate of state illness		
of earnings less the personal rate of state niness	benejn.	
Please select the deferred period (in weeks) bef	Fore which payments starts.	4 8 13 26 52
If you would like to receive part of your income c	over earlier,	€
enter the amount you would like and the period a		
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 ar		
per annum. If you select this option, you can opt o	out later.	
Do you want Eccelation in Ronaft during alaim?		Yes No
Do you want Escalation in Benefit during claim?		
For Executive Income Protection only, specify th	ne annual cover	€
required in respect of employer pension contrib	•	$\overline{\nabla}$
The maximum amount of employer pension contril		
subject to a monetary maximum of €50,000. Ann	nual pension contributions will always be paid	
after the longest deferred period selected above.		
3. Personal details		
This section should be completed by all ap	plicants.	
	plicants.	
All cover types		
	plicants. Monthly by Direct Debit Annually	
All cover types	Monthly by Direct Debit Annually	
All cover types		Second person to be covered
All cover types How do you wish to pay the premiums?	Monthly by Direct Debit Annually	Second person to be covered
All cover types How do you wish to pay the premiums? Date of Birth:	Monthly by Direct Debit Annually	Second person to be covered
All cover types How do you wish to pay the premiums? Date of Birth: Have you smoked or used any tobacco	Monthly by Direct Debit Annually	Second person to be covered
All cover types How do you wish to pay the premiums? Date of Birth: Have you smoked or used any tobacco or nicotine replacement products or	Monthly by Direct Debit Annually	
All cover types How do you wish to pay the premiums? Date of Birth: Have you smoked or used any tobacco or nicotine replacement products or e-cigarettes in the last 12 months?	Monthly by Direct Debit Annually	Second person to be covered M Y Y Yes No
All cover types How do you wish to pay the premiums? Date of Birth: 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	Monthly by Direct Debit Annually	
All cover types How do you wish to pay the premiums? Date of Birth: Have you smoked or used any tobacco or nicotine replacement products or e-cigarettes in the last 12 months?	Monthly by Direct Debit Annually	
All cover types How do you wish to pay the premiums? Date of Birth: 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.	Monthly by Direct Debit Annually	
All cover types How do you wish to pay the premiums? Date of Birth: 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	Monthly by Direct Debit Annually	
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All cover types How do you wish to pay the premiums? Date of Birth: 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.	Monthly by Direct Debit Annually	
All cover types How do you wish to pay the premiums? Date of Birth: 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. Personal information First Name:	Monthly by Direct Debit Annually	
All cover types How do you wish to pay the premiums? Date of Birth: 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. Personal information	Monthly by Direct Debit Annually	
All cover types How do you wish to pay the premiums? Date of Birth: 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. Personal information First Name: Surname:	Monthly by Direct Debit Annually	
All cover types How do you wish to pay the premiums? Date of Birth: 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. Personal information First Name:	Monthly by Direct Debit Annually	
All cover types How do you wish to pay the premiums? Date of Birth: 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. Personal information First Name: Surname: Title:	Monthly by Direct Debit Annually First person to be covered Image: Annually First person to be covered Image: Annually Yes No	D M M Y Y Y Yes No
All cover types How do you wish to pay the premiums? Date of Birth: Have you smoked or used any tobacco or nicotine replacement products or e-cigarettes in the last 12 months? <i>We may require you to perform a simple test</i> to confirm this. Personal information First Name: Surname:	Monthly by Direct Debit Annually	
All cover types How do you wish to pay the premiums? Date of Birth: 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. Personal information First Name: Surname: Title:	Monthly by Direct Debit Annually First person to be covered Image: Annually First person to be covered Image: Annually Yes No	D M M Y Y Y Yes No

Married

Widowed

Separated

Divorced

Married

Widowed

Separated

Divorced

3. Personal details continued

Contact details	First person to be covered	Second person to be covered
Main Contact Telephone Number: <i>This must be provided.</i>		
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?

