ROYAL LONDON

Protection

Pegasus Whole Of Life Plan

Data capture form

Adviser information

You should use this form to capture the information you'll need from your clients to use our online quote and apply system. We won't accept this form as a replacement for a paper application form.

The data capture form lets you capture a certain amount of information from your client. But if they answer Yes to some of the questions, our interactive system will ask for more information online before you can send the application to us. This means your client will need to be present or available by phone when you get to this stage in the application process. If they're not present, you can save the application at any time and go back when they're available.

Important information for each person covered

How we use your data

We need to make it clear how we will use your personal information, including information about your health.

We'll use your data to provide a quote and also for pricing and underwriting analytics. We may share your information with selected third parties for assessing and servicing your application. More details can be found online within our privacy notice: **royallondon.com/protectionprivacy**

ABI policy on genetic testing

- If you've had a predictive genetic test for Huntington's disease, you only have to tell us the results if these applications, when added together with any cover you have of the same type, is for more than £500,000 of Life Cover.
- If you've had a test and the results are in your favour, you can choose whether to tell us the results or not. However, you must tell us if you think you're having treatment for, or are experiencing symptoms of a genetic condition.

Obtaining medical reports

- We may request medical information as part of the application for up to six months after the plan has started to confirm the information you have given. Before we can do this we will ask for permission under the Access to Medical Reports Act 1988.
- If you don't give permission, or any statement is inaccurate and this affects our assessment of your application, we will then have the right to reconsider or withdraw terms and your plan may be cancelled.

Impact of misrepresentation

- Please answer all questions accurately and honestly and to the best of your knowledge and belief. If you're not sure about including any information, then you should include it.
- You must tell us if there is a change to **any** of the answers given to the questions in the application form (including in relation to your health, occupation or leisure activities) or any other information provided between the date the answer is given and the date we start the plan.

If you miss any information out, give us wrong, incomplete or misleading information, or don't tell us about changes it could mean we won't pay out if you have to make a claim. It could also delay the processing of your application or result in your plan being cancelled or amended should it affect the terms we would have offered.

If you need any help with filling in this form, please contact us on 0345 6094 500.

Important information for the plan owner

How we use your data

We need to make it clear how we will use your personal information.

We'll use your data to provide a quote and also for pricing and underwriting analytics. We may share your information with selected third parties for assessing and servicing your application. More detail can be found online within our privacy notice: **royallondon.com/protectionprivacy**

Key Facts documentation

You should have received a copy of the Key Facts document from your adviser. This contains important information about your application with us.

Obtaining medical reports

- We may request medical information as part of the application for up to six months after the plan has started to confirm the information given. Before we can do this we will ask for permission under the Access to Medical Reports Act 1988.
- If any of the people covered don't give permission, or any statement is inaccurate and this affects our assessment of the application, we will then have the right to reconsider or withdraw terms and your plan may be cancelled.

Impact of misrepresentation

- Please answer all questions accurately and honestly and to the best of your knowledge and belief. If you're not sure about including any information, then you should include it.
- You must inform us if there is a change to **any** of the answers that you or the person covered have given to the questions in the application form (including in relation to the person covered's health, occupation or leisure activities) or any other information provided between the date the answer is given and the date we start the plan.

If you miss any information out, give us wrong, incomplete or misleading information, or don't tell us about changes it could mean we won't pay out if you have to make a claim. It could also delay the processing of your application or result in your plan being cancelled or amended should it affect the terms we would have offered.

Further help and support

If you need any help with filling in this form, please contact us on **0345 6094 500**.

You can visit our Health and wellbeing directory at **royallondon.com/healthandwellbeing** which includes a list of organisations providing help and advice to support your mental and physical health.

For financial advisers

Quote number	
Adviser name	
Account number	
Special commission instructions	
Your unique reference	

1 Who will be the plan owner?

Please remember how important it is to answer all the questions on this form honestly and in full.

Will the person or people covered also be the plan owner(s)? Yes ☐ No ☐

If Yes, please go to section 2.

If you choose Employer in the following section please make sure you complete the company payment details in section 15.

Title	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other (please give details)
First name(s) If the other applicant is a Company or Employer, please give the registered name of the company.	
Surname	
Addressee name If the other applicant is a company, please give the addressee name within the company.	
Date of birth	D D M M Y Y Y Y
What is the other applicant's relationship to the person or people covered? If you choose employer, you must complete section 18.	Wife ☐ Husband ☐ Civil partner ☐ Living together as partners ☐ Business partner ☐ Employer ☐ Other ☐ If Other, please give details
If the other applicant's relationship to the plan owner is 'employer', please tell us the nature of the business.	
In which country is the other applicant permanently resident?	UK ☐ Jersey ☐ Guernsey ☐ Isle of Man ☐ Other ☐ If Other, please give details
In the next six months, will you be moving from the country in which you're permanently resident? If Yes, please give full details.	Yes ☐ No ☐
What is the other applicant's address?	
Postcode	
Email	

1 Who will be the plan owner? continued

Phone number Please enter at least one phone number.	Daytime		Evening	
	Mobile			

If you move house while we're processing your application, please contact us once you've moved to your new address.

Important information before you begin

Our underwriting process

When you apply for a protection product, we ask questions about the areas we know are relevant to determine whether you're eligible for cover and the premium you should pay for it. This process is known as underwriting. It's important you answer these questions honestly and to the best of your knowledge and belief. If we don't receive correct or complete information in your application form, it could mean that we won't be able to pay out if you need to make a claim.

To help us make a decision on your application, we'll ask you the following:

- height and weight
- smoking status, alcohol consumption and lifestyle
- occupation and travel
- past and present medical history
- family history

2 About the people covered

Please remember how important it is to answer all the questions on this form honestly and in full.

	Person 1	**Person 2**
Title	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other (please give details)	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other (please give details)
First name(s)		
Surname		
Date of birth	D D M M Y Y Y Y	D D M M Y Y Y Y
Gender Your gender doesn't affect the premium.	Male ☐ Female ☐	Male ☐ Female ☐
Marital status	Married ☐ Living together as partners ☐ Divorced ☐ Widowed ☐ Single ☐ Separated ☐ Civil partnership ☐ Surviving civil partner ☐	Married ☐ Living together as partners ☐ Divorced ☐ Widowed ☐ Single ☐ Separated ☐ Civil partnership ☐ Surviving civil partner ☐
What is your relationship to person 1?		Wife ☐ Husband ☐ Civil partner ☐ Living together as partners ☐

2 About the people covered continued

	Person 1	Person 2
		Business partner ☐ Company ☐ Employer ☐ Other ☐ If Other, please give details
If the relationship to person 1 is 'company' please tell us what type of business this is.		
Your home address		
Postcode		

If you move house while we're processing your application, please contact us once you've moved to your new address.

