DATA CAPTURE FORM

FOR PERSONAL, BUSINESS PROTECTION
AND RELEVANT LIFE COVER
SCOTTISH WIDOWS PROTECT

For financial adviser use only

SCOTTISH WIDOWS

IMPORTANT GUIDANCE NOTES FOR ADVISERS

This form should be used to help you capture the information you'll need from your client(s) to use our online quote and apply system.

This form won't replace a paper application.

In **section 12**, we include a declaration which must be explained to your client(s). It is a requirement of the application process that all points in this declaration, along with the Important Notes below, have been accepted by your client. If there is more than one client, please make sure all have understood the terms of the Declaration. We'll rely on the information in these notes and declarations when administering the policy and processing any claim.

Before you use the Data Capture Form, we recommend you highlight to your client(s) the importance of answering all questions honestly.

The answers you input into the online quote and apply system, along with the Declaration and Important Notes, will be issued to your client(s) in the form of an Application Summary as a record of what you have submitted to us on their behalf.

To meet FCA Regulatory Reporting requirements we must record whether advice was given to your client(s) during this application.

Advised ☐ **Non-advised** ☐

YOU'LL NEED TO EXPLAIN THESE IMPORTANT NOTES TO YOUR CLIENTS

DATA PRIVACY NOTICE

Your personal information will be held by Scottish Widows Ltd which is part of Lloyds Banking Group. More information on the Group can be found at **www.lloydsbankinggroup.com**

This privacy notice contains key information about how we will use and share your personal information and the rights you have in relation to this. If you want to know more please access our full privacy notice at **www.scottishwidows.co.uk/legalprivacy** or ask us for a copy.

We will use your personal information:

- to provide products and services, manage your relationship with us and comply with any laws or regulations we are subject to (for example the laws that prevent financial crime or the regulatory requirements governing the products we offer).
- for other purposes including improving our services, exercising our rights in relation to agreements and contracts and identifying products and services that may be of interest.

To support us with the above we analyse information we know about you and how you use our products and services, including some automated decision making. You can find out more about how we do this, and in what circumstances you can ask us to stop, in our full privacy notice.

Your personal information will be shared within Lloyds Banking Group and other companies that provide services to you or us, so that we and any other companies in our Group can look after your relationship with us. By sharing this information it enables us to better understand our customer's needs, run accounts and policies, and provide products and services efficiently. This processing may include activities which take place outside of the European Economic Area. If this is the case we will ensure appropriate safeguards are in place to protect your personal information. You can find out more about how we share your personal information with credit reference agencies below and can access more information about how else we share your information in our full privacy notice.

We will collect personal information about you from a number of sources including:

- information given to us on application forms, when you talk to us in branch, over the phone or through the device you use and when new services are requested.
- from analysis of how you operate our products and services, including the frequency, nature, location, origin and recipients of any payments.
- from or through other organisations (for example card associations, credit reference agencies, insurance companies, retailers, comparison websites, social media and fraud prevention agencies).
- in certain circumstances we may also use information about health or criminal convictions but we will only do this where allowed by law or if you give us your consent.

You can find out more about where we collect personal information about you from in our full privacy notice.

We may be required by law, or as a consequence of any contractual relationship we have, to collect certain personal information. Failure to provide this information may prevent or delay us fulfilling these obligations or performing services.

The law gives you a number of rights in relation to your personal information including:

- the right to access the personal information we have about you. This includes information from application forms, statements, correspondence and call recordings.
- the right to get us to correct personal information that is wrong or incomplete.
- in certain circumstances, the right to ask us to stop using or delete your personal information.
- from 25th May 2018 you will have the right to receive any personal information we have collected from you in an easily re-usable format when it's processed on certain grounds, such as consent or for contractual reasons. You can also ask us to pass this information on to another organisation.

You can find out more about these rights and how you can exercise them in our full privacy notice.

We may also collect personal information about other individuals who you have a financial link with. This may include people who you have joint accounts or policies with such as your partner/ spouse, dependents, beneficiaries or people you have commercial links to, for example other directors or officers of your company.

We will collect this information to assess any applications, provide the services requested and to carry out credit reference and fraud prevention checks. You can find out more about how we process personal information about individuals with whom you have a financial link in our full privacy notice.

In order to process your application we may supply your personal information to credit reference agencies (CRAs) including how you use our products and services and they will give us information about you, such as about your financial history. We do this to assess creditworthiness and product suitability, check your identity, manage your account, trace and recover debts and prevent criminal activity.