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:

No

No

Yes

- 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.

Yes

- 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 C	lose associate of a PEP
If there is a second Policy Owner named above, the	y should answer the following:	
PEP Function:		
PEP Status:	PEP Close relative of a PEP C	lose associate of a PEP
Note: If you are a PEP, or a close relative or close a You will be required to provide evidence of identity 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 Women's	Section Partners Other Other
Your policy will not be placed in trust until Royal Log *Executive Income Protection is only available if the		
5. Doctor details		
This section should be completed by all appli	cants.	
	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):		

• 0	
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.		
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	feet
	inches	inches
	or cm	or cm
How much do you weigh?	st	st
The weight provided must be current and accurate. If you are currently pregnant, please tell us your weight	lbs	lbs
immediately before your pregnancy.	or kg	or kg

6. Lifestyle and Family history continued

	First person	Second person
Have your birth parents, brothers or sisters had any of these before they were 60?	to be covered	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.
- b. I've attended, or been referred for, alcohol or drug specialist support such as Alcoholics Anonymous or Narcotics Anonymous.
- c. I've used recreational drugs, or received treatment regarding the use of recreational drugs, in the last 10 years.
- d. I've been addicted to, misused or overused medication, prescribed or not, in the last 10 years.

Yes	No	Yes	No
Yes	No	Yes	No
Yes	No	Yes	No
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
- b. Oil or gas platform work
- c. Working with explosives or any other hazardous materials
- d. Tunnelling or underground work
- e. Working at sea or commercial diving

Are you:

- a. Employed?
- b. Self-Employed?
- c. A Shareholding Director?

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?

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

Does your job involve manual work, driving or working at heights?

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):

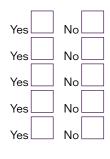
If you perform any manual work, please record typical manual duties.

Do any of the following apply?

I'm currently off work due to sickness or injury.

 $l^{\prime}\!m$ working reduced hours due to sickness or injury.

I've altered my duties due to sickness or injury.

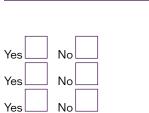




Yes



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 oth condition or heart surgery?	er heart 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 disor If YES , please also complete the questions in Section 12 on pages 17 and 18.	der? Yes No	Yes No
 e. Tried to take your own life, intentionally harmed yourself, or had thoughts of e f. (Under 55s only) Multiple sclerosis, epilepsy, Parkinson's or any other disord brain or nervous system? 		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 Hepatit If the result of a test you're waiting on turns out to be negative, the fact you had won't affect the terms we offer you.		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 additiona	Il questions as directed above.	
First person to be covered Second pe	rson 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
-	Crohn's, colitis, IBS, or anything else affecting your stomach, bowel or digestive system? (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:

- a. Back pain, sciatica, whiplash or anything else affecting your back or neck?
- b. Arthritis, gout or anything else affecting your bones, joints, ligaments, tendons or muscles?
- c. Numbness, pins and needles, muscle weakness, tremor or difficulty with co-ordination?
- d. Tinnitus, labyrinthitis, or anything else affecting your ears, hearing or balance?
- e. Impaired, blurred or double vision, optic neuritis or anything else affecting your eyes?
- f. Chronic fatigue syndrome, ME, fibromyalgia or persistent tiredness?

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

First person to be covered

g your eyes?	Yes No	Yes No
d person to be	covered	

First person to be covered

No

No

No

Yes

Yes

Yes

First person

Yes

Yes

Yes

Yes

Secon

to be covered

No

No

No

No

Regardless of the type of cover you are applying for, please tell us if, in the last 3 years, you have:

- 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.
- 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.
- 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.

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

First person to be covered

Second person to be covered						

 Second to be c	d person overed
Yes	No
Yes	_ No _
Yes	_ No _
Yes	No
Yes	No

Second person

No

Nr

to be covered

Yes

Yes

Yes

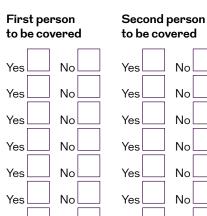
8. Health continued

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.