In which country are you permanently resident?	UK ☐ Jersey ☐ Guernsey ☐ Isle of Man ☐ Other ☐ If Other, please give details	UK ☐ Jersey ☐ Guernsey ☐ Isle of Man ☐ Other ☐ If Other, please give details
In the next six months, will you be moving from the country in which you're permanently resident? If Yes, please give full details.	Yes ☐ No ☐	Yes ☐ No ☐
Email		
Phone number Please enter at least one phone number.	Daytime Evening Mobile	Daytime Evening Mobile

3 Previous applications and cover

	Person 1	Person 2
a) Do you have an existing plan or application with Royal London? Royal London includes Bright Grey, Scottish Provident and Pegasus. Please include in-force plans as well as any previous applications which didn't go in force or that's pending. We don't need to know about any pension plans. If No, please go to question 3h).	Yes ☐ No ☐ If Yes, please give full details	Yes ☐ No ☐ If Yes, please give full details
b) Does the total amount of your current application and all existing plan(s) with Royal London amount to, or exceed: • £600,000 Life Cover or • £500,000 Critical Illness Cover?	Yes ☐ No ☐	Yes ☐ No ☐
c) Have any of your Royal London applications or plans been: • **accepted on special terms, or** • **not accepted as we've been unable to offer you cover?** If Yes, please give full details	Yes ☐ No ☐ If Yes, please give full details	Yes ☐ No ☐ If Yes, please give full details
d) Please confirm all the plan numbers you have, or have had, with Royal London.		
e) Do you want us to cancel all your existing Royal London plans when this plan starts? If Yes, we will cancel your existing Royal London plans from the next monthly anniversary of those plans starting. If you intend to use Underwrite Later, we strongly recommend that you DO NOT cancel your existing plan(s) until underwriting is complete as there is a risk you may be left without any cover.	Yes ☐ No ☐	Yes ☐ No ☐
f) If you answered No to question e), are you cancelling any of your existing plans?	Yes ☐ No ☐	Yes ☐ No ☐
g) If you answered Yes to question f), please tell us which plans you are cancelling.		

If you need to tell us about more previous applications and cover, please use the additional information section on page 30.

3 Previous applications and cover continued

	Person 1	Person 2
h) Does the total amount of insurance cover you're applying for, added to the amount you already have, across all insurance companies, exceed: • £1,000,000 life cover or • £500,000 critical illness cover? Answer No to this question if you've no existing cover elsewhere and it's only this application that breaches these limits. You need to tell us about: • Any other plans that are already in force if they break these limits, even if you intend to cancel them. • Any other applications you're making elsewhere which are additional to this application or any other cover you're intending to apply for. You don't need to include death in service benefits in this total.	Yes ☐ No ☐	Yes ☐ No ☐
i) If Yes, please tell us how many applications or plans you have, or have made, for these types of cover.		
j) What is the cover for?	Personal ☐ Business ☐ Relevant life plan ☐	Personal ☐ Business ☐ Relevant life plan ☐
k) What is the cover type?	Life cover only ☐ Life or critical illness cover ☐ Critical illness cover only ☐	Life cover only ☐ Life or critical illness cover ☐ Critical illness cover only ☐
l) What is the amount of the cover?	£	£
m) Will the cover be cancelled when this plan starts? If Yes, please go to section 4 (Lifestyle).	Yes ☐ No ☐	Yes ☐ No ☐
n) Is the cover in force or a current application?	In force ☐ Current application ☐	In force ☐ Current application ☐
o) Will the cover be paid as a lump sum or as an income? If income, please answer question 3p).	Lump sum ☐ Income ☐	Lump sum ☐ Income ☐
p) What is the remaining term of the cover?	years	years

3 Previous applications and cover continued

	Person 1	Person 2
q) What is the reason for the cover?	Personal/family protection ☐ Mortgage protection ☐ Relevant life plan ☐ Shareholder ☐ Key person ☐ Key person loan ☐ Inheritance tax ☐ Other ☐ If Other, please give full details	Personal/family protection ☐ Mortgage protection ☐ Relevant life plan ☐ Shareholder ☐ Key person ☐ Key person loan ☐ Inheritance tax ☐ Other ☐ If Other, please give full details

If you need to tell us about more previous applications and cover, please use the additional information section on page 30.

4 Lifestyle

	Person 1	Person 2
a) What is your height?	☐ ft ☐ in or ☐ m ☐ cm	☐ ft ☐ in or ☐ m ☐ cm
b) What is your weight? If you're pregnant, please tell us your weight immediately before your pregnancy.	☐ st ☐ lbs or ☐ kg	☐ st ☐ lbs or ☐ kg
c) What is your current trouser size, UK dress size or skirt size? If you're pregnant, please tell us your size immediately before your pregnancy.	☐ cm ☐ in ☐ UK dress or skirt size	☐ cm ☐ in ☐ UK dress or skirt size
d) Have you smoked, vaped, used e-cigarettes, tobacco or nicotine products in the last 12 months? If Yes, please go to question 4h).	Yes ☐ No ☐	Yes ☐ No ☐
e) Have you ever smoked, vaped, used e-cigarettes, tobacco or nicotine products? Answer Yes if you have used them even on an occasional basis. If No, please go to question 4i).	Yes ☐ No ☐	Yes ☐ No ☐
f) When did you last smoke, vape, use e-cigarettes, tobacco or nicotine products?	M M Y Y Y Y	M M Y Y Y Y

4 Lifestyle continued

	Person 1	Person 2
g) How much of each of the following products did you use on a daily basis before stopping? Once answered, please go to question 4i)	Cigarettes ☐ Cigars ☐ Pipes ☐ Nicotine products ☐ Vapes or e-cigarettes ☐ Any other tobacco product ☐ If Any other tobacco product, please give full details ☐	Cigarettes ☐ Cigars ☐ Pipes ☐ Nicotine products ☐ Vapes or e-cigarettes ☐ Any other tobacco product ☐ If Any other tobacco product, please give full details ☐
h) How much of each of the following do you use on a daily basis?	Cigarettes ☐ Cigars ☐ Pipes ☐ Nicotine products ☐ Vapes or e-cigarettes ☐ Any other tobacco product ☐ If Any other tobacco product, please give full details ☐	Cigarettes ☐ Cigars ☐ Pipes ☐ Nicotine products ☐ Vapes or e-cigarettes ☐ Any other tobacco product ☐ If Any other tobacco product, please give full details ☐
i) How many units of alcohol do you drink in a typical week? 1 pint of beer = 2 units 1 glass of wine (175 ml) = 2 units 1 measure of spirits = 1 unit	☐ units	☐ units
j) Have you ever been medically advised to reduce your alcohol consumption? This includes being referred for treatment or specialist support such as an alcohol addiction unit or Alcoholics Anonymous. If Yes, please give details.	Yes ☐ No ☐	Yes ☐ No ☐
k) Please provide details about your driving. Tick all that apply. You don't need to tell us about any spent driving convictions. If you've been disqualified from driving, please tell us the date you were disqualified and the reason why.	I've been disqualified from, or charged with, driving whilst unfit due to alcohol or drugs ☐ I ride a motorbike, scooter or moped on the road ☐ None of the above ☐ ☐	I've been disqualified from, or charged with, driving whilst unfit due to alcohol or drugs ☐ I ride a motorbike, scooter or moped on the road ☐ None of the above ☐ ☐