We may also continue to exchange information about you with CRAs on an ongoing basis, including about your settled accounts and any debts not fully repaid on time, information on funds going into the account, the balance on the account and, if you borrow, details of your repayments or whether you repay in full and on time. CRAs will share your information with other organisations, for example other organisations you ask to provide you with products and services. Your data will also be linked to the data of any joint applicants or other financial associates as explained above.

You can find out more about the identities of the CRAs, and the ways in which they use and share personal information, in our full privacy notice.

The personal information we have collected from you and anyone you have a financial link with may be shared with fraud prevention agencies who will use it to prevent fraud and money laundering and to verify your identity. If fraud is detected, you could be refused certain services, finance or employment. Further details of how your information will be used by us and these fraud prevention agencies, and your data protection rights, can be found in our full privacy notice.

If you apply to us for insurance, we may pass your details to the relevant insurer and their agents. If a claim is made, any personal information given to us, or to the insurer, may be put onto a register of claims and shared with other insurers to prevent fraudulent claims.

It is important that you understand how the personal information you give us will be used. Therefore, we strongly advise that you read our full privacy notice, which you can find at **www.scottishwidows.co.uk/legalprivacy** or you can ask us for a copy.

If you have any questions or require more information about how we use your personal information please contact us using **https://www.scottishwidows.co.uk/secure/forms/contact_us/individual_customers/policy-enquiries** You can also call us on 0345 300 2244.

If you feel we have not answered your question Lloyds Banking Group has a Group Data Privacy Officer, who you can contact on 0345 300 2244 and tell us you want to speak to our Data Privacy Officer.

MONEY LAUNDERING REGULATIONS

We may need to verify your identity to comply with current regulations and to help identify and prevent fraud. We'll use a credit reference agency to do this (this is not to check your creditworthiness). They use a range of databases (including the Electoral Register) to verify your name and address. We then use a scoring method to authenticate your identity. If this search does not verify your identity, we may ask you to give us some documents to do this instead. The search isn't used to assess insurance risks. If you want to know which credit reference agency we use, please ask us.

We may share this information with other organisations involved in the prevention of money laundering, fraud and other financial crime.

GENETIC TESTING

It is important that you read this section to your client if they have ever had a genetic test.

We comply with the Association of British Insurers' policy on genetics and insurance.

We'll never ask you to take a genetic test. You don't have to tell us about any genetic test result you've had if:

i) You're applying for Life Cover and the total amount of that cover, added to any existing life insurance policies you have, is less than £500,000;

ii) You're applying for Critical Illness Cover and the total amount of that cover, added to any existing critical illness policies you have, is less than £300,000;

You may need to tell us if your benefit amount goes over these limits.

The Government's Genetics and Insurance Committee has agreed that certain genetic test results can be used for insurance and we will only use these ones. Please ask us if you think this may apply to you or go to **www.ABI.org.uk/consumer2/disclosure.htm** However, you must always tell us about any genetically inherited condition which your family has a history of, or which you have symptoms of or are being treated for. If you want, you can tell us about any negative genetic test results to show you have not inherited a genetic disorder and we'll take this into account.

MEDICAL INFORMATION

We may request medical information to help us assess your application or after the start date of your policy as part of our quality control procedures. If this is required we will ask you to complete a consent form. We may amend the terms or at worst cancel your policy if any misrepresentation is found.

YOUR ANSWERS TO OUR QUESTIONS

You should answer all questions we have asked in this application honestly and fully. The answers you provide will affect our decision to accept your application or the amount of premium you will pay. We may not pay any claim, have to amend the terms of your cover or at worst cancel your cover if you:

- **don't answer the questions honestly**
- **give us incomplete or misleading answers, or**
- **don't advise us of a change in the information you provided in response to our questions prior to the date we have agreed the terms of your cover.**

1. COVER CHOICES

If you already have a quote please complete 1.1 with the quote number, and then you can move on to section 2.

If you don't have a quote you can complete section 1.2 with your client's cover choice details.

1.1 Quote reference number

1.2 Cover choices

LIFE COVER

	Life assured 1		Life assured 2	
Type of benefit	☐ Single life	☐ Life of another	☐ Joint life	
Payable	☐ Lump sum	☐ Monthly income		
Amount of cover				
Term	☐ Years or	☐ Age when policy ends (single life only)		
Renewable cover*	☐	☐		
Basis of cover	☐ Level	☐ Decreasing**	☐ Increasing	
Premium protection	☐	☐		

Notes: You can use this space to tell us if you require another policy on a different basis. If the plan is to be set in trust, please make sure your client(s) completes the correct trust form and you collect the trust and start date information in section 15.