- a. (Female only) Any lump, growth or hardening affecting either breast?
- b. (Male only) Any lump, growth or hardening affecting either testicle?
- c. Bleeding from the bowel or a change in bowel habit?
- d. Unexplained weight loss of 10lbs/4kg or more?
- e. A cough lasting more than 3 weeks?
- f. A fit or seizure?
- g. A mole or skin blemish which has bled, become painful, or changed in appearance?

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

First person to be covered



Yes

No

Second person to be covered

Yes

No

9. Hobbies, Travel and Other cover

Are you involved in any of these?

- a. Defence forces (including reserves)
- b. Scuba diving
- c. Private flying, gliding or parachuting
- d. Motor car or motorcycle sport
- e. Mountaineering or rock climbing
- f. Professional or semi-professional sports
- g. Martial arts or combat sports
- h. Off-piste snow sports
- Sailing at sea or powerboat racing i.
- Competitive horse riding j.

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.

First person to be covered		Second person to be covered		
Yes	No	Yes	No	
Yes	No	Yes	No	
Yes	No	Yes	No	
Yes	No	Yes	No	
Yes	No	Yes	No	
Yes	No	Yes	No	
Yes	No	Yes	No	
Yes	No	Yes	No	
Yes	No	Yes	No	
Yes	No	Yes	No	





9. Hobbies, Travel and Other cover continued

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?

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?

If you have existing Income Protection Cover in force, is it being replaced by this application?

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?

If ${\bf YES},$ please provide details of type and amount of cover and name of current insurer.

First person to be covered

Second person to be covered

Yes No	Yes No
Yes No	Yes No
Yes No	Yes No
Yes No	Yes No

Second person

to be covered

First person

to be covered

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

Are you awaiting hospital referral, tests or investigations or the results of any tests or investigations for your blood pressure?

Have you had any of the following?

- a. Kidney problems or protein in your urine
- b. Angina, a heart attack or stroke, a TIA or blocked or narrow arteries in your legs
- c. An ECG or heart test that was abnormal or needed further investigation
- d. Chest pain that required attendance at an Accident and Emergency department or any clinic or hospital
- e. Eye problems as a result of your condition

Are you currently on prescribed treatment to control your blood pressure?

If **NO**, have you ever not taken or stopped treatment without your doctor's approval?

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.

If you know the result of your last blood pressure reading:

What was the first or top number?

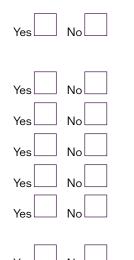
What was the second or bottom number?

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 monthsc. 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



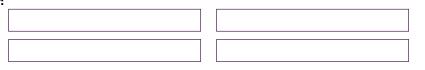
First person to be covered

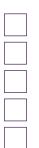


Yes	No
Yes	No

les	No	
/es	No	

DD	Μ	\mathbb{N}	Y	Y	Y	Y
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Second person to be covered

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11. Health – Cholesterol

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

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.

Have you had any of the following?

- a. Kidney problems or protein in your urine
- b. Angina, a heart attack or stroke, a TIA or blocked or narrow arteries in your legs
- c. An ECG or heart test that was abnormal or needed further investigation
- d. Chest pain that required attendance at an Accident and Emergency department or any clinic or hospital
- e. Eye problems as a result of your condition

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.

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?

Are you currently on prescribed treatment to control your cholesterol?

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?

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*)

- a. High and needs to be reduced
- b. Satisfactory but slightly raised
- c. Normal
- d. Low
- e. Don't know

First person to be covered	Second person to be covered
Yes No	Yes No
Yes No	Yes No
D D M M Y Y Y Y	D D M M Y Y Y
Yes No	Yes No
Yes No	Yes No
Yes No	Yes No
[]	



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
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
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
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	D D M M 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



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