4 Lifestyle continued

	Person 1	Person 2
l) Have you used recreational drugs during the last 10 years? Examples of recreational drugs include ecstasy, cannabis, cocaine, heroin, amphetamines and anabolic steroids. If Yes, please give details including the drug, the frequency of use and when you last used each drug.	Yes ☐ No ☐	Yes ☐ No ☐
m) Do you intend to take part in any of the following activities? Please tick all that apply. Flying includes hang gliding, paragliding, microlighting, parachuting & skydiving. Please ignore one-off parachute jumps. Don't select flying if you only fly as a fare-paying passenger or cabin crew on a scheduled aircraft. Extreme sports include for example, bungee jumping, canyoning and white water rafting.	Flying ☐ Motor car or motorcycle sport ☐ Mountaineering or rock climbing ☐ Powerboat racing ☐ Caving or potholing ☐ Diving ☐ Sailing (other than inland) ☐ Horse riding (other than private hacking) ☐ Professional sport ☐ Martial arts ☐ Any extreme sport ☐ No to all ☐	Flying ☐ Motor car or motorcycle sport ☐ Mountaineering or rock climbing ☐ Powerboat racing ☐ Caving or potholing ☐ Diving ☐ Sailing (other than inland) ☐ Horse riding (other than private hacking) ☐ Professional sport ☐ Martial arts ☐ Any extreme sport ☐ No to all ☐
n) If you intend to take part in any of the above activities, please give full details of all the activities you intend to take part in, i.e. how often you'll do this and where. Please use the additional information section on page 31 if you need more space.		

5 Occupation and travel

	Person 1	Person 2
a) What is your current job?		
b) What is your employment status?	Salaried employee ☐ Self-employed ☐ House person ☐ Student ☐ Retired ☐ Not employed ☐	Salaried employee ☐ Self-employed ☐ House person ☐ Student ☐ Retired ☐ Not employed ☐

5 Occupation and travel continued

	Person 1	Person 2
c) How much did you earn over the last 12 months before tax? This should be gross earnings from employment or self-employment. If applying for Income Protection, you may be able to include additional income such as certain P11D benefits, dividends, nominal spouse's salary and fixed overheads. Please see the definition of pre-incapacity earnings in the plan details booklet for full details.	£	£

If you're applying for Waiver of Premium (Sickness), please answer the following question, otherwise go to question 5e)

	Person 1	Person 2
d) Does your current job involve manual work or driving? If Yes, please advise what percentage of your working day you spend on each of these activities. Only include driving as part of your job, excluding time spent commuting.	Yes ☐ No ☐ Manual work % Driving % Annual mileage (excluding commuting)	Yes ☐ No ☐ Manual work % Driving % Annual mileage (excluding commuting)
e) Are you involved in any of the following hazardous duties? You don't have to tell us about any aviation as a fare-paying passenger on a scheduled commercial airline.	Working at heights over 40ft ☐ Armed forces Territorial Army or reservist duties ☐ Oil or gas platform work ☐ Working on a fishing vessel at sea ☐ Merchant marine ☐ Commercial diving ☐ Aviation ☐ Tunnelling or underground work ☐ Working with explosives ☐ Working with asbestos ☐ None of the above ☐	Working at heights over 40ft ☐ Armed forces Territorial Army or reservist duties ☐ Oil or gas platform work ☐ Working on a fishing vessel at sea ☐ Merchant marine ☐ Commercial diving ☐ Aviation ☐ Tunnelling or underground work ☐ Working with explosives ☐ Working with asbestos ☐ None of the above ☐

5 Occupation and travel continued

	Person 1	Person 2
If you work at heights over 40ft, please tell us:	Average height worked at ☐ ft How often you work at heights? Daily ☐ Once or twice a week ☐ Once or twice a month ☐ Less than once or twice a month ☐	Average height worked at ☐ ft How often you work at heights? Daily ☐ Once or twice a week ☐ Once or twice a month ☐ Less than once or twice a month ☐
f) Have you lived, worked or travelled outside the UK, European Union, North America, Japan, Australia or New Zealand during the last two years or do you intend to or expect to do so in the next two years? Ignore holidays of up to a month.	Yes ☐ No ☐	Yes ☐ No ☐
If Yes, please give us the name of each country together with the reason, frequency and duration of each visit. Please also include the area within each of the countries you list.		

6 Mental health

	Person 1	Person 2
a) During the last 5 years have you had, or do you currently have any of the following?	Depression ☐ Anxiety ☐ Stress ☐ Any other mental health condition ☐ None of the above ☐	Depression ☐ Anxiety ☐ Stress ☐ Any other mental health condition ☐ None of the above ☐
If Yes, please tell us the name of the condition **and** complete the additional medical details section (section 11) for each condition you have.		
b) Have you ever had, or do you currently have, any of the following?	Eating disorder ☐ Bipolar disorder ☐ Schizophrenia ☐ Psychosis ☐ None of the above ☐	Eating disorder ☐ Bipolar disorder ☐ Schizophrenia ☐ Psychosis ☐ None of the above ☐
If Yes, please tell us the name of the condition **and** complete the additional medical details section (section 11) for each condition you have.		

6 Mental health continued

	Person 1	Person 2
c) Have you ever:	Tried to take your own life ☐	Tried to take your own life ☐
	Had thoughts about taking your own life ☐	Had thoughts about taking your own life ☐
	Intentionally harmed yourself ☐	Intentionally harmed yourself ☐
	Had thoughts about harming yourself ☐	Had thoughts about harming yourself ☐
	None of the above ☐	None of the above ☐
Please give details including relevant dates and any treatment or follow up		

7 Physical health

Have you ever had, or do you currently have, any of the following?