LIFE WITH CRITICAL ILLNESS COVER

	Life assured 1		Life assured 2	
Type of benefit	☐ Single life	☐ Life of another	☐ Joint life	
Payable	☐ Lump sum	☐ Monthly income		
Amount of cover				
Term	☐ Years or	☐ Age when policy ends (single life only)		
Life Cover buyback	☐	☐		
Renewable cover*	☐	☐		
Basis of cover	☐ Level	☐ Decreasing**	☐ Increasing	
Premium protection	☐	☐		

Notes: You can use this space to tell us if you require another policy on a different basis. If the plan is to be set in trust, please make sure your client(s) completes the correct trust form and you collect the trust and start date information in section 15.

1. COVER CHOICES (CONTINUED)

1.2 Cover choices (continued)

CRITICAL ILLNESS COVER

Life assured 1	☐		Life assured 2	☐	
Type of benefit	☐	Single life	☐ Life of another	☐	Joint life
Payable	☐	Lump sum	☐ Monthly income		
Amount of cover	☐				
Term	☐	Years or	☐ Age when policy ends (single life only)		
Renewable cover*	☐		☐		
Basis of cover	☐	Level	☐ Decreasing**	☐	Increasing
Premium protection	☐		☐		

Notes: You can use this space to tell us if you require another policy on a different basis. If the plan is to be set in trust, please make sure your client(s) completes the correct trust form and you collect the trust and start date information in section 15.

WHOLE OF LIFE COVER

Life assured 1	☐		Life assured 2	☐	
Type of benefit	☐	Single life	☐ Life of another	☐	Joint life second death
Payable	☐	Lump sum			
Amount of cover	☐				
Basis of cover	☐	Level	☐ Increasing		
Premium protection	☐		☐		

Notes: You can use this space to tell us if you require another policy on a different basis. If the plan is to be set in trust, please make sure your client(s) completes the correct trust form and you collect the trust and start date information in section 15.

* Renewable cover is only available under business protection.

** Our decreasing term assurance default interest rate is 7%. You can choose a different interest rate between 0% and 18%.

1. COVER CHOICES (CONTINUED)

1.2 Cover choices (continued)

RELEVANT LIFE COVER				
Life assured 1	☐			
Type of benefit	☐	Life of another		
Payable	☐	Lump sum		
Amount of cover	☐			
Term	☐	Years	or	☐ Age when policy ends (single life only)
Basis of cover	☐	Level		☐ Increasing

Notes: **Relevant Life Cover must be set up in trust.** Please make sure your client completes the correct trust form and completes section 15 on start dates and trusts.

2. DETAILS OF APPLICANT(S) (IF DIFFERENT FROM THE LIFE ASSURED)

This section should be completed by the owner if they are applying for a life of another policy.

Who is the owner of the plan? Applicant ☐ Company ☐

APPLICANT

If the applicant is the owner, please complete the applicant details below:

Full name (Mr/Mrs/Miss/Ms/Other)	
Sex	Male ☐ Female ☐
Date of birth (DD/MM/YYYY)	
Phone number	
Email address	
Address	
Postcode	
Nationality	
UK resident?	☐ Yes
Relationship to life/lives assured?	Partner/spouse ☐ Parent, child or sibling ☐ Other relationship ☐

If the company is the applicant, please complete the company and contact details below:

Company name	
Company address	
Contact name	
Contact phone number	
Email address	
Relationship to life/lives assured?	Director of Business ☐ Key Person ☐ Partner in Business ☐ Other relationship ☐

3. PERSONAL DETAILS OF THE LIFE ASSURED

	FIRST LIFE	SECOND LIFE
Full name (Mr/Mrs/Miss/Ms/Other)		
Sex	Male ☐ Female ☐	Male ☐ Female ☐
Date of birth (DD/MM/YYYY)		
Phone number		
Email address		
Address		
Postcode		
Nationality		
UK resident?	Yes ☐	Yes ☐

4. DOCTOR'S DETAILS

	FIRST LIFE	SECOND LIFE
Doctor's name		
Surgery address		
Postcode		
Telephone number		

5. EXISTING COVER

Please answer the following questions about existing cover. If there is already cover in place which you are planning to cancel, you don't need to include it in this section.

	FIRST LIFE	SECOND LIFE
Including this application, concurrent applications and any existing policies, will the total amount of cover on your life exceed: *Please include any cover you have with Scottish Widows or any other protection provider. You don't need to include cover that will be cancelled or any applications used for comparison purposes.*		
£1,000,000 life cover	Yes ☐ No ☐	Yes ☐ No ☐
or £500,000 critical illness cover?	Yes ☐ No ☐	Yes ☐ No ☐

If yes, please complete the Financial Questionnaire on pages 38 and 39.

6. OCCUPATION AND DRIVING

Please answer the following questions about your occupation and driving.
The job you do affects how likely you might have time off work – for example a builder couldn't work with a bad back but an office worker might. Please take care to answer these questions honestly and accurately as your answers may affect any claim.

	FIRST LIFE	SECOND LIFE
What is your job?		
Do you work less than 16 hours per week?	Yes ☐ No ☐	Yes ☐ No ☐
Are you a member of the armed forces, territorial army or a reservist?	Yes ☐ No ☐	Yes ☐ No ☐

(If yes, please complete an Armed Forces questionnaire. You can find this on our website.)

Have you been banned from driving or convicted of careless or reckless driving in the last 5 years?	Yes ☐ No ☐	Yes ☐ No ☐

You don't need to tell us about any spent convictions or speeding offences that didn't result in a ban.

Have you ridden a motorcycle or scooter on the road in the last 12 months?	Yes ☐ No ☐	Yes ☐ No ☐

You don't need to tell us about a one - off journey only. This question also applies to passengers.

You may also be asked the following depending on what your job is.

Does your work involve any physical or manual work?	Yes ☐ No ☐	Yes ☐ No ☐

If yes, which one of the following best describes the manual duties you perform most frequently?

Generalised shop/retail work	☐	☐
Lifting which is assisted by relevant machinery provided by your employer	☐	☐
Light lifting (involving lifting weights less than 25kgs unassisted)	☐	☐
Heavy lifting (involving lifting weights greater than 25kgs unassisted)	☐	☐

Do you regularly work outside at heights over 15m?	Yes ☐ No ☐	Yes ☐ No ☐

If yes, please advise percentage of time on average each week that you spend working at heights over 50ft/15m on exposed platforms, scaffolding, ladders, roofs etc

Do you work in the Merchant Navy?	Yes ☐ No ☐	Yes ☐ No ☐

If yes, please confirm the type of vessel you work on

Ocean liners	☐	☐
Other passenger vessels (minimum 12 berths) and ferries	☐	☐
Cargo vessels operating in coastal waters; barges (excluding oil rig barges), dredgers, lightships, tugs and weather ships	☐	☐
Other cargo vessels; cable and pipe laying vessels, factory ships, oil rig barges/supply vessels	☐	☐

6. OCCUPATION AND DRIVING (CONTINUED)

	FIRST LIFE	SECOND LIFE
Does your occupation involve flying (other than as a fare paying passenger)?	Yes ☐ No ☐	Yes ☐ No ☐
	(If yes, please complete an aviation questionnaire. You can find this on our website.)	
Do you work underwater?	Yes ☐ No ☐	Yes ☐ No ☐
	(If yes, please complete a diving questionnaire. You can find this on our website.)	
Do you work in offshore fishing?	Yes ☐ No ☐	Yes ☐ No ☐
	(If yes, please complete a fishing questionnaire. You can find this on our website.)	
If yes, please confirm the size of boat		
Do you use explosives?	Yes* ☐ No ☐	Yes* ☐ No ☐
Do you work offshore in the oil and gas industry?	Yes* ☐ No ☐	Yes* ☐ No ☐
Are you a professional sportsperson?	Yes* ☐ No ☐	Yes* ☐ No ☐
* If yes, please provide details		

7. TRAVEL AND RESIDENCE

Please answer the following questions about travel and residence.

	FIRST LIFE	SECOND LIFE
Have you lived in Africa, Thailand or the Caribbean for more than 3 months during the last 5 years?	Yes ☐ No ☐	Yes ☐ No ☐

If yes, please complete the Travel Questionnaire on page 34.

HIV and Hepatitis tests may be required, do you wish to continue with the application?	Yes ☐ No ☐	Yes ☐ No ☐

If the answer is 'no' to the tests, then we will not be able to consider your application.

In the next 2 years are you planning to travel, live or work outside of the European Union (EU), Isle of Man, Channel Islands, North America, Australia or New Zealand? *You don't need to tell us about any holiday you are taking which is fewer than 30 days in a year; any business trips of up to one week in length and not adding up to more than 4 weeks in any year. If you are a member of the Armed Forces you don't need to include travel that's required for your occupation.*	Yes ☐ No ☐	Yes ☐ No ☐

If yes, please complete the Travel Questionnaire on page 34.