	Person 1	Person 2
a) Any form of cancer, tumour, lymphoma, leukaemia or any growth or cyst of either the brain or spine?	Yes ☐ No ☐	Yes ☐ No ☐
Including: • Hodgkin's lymphoma • Non-Hodgkin's lymphoma • Leukaemia • Melanoma		
If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 11) for each condition you've had.		
b) Heart disease or disorder, circulatory disease or diabetes?	Yes ☐ No ☐	Yes ☐ No ☐
Including: • Angina or heart attack • Disease of, or surgery to, your heart or arteries • Cardiomyopathy • Heart valve or heart structure abnormalities • Irregular or rapid heart beat • Aortic aneurysm • Peripheral vascular disease • Heart murmur • Deep vein thrombosis (DVT)		
If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 11) for each condition you've had.		

7 Physical health continued

	Person 1	Person 2
c) A stroke, brain haemorrhage or surgery to your blood vessels in the brain or neck? Including: • Stroke or mini-stroke • Transient ischaemic attack • Brain or artery surgery • Aneurysm • Brain injury • Any bleeding within the skull	Yes ☐ No ☐	Yes ☐ No ☐
If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 11) for each condition you've had.		
d) Multiple sclerosis or been diagnosed with any neurological disorder? Including: • Parkinson's disease • Epilepsy, fit or seizure • Optic or retrobulbar neuritis • Alzheimer's disease • Dementia • Cerebral palsy • Paralysis • Muscular dystrophy • Motor neurone disease	Yes ☐ No ☐	Yes ☐ No ☐
If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 11) for each condition you've had.		
e) A positive test for HIV/AIDS or Hepatitis B or C, or are you awaiting the results of such a test? If the results of a test you're waiting for turns out to be negative, the fact that you had a test won't affect the terms we offer you.	Yes ☐ No ☐	Yes ☐ No ☐
If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 11) for each condition you've had.		

8 Physical health in the last 5 years

Apart from anything you've already told us about, during the last 5 years have you had, or do you currently have, any of the following:

	Person 1	Person 2
a) Raised blood pressure, raised cholesterol, chest pain or pre-diabetes? Including borderline diabetes, sugar in the urine and raised blood glucose. If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 11) for each condition you've had.	Yes ☐ No ☐	Yes ☐ No ☐
b) Any form of: • Numbness • Pins and needles • Tremor • Change in skin sensation • Tingling • Muscle weakness • Loss or reduced power in limbs, including amputation • Difficulty with co-ordination • Persistent tiredness or fatigue This includes symptoms that you've had even if you haven't consulted a doctor. If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 11) for each condition you've had.	Yes ☐ No ☐	Yes ☐ No ☐
c) Any form of joint pain, arthritis or neck, back, spine, or muscle pain or stiffness? Including: • Back or neck pain, stiffness or surgery • Joint pain, stiffness or surgery (including that affecting your knees, shoulders, hips, ankles, wrists or hands) • All forms of arthritis • Repetitive strain injury (RSI) • Gout • Muscle strain If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 11) for each condition you've had.	Yes ☐ No ☐	Yes ☐ No ☐

8 Physical health in the last 5 years continued

	Person 1	Person 2
d) Any condition affecting your ears or hearing, or your eyes or vision that is not wholly corrected by spectacles or lenses? Including: • Blindness or impaired vision • Deafness or impaired hearing • Blurred or double vision • Tinnitus, Meniere's disease, Labyrinthitis • Glaucoma If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 11) for each condition you've had.	Yes ☐ No ☐	Yes ☐ No ☐
e) A tumour, lump, cyst, polyp, growth, or any mole/naevus that has bled, changed in appearance or become painful? Please answer Yes whether seen by a doctor or not. If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 11) for each condition you've had.	Yes ☐ No ☐	Yes ☐ No ☐
f) Asthma, bronchitis, or any other disorder affecting your lungs or breathing? Including: • Sleep apnoea • Sarcoidosis • Emphysema • Chronic obstructive pulmonary disease (COPD) • Pneumonia You don't need to tell us about: • Common colds or flu • One-off chest infections that you've fully recovered from If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 11) for each condition you've had.	Yes ☐ No ☐	Yes ☐ No ☐

8 Physical health in the last 5 years continued

	Person 1	Person 2
g) Any stomach, digestive system, bowel, liver or blood disorder? Including: • A liver condition, including fatty liver and raised liver blood test(s) • A condition of the pancreas or gallbladder • Bowel disorder • Crohn's disease • Ulcerative colitis • Anaemia • Clotting disorders • Hepatitis • Gastric and duodenal ulcers • Disorders of the oesophagus including Barrett's oesophagus If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 11) for each condition you've had.	Yes ☐ No ☐	Yes ☐ No ☐
h) Any disorder of the kidney, bladder, prostate or thyroid? Including: • Blood or protein in the urine • Multiple urine infections • Kidney or bladder stones • Over or under-active thyroid If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 11) for each condition you've had.	Yes ☐ No ☐	Yes ☐ No ☐

9 Medical history in the last 3 years

	Person 1	Person 2
a) Been prescribed medication or treatment regularly for a period of four consecutive weeks or more, or have you been under review from your doctor or a medical professional? Including: • Physio • Counselling • Prescriptions from your own doctor even if you did not take them You don't need to tell us about contraception, fertility, dental treatment or reviews purely in relation to pregnancy. If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 11) for each condition you've had.	Yes ☐ No ☐	Yes ☐ No ☐

9 Medical history in the last 3 years continued

	Person 1	Person 2
b) Been referred to a specialist or had or been advised to have any investigations? Including: • Blood tests • Biopsy • Ultrasound, X-Ray, CT/MRI or other scan • ECG, echocardiogram or other heart investigation • Abnormal smear or abnormal mammogram • Investigations using an internal camera such as an endoscopy, colonoscopy or laparoscopy You don't need to tell us about investigations which were purely for pregnancy, infertility or simple fractures which have been resolved with no time off work, or about genetic tests that meet the criteria outlined on the front page of this application form.	Yes ☐ No ☐	Yes ☐ No ☐
If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 11) for each condition you've had.		
c) Do you have any symptoms for which you haven't yet sought medical advice, or are you awaiting referral, investigation, results or treatment for anything else? For example: • A mole/blemish which has changed in appearance • Any lump, growth or hardening affecting the skin, breasts or testicles • Bleeding from the bowels, change in bowel habit • Persistent cough • Weight loss or unexplained bleeding • Onset of fits or seizures • Dizziness, blackouts/fainting	Yes ☐ No ☐	Yes ☐ No ☐
If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 11) for each condition you've had.		

9 Medical history in the last 3 years continued

If you're applying for Waiver of Premium (Sickness), please answer the following question, otherwise go to question e).