8. LIFESTYLE, BUILD AND HABITS

Please answer the following questions about your build and habits. Your lifestyle is an important indicator of your health. Please take care to answer questions honestly and accurately as your answers may affect any claim.

	FIRST LIFE	SECOND LIFE
What is your height without shoes?	☐ ft ☐ inches or ☐ metres ☐ centimetres	☐ ft ☐ inches or ☐ metres ☐ centimetres
What is your weight in normal indoor clothing?	☐ stones ☐ pounds or ☐ kilos	☐ stones ☐ pounds or ☐ kilos

If you are pregnant, please tell us your weight immediately before your pregnancy.

8. LIFESTYLE, BUILD AND HABITS (CONTINUED)

	FIRST LIFE	SECOND LIFE
Have you ever smoked cigarettes, a pipe or cigars?	Yes ☐ No ☐	Yes ☐ No ☐

If you tell us that you are a non smoker you may be asked to have a simple test (e.g. saliva or urine test) to confirm you are a non-smoker.

In the last 12 months, have you smoked cigarettes, a pipe or cigars, or used any tobacco or nicotine replacement products?
(Tobacco products include cigarettes, cigars and pipes. Nicotine replacement products include patches, electronic cigarettes, vaping, chewing gum, lozenges, inhalers and sprays.)

	FIRST LIFE	SECOND LIFE
No	☐	☐
Yes – occasionally	☐	☐
Yes – daily	☐	☐

If you smoke cigarettes daily, how many on average do you smoke per day?

	FIRST LIFE	SECOND LIFE
	☐ cigarettes each day	☐ cigarettes each day

How much alcohol do you drink in a typical week?

	FIRST LIFE	SECOND LIFE
Beer	☐ pints per week	☐ pints per week
Wine	☐ glasses (175ml) per week	☐ glasses (175ml) per week
Spirits	☐ standard measures (35ml) per week	☐ standard measures (35ml) per week

In the last 5 years have you:
Been advised to stop or reduce your alcohol consumption by a medical practitioner or have you received treatment, counselling or been advised to have a blood test as a result of your drinking?

	FIRST LIFE	SECOND LIFE
	Yes ☐ No ☐	Yes ☐ No ☐
If yes, please provide details		

Used recreational drugs? For example cocaine, heroin, methadone, ecstasy or cannabis etc (this list is not exhaustive).
We will only use this question to assess your health in relation to your application. There are no legal implications in answering yes to this question.

	FIRST LIFE	SECOND LIFE
	Yes ☐ No ☐	Yes ☐ No ☐
If yes, please provide details		

9. YOUR HEALTH

Your previous medical history is also an important indicator of your health. Please take care to answer these questions honestly and accurately as your answers may affect any claim.

	FIRST LIFE		SECOND LIFE	
Do you have or have you ever had any of the following?:				
Cancer, brain tumour, leukaemia, Hodgkin disease, lymphoma, skin cancer, melanoma or benign tumour or growth in the brain or spine?	Yes ☐	No ☐	Yes ☐	No ☐
Heart attack, angina, cardiomyopathy, heart valve disorders or any other heart condition?	Yes ☐	No ☐	Yes ☐	No ☐
Stroke, brain haemorrhage, aneurysm, cerebral arteriovenus malformation, Transient Ischaemic Attack (TIA – mini stroke) or any permanent brain damage?	Yes ☐	No ☐	Yes ☐	No ☐
Any disorder of the arteries including the aorta or poor circulation in the legs? *You don't need to tell us about varicose veins unless there has been ulceration.*	Yes ☐	No ☐	Yes ☐	No ☐
MS (Multiple Sclerosis), optic neuritis, paralysis or any other disorder of the nervous system (the brain, spinal cord and nerves)?	Yes ☐	No ☐	Yes ☐	No ☐
Double vision, blurred vision, numbness, loss of feeling, tingling or pins and needles for which you have seen a doctor?	Yes ☐	No ☐	Yes ☐	No ☐
Epilepsy, Parkinson's disease, Alzheimer's disease, dementia or cerebral palsy?	Yes ☐	No ☐	Yes ☐	No ☐
Kidney or liver disease or disorders for which you are either continuing to have hospital reviews or have not been discharged from follow-up?	Yes ☐	No ☐	Yes ☐	No ☐
Diabetes? *Diabetes includes conditions managed with or without medication.*	Yes ☐	No ☐	Yes ☐	No ☐
Sugar in urine, borderline diabetes or impaired glucose tolerance?	Yes ☐	No ☐	Yes ☐	No ☐
Chronic bronchitis, recurrent bronchitis (more than 2 attacks in the last year), emphysema or chronic obstructive pulmonary/airways disease (COPD or COAD)? *You don't need to tell us about one-off chest infections that you have fully recovered from.*	Yes ☐	No ☐	Yes ☐	No ☐
Colitis, Crohn's disease or pancreatic disorder?	Yes ☐	No ☐	Yes ☐	No ☐
A positive test for HIV or Hepatitis B or C or are you waiting for the results of such a test? *A negative HIV test won't by itself have any effect on your acceptance terms for insurance.*	Yes ☐	No ☐	Yes ☐	No ☐
A mental health problem that has required hospital treatment, referral to a psychiatrist or have you ever attempted suicide?	Yes ☐	No ☐	Yes ☐	No ☐