	Person 1		Person 2	
d) Through illness or injury in the last two years, which of the following apply?	Currently off work	☐	Currently off work	☐
	Altered duties in the last two years	☐	Altered duties in the last two years	☐
	Reduced hours in the last two years	☐	Reduced hours in the last two years	☐
	Required more than four consecutive weeks off work	☐	Required more than four consecutive weeks off work	☐
	None of the above	☐	None of the above	☐

Regardless of anything you have already told us about:

e) Have you had treatment at hospital for Coronavirus?	Yes ☐ No ☐		Yes ☐ No ☐	
If Yes, please give full details.				

10 Your family

	Person 1		Person 2	
a) Have any of your parents, brothers or sisters ever been diagnosed with or died from any of the following conditions before the age of 60?	Heart attack or angina	☐	Heart attack or angina	☐
	Stroke	☐	Stroke	☐
	Diabetes	☐	Diabetes	☐
	Cancer	☐	Cancer	☐
	Leukaemia or lymphoma	☐	Leukaemia or lymphoma	☐
	Multiple sclerosis	☐	Multiple sclerosis	☐
	Huntington's disease	☐	Huntington's disease	☐
	Cardiomyopathy	☐	Cardiomyopathy	☐
	Polycystic kidney disease	☐	Polycystic kidney disease	☐
	Muscular dystrophy	☐	Muscular dystrophy	☐
	Motor neurone disease	☐	Motor neurone disease	☐
	Alzheimer's disease	☐	Alzheimer's disease	☐
	Parkinson's disease	☐	Parkinson's disease	☐
	Haemochromatosis	☐	Haemochromatosis	☐
	Familial colon polyps	☐	Familial colon polyps	☐
	Any other disorder which runs in your family for which you've received or been advised to have screening for	☐	Any other disorder which runs in your family for which you've received or been advised to have screening for	☐
	None of the above	☐	None of the above	☐

Screening includes any test, investigation or blood test. In line with the ABI's policy on genetics and insurance, you don't need to tell us about any predictive genetic test result you've had unless that test was for Huntington's disease and you're applying for life insurance which, when added to any existing life insurance policies you have, exceeds £500,000 of life cover. If you've had any genetic test and feel that the result may be in your favour then you may tell us about this if you wish. You need to tell us if you're having treatment for, or are experiencing symptoms of, a genetic condition.

10 Your family continued

For each condition, please answer the following questions:

	Person 1	Person 2
Condition 1 **b) What is the name of the condition that any of your parents, brothers or sisters have had before the age of 60?**		
c) Where this is cancer, what was the type of cancer?		
d) How many of your parents, brothers or sisters have had this condition?		
e) Which relatives have had this condition? For each relative, please tell us the age they were diagnosed with this condition.	**Relative(s) affected** / **Age at diagnosis** Father ☐ ☐ Mother ☐ ☐ Brother ☐ ☐ Sister ☐ ☐	**Relative(s) affected** / **Age at diagnosis** Father ☐ ☐ Mother ☐ ☐ Brother ☐ ☐ Sister ☐ ☐
Condition 2 **f) What is the name of the condition that any of your parents, brothers or sisters have had before the age of 60?**		
g) Where this is cancer, what was the type of cancer?		
h) How many of your parents, brothers or sisters have had this condition?		
i) Which relatives have had this condition? For each relative, please tell us the age they were diagnosed with this condition.	**Relative(s) affected** / **Age at diagnosis** Father ☐ ☐ Mother ☐ ☐ Brother ☐ ☐ Sister ☐ ☐	**Relative(s) affected** / **Age at diagnosis** Father ☐ ☐ Mother ☐ ☐ Brother ☐ ☐ Sister ☐ ☐

If you need to tell us about any more conditions, please use the additional information section on page 30.

11 Additional medical details 1

For each of the medical history questions you've answered Yes to, please give us the following information. This will help us to assess the application but please be aware that we may still need to ask for more information.

	Person 1	Person 2
a) What is the name of the medical condition?		
b) When did symptoms first occur?		
c) Do you have recurrent symptoms?	Yes ☐ No ☐	Yes ☐ No ☐
d) If Yes, please state how many episodes or attacks of symptoms you've had since the onset of the condition.		
e) How often do you have symptoms?	All the time ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ No longer have symptoms ☐	All the time ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ No longer have symptoms ☐
f) If you no longer have symptoms, when did you last have symptoms?		
g) Please describe the nature and severity of the symptoms.		
h) Do these symptoms restrict you in any way?	Yes ☐ No ☐	Yes ☐ No ☐
i) Have you seen a specialist for the condition?	Yes ☐ No ☐	Yes ☐ No ☐
j) If Yes, please give details of the specialist's name and hospital.		
k) What medical investigations have been performed?		
l) Are you awaiting any investigations, tests, or referral to a specialist?		
m) Have you had any surgery, investigations or tests for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

11 Additional medical details 1 continued

	Person 1	Person 2
n) If Yes, please give full details. Please use the additional information section on page 30 if you need more space.		
o) What treatment have you been prescribed?		
p) Is it continuing?	Yes ☐ No ☐	Yes ☐ No ☐
q) How many days have you been off work because of this condition?		
r) Which of the following best describes the severity of your condition?	Fully recovered with no remaining disability ☐ Ongoing condition with no restrictions in daily activities or mobility ☐ Mild symptoms with infrequent restriction of daily activities or mobility ☐ Moderate symptoms with infrequent restriction of daily activities or mobility ☐ Severe symptoms with infrequent restriction of daily activities or mobility ☐ Daily activities or tasks significantly or regularly restricted ☐	Fully recovered with no remaining disability ☐ Ongoing condition with no restrictions in daily activities or mobility ☐ Mild symptoms with infrequent restriction of daily activities or mobility ☐ Moderate symptoms with infrequent restriction of daily activities or mobility ☐ Severe symptoms with infrequent restriction of daily activities or mobility ☐ Daily activities or tasks significantly or regularly restricted ☐

11 Additional medical details 2

	Person 1	Person 2
a) What is the name of the medical condition?		
b) When did symptoms first occur?		
c) Do you have recurrent symptoms?	Yes ☐ No ☐	Yes ☐ No ☐
d) If Yes, please state how many episodes or attacks of symptoms you've had since the onset of the condition.		

11 Additional medical details 2 continued

	Person 1	Person 2
e) How often do you have symptoms?	All the time ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ No longer have symptoms ☐	All the time ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ No longer have symptoms ☐
f) If you no longer have symptoms, when did you last have symptoms?		
g) Please describe the nature and severity of the symptoms.		
h) Do these symptoms restrict you in any way?	Yes ☐ No ☐	Yes ☐ No ☐
i) Have you seen a specialist for the condition?	Yes ☐ No ☐	Yes ☐ No ☐
j) If Yes, please give details of the specialist's name and hospital.		
k) What medical investigations have been performed?		
l) Are you awaiting any investigations, tests, or referral to a specialist?		
m) Have you had any surgery, investigations or tests for this condition?	Yes ☐ No ☐	Yes ☐ No ☐
n) If Yes, please give full details. Please use the additional information section on page 30 if you need more space.		
o) What treatment have you been prescribed?		
p) Is it continuing?	Yes ☐ No ☐	Yes ☐ No ☐

11 Additional medical details 2 continued

	Person 1	Person 2
q) How many days have you been off work because of this condition?		
r) Which of the following best describes the severity of your condition?	Fully recovered with no remaining disability ☐ Ongoing condition with no restrictions in daily activities or mobility ☐ Mild symptoms with infrequent restriction of daily activities or mobility ☐ Moderate symptoms with infrequent restriction of daily activities or mobility ☐ Severe symptoms with infrequent restriction of daily activities or mobility ☐ Daily activities or tasks significantly or regularly restricted ☐	Fully recovered with no remaining disability ☐ Ongoing condition with no restrictions in daily activities or mobility ☐ Mild symptoms with infrequent restriction of daily activities or mobility ☐ Moderate symptoms with infrequent restriction of daily activities or mobility ☐ Severe symptoms with infrequent restriction of daily activities or mobility ☐ Daily activities or tasks significantly or regularly restricted ☐

11 Additional medical details 3

	Person 1	Person 2
a) What is the name of the medical condition?		
b) When did symptoms first occur?		
c) Do you have recurrent symptoms?	Yes ☐ No ☐	Yes ☐ No ☐
d) If Yes, please state how many episodes or attacks of symptoms you've had since the onset of the condition.		
e) How often do you have symptoms?	All the time ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ No longer have symptoms ☐	All the time ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ No longer have symptoms ☐
f) If you no longer have symptoms, when did you last have symptoms?		

11 Additional medical details 3 continued

	Person 1	Person 2
g) Please describe the nature and severity of the symptoms.		
h) Do these symptoms restrict you in any way?	Yes ☐ No ☐	Yes ☐ No ☐
i) Have you seen a specialist for the condition?	Yes ☐ No ☐	Yes ☐ No ☐
j) If Yes, please give details of the specialist's name and hospital.		
k) What medical investigations have been performed?		
l) Are you awaiting any investigations, tests, or referral to a specialist?		
m) Have you had any surgery, investigations or tests for this condition?	Yes ☐ No ☐	Yes ☐ No ☐
n) If Yes, please give full details. Please use the additional information section on page 30 if you need more space.		
o) What treatment have you been prescribed?		
p) Is it continuing?	Yes ☐ No ☐	Yes ☐ No ☐
q) How many days have you been off work because of this condition?		

11 Additional medical details 3 continued

	Person 1	Person 2
r) Which of the following best describes the severity of your condition?	Fully recovered with no remaining disability ☐ Ongoing condition with no restrictions in daily activities or mobility ☐ Mild symptoms with infrequent restriction of daily activities or mobility ☐ Moderate symptoms with infrequent restriction of daily activities or mobility ☐ Severe symptoms with infrequent restriction of daily activities or mobility ☐ Daily activities or tasks significantly or regularly restricted ☐	Fully recovered with no remaining disability ☐ Ongoing condition with no restrictions in daily activities or mobility ☐ Mild symptoms with infrequent restriction of daily activities or mobility ☐ Moderate symptoms with infrequent restriction of daily activities or mobility ☐ Severe symptoms with infrequent restriction of daily activities or mobility ☐ Daily activities or tasks significantly or regularly restricted ☐

11 Additional medical details 4

	Person 1	Person 2
a) What is the name of the medical condition?		
b) When did symptoms first occur?		
c) Do you have recurrent symptoms?	Yes ☐ No ☐	Yes ☐ No ☐
d) If Yes, please state how many episodes or attacks of symptoms you've had since the onset of the condition.		
e) How often do you have symptoms?	All the time ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ No longer have symptoms ☐	All the time ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ No longer have symptoms ☐
f) If you no longer have symptoms, when did you last have symptoms?		
g) Please describe the nature and severity of the symptoms.		
h) Do these symptoms restrict you in any way?	Yes ☐ No ☐	Yes ☐ No ☐
i) Have you seen a specialist for the condition?	Yes ☐ No ☐	Yes ☐ No ☐

11 Additional medical details 4 continued

	Person 1	Person 2
j) If Yes, please give details of the specialist's name and hospital.		
k) What medical investigations have been performed?		
l) Are you awaiting any investigations, tests, or referral to a specialist?		
m) Have you had any surgery, investigations or tests for this condition?	Yes ☐ No ☐	Yes ☐ No ☐
n) If Yes, please give full details. Please use the additional information section on page 30 if you need more space.		
o) What treatment have you been prescribed?		
p) Is it continuing?	Yes ☐ No ☐	Yes ☐ No ☐
q) How many days have you been off work because of this condition?		
r) Which of the following best describes the severity of your condition?	Fully recovered with no remaining disability ☐ Ongoing condition with no restrictions in daily activities or mobility ☐ Mild symptoms with infrequent restriction of daily activities or mobility ☐ Moderate symptoms with infrequent restriction of daily activities or mobility ☐ Severe symptoms with infrequent restriction of daily activities or mobility ☐ Daily activities or tasks significantly or regularly restricted ☐	Fully recovered with no remaining disability ☐ Ongoing condition with no restrictions in daily activities or mobility ☐ Mild symptoms with infrequent restriction of daily activities or mobility ☐ Moderate symptoms with infrequent restriction of daily activities or mobility ☐ Severe symptoms with infrequent restriction of daily activities or mobility ☐ Daily activities or tasks significantly or regularly restricted ☐

If you need to tell us about further conditions, please use the additional information section on page 30.

12 Financial information

Please complete this section if:

- Your application is on a joint life second event basis, and
- The amount of cover is more than £2.5 million.

If your amount of cover is more than £4 million, we'll normally ask for independent evidence to confirm the details.

Examples of independent evidence may include:

- An accountant's or solicitor's letter confirming the value of your estate.
- A copy of the inheritance tax planning exercise.

Please give joint assets and liabilities proportionately.

	Person 1	**Person 2**
Please give the assets of each person covered providing an individual breakdown of items and amounts. • **Property**	Description Value £	Description Value £
• **Investments** (please provide a detailed breakdown)	Description Value £	Description Value £
• **Others** (please specify)	Description Value £	Description Value £
Total value	£	£

Please give the liabilities of each person covered, providing an individual breakdown of items and amounts. • **Property**	Description Value £	Description Value £

12 Financial information continued

	Person 1	Person 2
• **Investments** (please provide a detailed breakdown)	Description Value £	Description Value £
• **Others** (please specify)	Description Value £	Description Value £
Total value	£	£
What is the total inheritance tax liability?	£	£
Please explain how the inheritance tax liability is calculated. If the sum assured does not match the calculated inheritance tax liability, please explain the reason for the difference here.		
Who has calculated the valuation?		

If you need more space please use the additional information section on page 30.

13 Additional information

14 GP details

We may request medical reports if we need more information to underwrite your plan, if your plan is selected for sample checks (within 6 months of the start of the plan), or if there is a future claim.

	Person 1	Person 2
Name of doctor or practice		
Address		
Postcode		
Phone number		

If you've changed GP in the last six months, please give the details of your previous GP in the additional information section on page 30.

15 Premium payment details

If this is not the plan owner or the life assured, we'll only use this data to validate their identity and to take payments.

Is the person paying for the plan the plan owner? If Yes, please go to payment frequency question.	Yes ☐ No ☐
Account name If the payer is a company or employer, we'll need you to send us a bank statement dated within the last 3 months.	
What is the plan payer's relationship to the plan owner(s)? If you tell us the relationship is employer, you must complete section 18.	Wife ☐ Husband ☐ Civil partner ☐ Living together as partners ☐ Parent ☐ Child ☐ Grandchild ☐ Grandparent ☐ Brother ☐ Sister ☐ Step Parent ☐ Business partner ☐ Employer ☐ Other
If the payer is an 'employer', please tell us the nature of the business.	
First name(s)	
Surname	

15 Premium payment details continued

We may need to verify the identity of the person paying for this plan. So we can do this, please give us their home address and date of birth.

Address	
Postcode	
Date of birth	D D M M Y Y Y Y
Payment frequency	Monthly ☐ Yearly ☐
Payment day Which day would you prefer us to collect your premiums? Please choose between 1st - 28th of each month.	
Sort Code	☐☐☐☐☐☐
Account number	☐☐☐☐☐☐☐☐

16 Trusts

Is this plan to be in trust?	Yes ☐ No ☐

If the plan is to be written under the business trust, the trust form must be completed before the plan starts. If these trust forms have not yet been completed, please choose 'To be advised' in section 17 below for when the plan is to start.

17 Start date

Would you like to use Underwrite Later to start this cover before we've completed our underwriting assessment? If you would like to use this option, please read and sign the terms and conditions for Underwrite Later. You can get this from our website: **adviser.royallondon.com/underwritelater** If you answer yes for Underwrite Later, you may choose a specific start date up to 30 days from submission. Any dates chosen after 30 days cannot be accommodated for this option. Further info can be found at **adviser.royallondon.com/underwritelater**	Yes ☐ No ☐
a) The plan is to start on the date shown	D D M M Y Y Y Y
b) The plan is to start as soon as we accept it	☐
c) To be advised	☐

18 Company or employer additional role details

You must complete this section if:

- **you've told us in section 1 that the plan owner is a company or employer, or**
- **you've told us in section 15 or 20 that the payer is a company or employer.**

As you have told us that the plan owner / payer on this application is a company we need you to provide the details of all Beneficial Owners and Persons of Significant Control (if not a Beneficial Owner) or key decision makers (if there are no beneficial owners or persons of significant control).

We require this information because we need to identify the individual(s) who is the ultimate beneficial owner of a corporate structure.

A Beneficial Owner is an individual who directly or indirectly owns a 25% or more share of the business.

If a beneficial owner is another company, we also require details of the individual beneficial owners of the owning company.

A Person of Significant Control is an individual who:

- **directly or indirectly controls 25% or more of the voting rights,**
- **directly or indirectly has the right to appoint or remove the majority of directors, or**
- **has the right to otherwise exercise or actually exercises significant influence or control within the business.**

A key decision maker is an individual who

- **has the right to make strategic decisions on how the company is run,**
- **is permitted to operate the company bank account and or finances.**

For more detailed information on the above definitions, please see Companies House.

To protect our customers we may have to verify the identity of certain individuals connected to a policy. We do this electronically to make things easier for you. If these individuals would prefer us not to do this electronically please call us on 0345 6094 500 so we can talk through what needs to be sent to us.

	Additional Role 1
Title	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other (please give details)
First name(s)	
Surname	
Date of birth	D D M M Y Y Y Y
Address	

18 Company or employer additional role details continued

Additional Role 2

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Other (please give details)

First name(s)

Surname

Date of birth

D D M M Y Y Y Y

Address

Additional Role 3

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Other (please give details)

First name(s)

Surname

Date of birth

D D M M Y Y Y Y

Address

Additional Role 4

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Other (please give details)

First name(s)

Surname

Date of birth

D D M M Y Y Y Y

Address

19 Client declaration

Declaration for the person covered

Before the application is submitted we need you to confirm the following statements:

- You're aware of how we'll use your personal data.
- You declare that the answers in this online application form are true and complete, to the best of your knowledge and belief. If any information in this online application is missing or inaccurate you'll inform us within 60 days of the application being sent to us. We will then have the right to change or withdraw terms, if appropriate.

Plan Owner Declaration

We're keen to tell you about our latest products, services and great offers – we think they're worth hearing about and we don't want you to miss out.

From time to time, we may contact you by post, email or SMS – either directly or through an approved financial adviser – with further offers and information about our products and services that may be of interest to you.

Please let us know if you **do not** want to receive these communications.

I do not want to receive these communications ☐

Did you receive financial advice from an adviser about buying this plan? Yes ☐ No ☐

If you've selected your premium payment to be reviewable, please note that Royal London will only accept your application if you've received financial advice from an adviser. This requirement is due to the complexity of the chosen cover and the potential for your premiums to increase significantly at the review period of your plan.

Before the application is submitted we need to you to confirm the following statements:

- You're aware of how we'll use your personal data and if you've provided data on behalf of another person you've made them aware of how we'll use their data.
- You've been provided with a copy of the Key Facts document as part of this application.
- You agree that, where you've a financial adviser they're authorised to provide information, agree amendments to and provide the start date for your plan on your behalf.
- You declare that the answers in this online application form are true and complete, to the best of your knowledge and belief. If any information in this online application is missing or inaccurate you'll inform us within 60 days of the application being sent to us. We'll then have the right to change or withdraw terms if appropriate.

Please tick this box to confirm that you've read and agreed to the statements above:

Person 1 ☐ **Person 2** ☐ **Other applicant** ☐

20 Direct Debit details

Please complete and return this form to: Royal London, 22 Haymarket Yards, Edinburgh EH12 5BH.

You must complete this form if:	• The person, or people, paying for the plan are not the applicant(s). • More than one signature is required to authorise payments for the plan.

So that we can identify the plan when you return this form, please give us the full name of the person or people covered.

	Person 1	**Person 2**
Name		
Postcode		
Date of birth	D D M M Y Y Y Y	D D M M Y Y Y Y
Application number		

What is the plan payer's relationship to the plan owner(s)?

If you tell us the relationship is employer, you must complete section 18.

- Wife ☐
- Husband ☐
- Civil partner ☐
- Living together as partners ☐
- Parent ☐
- Child ☐
- Grandchild ☐
- Grandparent ☐
- Brother ☐
- Sister ☐
- Step Parent ☐
- Business partner ☐
- Employer ☐
- Other

If the payer is an 'employer', please tell us the nature of the business.

If the payer is a company we'll need you to send us a certified copy of the bank statement dated within the last 3 months.

20 Direct Debit details continued

The Royal London Mutual Insurance Society Limited

Instruction to your bank or building society to pay by Direct Debit

Please complete all of this form.

Service user number

6	7	1	7	5	2

Reference (internal use only)

Name and full postal address of your bank or building society

To: The Manager — Bank/building society

Address

Postcode

Name(s) of account holder(s)

Bank/building society account number

Branch sort code

Instruction to your bank or building society
Please pay The Royal London Mutual Insurance Society Limited Direct Debits from the account detailed in this Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with The Royal London Mutual Insurance Society Limited and, if so, details will be passed electronically to my bank/building society.

Signature(s)

Date

Banks and building societies may not accept Direct Debit Instructions for some types of account.

This Guarantee should be detached and retained by the payer.

The Direct Debit Guarantee

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits
- If there are any changes to the amount, date or frequency of your Direct Debit The Royal London Mutual Insurance Society Limited will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request The Royal London Mutual Insurance Society Limited to collect a payment, confirmation of the amount and date will be given to you at the time of the request
- If an error is made in the payment of your Direct Debit, by The Royal London Mutual Insurance Society Limited 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 The Royal London Mutual Insurance Society Limited 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.

Verifying your identity and preventing fraud

To protect our customers we may have to verify the identity of certain individuals connected to a policy. We do this electronically to make things easier for you. If these individuals would prefer us not to do this electronically please call us on 0345 6094 500 so we can talk through what needs to be sent to us.

21 Access to medical reports

We may need to obtain a medical report from your current GP or specialist, or from a doctor you've seen in the past. You have specific rights in relation to medical reports, which are covered in the Access to Medical Reports Act 1988 (also the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991, and the Access to Health Records and Reports Act 1993 (Isle of Man)). Before we ask for such a report, we need your consent, which you can give by signing the declaration in section 22. You can choose not to give your consent, but then we may not be able to continue with your application. This doesn't prevent you from applying to other insurance companies for insurance. Under the above Acts, you can choose to see your medical report before it is sent to us. You'll then have 21 days to make arrangements with your doctor to see it.

You should indicate below whether you want to see your report. If you don't want to see the report now, you can still contact your doctor later and tell them that you do in fact want to see it. As long as it hasn't already been sent to us, you'll still have 21 days from the time you contact your doctor to make arrangements to see it.

If the report has already been sent to us, you're entitled to see a copy of the report at any time during the six months following the date the report was sent to us. We can send a copy of the report to your doctor if you ask to see it at a later date. If you say that you do want to see the report, then it won't be sent to us until:

either you've seen the report

or

21 days have passed since we requested the report and the doctor hasn't heard from you. If you see the report, you can withdraw your consent for the doctor showing it to us, or you can ask the doctor to change it if you disagree with it. If the doctor refuses to change it, you can insist that they attach a statement of your views to the report. A doctor may refuse to let you see your report if they feel that seeing it will cause physical or mental harm to you or others.

Note: Your doctor is entitled to charge you for supplying you with a copy of the report.

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

- Your current health
  - any care, medication or treatment you're currently receiving
  - the results of referrals or tests you're waiting for
- Any time off work in the last three years
- Your past health
  - details of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultation with your GP or any other medical adviser, therapist or counsellor, in particular whether you have a history of:
  - malignancy (cancer), cardiovascular (heart) disease, diabetes, and degenerative (gradually worsening) diseases
  - musculoskeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles
  - anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue
  - suicidal thoughts or attempts at suicide; or
  - conditions related to drug or alcohol misuse or smoking or chewing tobacco
- Details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations
- Any blood pressure readings in the last three years
- Any history of disease among your parents or brothers or sisters that you've told your doctor about

We have asked your doctor not to reveal information about:

- Negative tests for Human Immunodeficiency Virus (HIV), Hepatitis B or C
- Any sexually-transmitted diseases unless there could be long-term effects on your health; **or**
- Predictive genetic test results unless there is a favourable test result which shows that you've not inherited a condition your family suffers from.

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

- Setting premiums at standard rates
- Increasing premiums above standard rates, or
- Being unable to provide Insurance.

If you have any questions about your rights or questions relating to the process of getting, assessing or storing medical information, please write to us at **Royal London, 22 Haymarket Yards, Edinburgh EH12 5BH.**

22 Client declaration

Access to medical reports declaration

Person 1 and Person 2 should always complete these boxes.

	Person 1	Person 2
Name		
Postcode		
	I've read the statement in section 21 notifying me of my rights under the Access to Medical Reports (AMRA) legislation, and consent to my doctor providing medical reports to Royal London so that they can deal with my application for a protection plan.	I've read the statement in section 21 notifying me of my rights under the Access to Medical Reports (AMRA) legislation, and consent to my doctor providing medical reports to Royal London so that they can deal with my application for a protection plan.
Please only tick this box if you DO want to see your medical report before it's sent to Royal London.	Yes ☐ I **DO** want to see my medical report. I understand that it won't be sent to Royal London until I've seen it, and that they won't be able to make a decision on my application until then.	Yes ☐ I **DO** want to see my medical report. I understand that it won't be sent to Royal London until I've seen it, and that they won't be able to make a decision on my application until then.
Enter plan number here if your financial adviser is sending this page to Royal London as an AMRA declaration for an application submitted online.		

Client declaration

	Person 1	Person 2
Signature		
Date	D D M M Y Y Y Y	D D M M Y Y Y Y

Royal London
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We're happy to provide your documents in a different format, such as braille, large print or audio, just ask us when you get in touch.

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