If your client has answered yes to any question, please complete section 16 which asks more questions about the specific illness.

If there isn't an exact match for your client's condition, you can use the generic questionnaire at the end of section 16 to gather more information.

9. YOUR HEALTH (CONTINUED)

Please answer the following questions about your current health

	FIRST LIFE		SECOND LIFE	
Are you aware of any symptoms or complaints for which you have not yet consulted a doctor or received treatment? For example unexplained bleeding, change in bowel habit, persistent cough, unexplained weight loss?	Yes ☐	No ☐	Yes ☐	No ☐
Have you been asked to return to any doctor, including your GP, for a follow up appointment, regular reviews, further investigations, counselling, or are you currently waiting for any surgical procedure or for the results of investigations or tests? *You don't need to tell us about any routine reviews in relation to minor injuries, pregnancy, fertility or dental treatment.*	Yes ☐	No ☐	Yes ☐	No ☐

Apart from anything you have already told us about, during the last 5 years have you:

Taken (or are you currently taking) any form of medication, prescribed by a doctor, that has lasted more than 4 weeks? *You don't need to tell us about medication for minor injuries, antibiotics for one -off chest infections, contraception, fertility or dental treatment.*	Yes ☐	No ☐	Yes ☐	No ☐
Attended a hospital or clinic: *You don't need to tell us about pregnancy, fertility treatment, routine smear tests or mammograms reported as normal and not requiring further treatment or investigation.*				
• as an in-patient for more than 5 continuous days,	Yes ☐	No ☐	Yes ☐	No ☐
• as an out-patient for more than 6 months from initial consultation to discharge	Yes ☐	No ☐	Yes ☐	No ☐
• for investigation of a condition not already mentioned. For example blood tests, biopsy, ultrasound, CT, MRI or other scan, ECG, echocardiogram or other heart investigation	Yes ☐	No ☐	Yes ☐	No ☐
• or are you awaiting an appointment with a hospital or clinic?	Yes ☐	No ☐	Yes ☐	No ☐
• Had stress, depression, anxiety, an eating disorder, chronic fatigue, or any mental health problem that has: – required you to consult a health professional (nurse, doctor, psychologist etc), have counselling or other psychotherapy, or – prevented you from working or carrying out your normal daily activities for more than 5 continuous days?	Yes ☐	No ☐	Yes ☐	No ☐
Had an irregular heartbeat, high blood pressure or raised cholesterol?	Yes ☐	No ☐	Yes ☐	No ☐
Had a lump, cyst, tumour or growth of any kind; or any mole or freckle that has bled, become painful, changed colour or increased in size whether seen by a doctor or not? *You need to tell us about any lumps or growths you are aware of even if you haven't consulted your doctor. You don't need to tell us about birthmarks where no treatment or specialist referral was required.*	Yes ☐	No ☐	Yes ☐	No ☐
Suffered from any back, neck, joint, or muscular condition (including arthritis, repetitive strain injury etc) requiring you to take any form of medication or consult a health professional (GP, nurse, physiotherapist, chiropractor etc)?	Yes ☐	No ☐	Yes ☐	No ☐

9. YOUR HEALTH (CONTINUED)

Suffered from any recurrent or persisting condition affecting your eyes or ears, or sight or hearing (excluding problems corrected by contact lenses or glasses)?
You don't need to tell us about eye problems corrected with glasses, lenses or laser surgery, simple earache or ear infections that resolved without any surgical intervention and didn't cause any hearing loss.

Yes ☐ No ☐ Yes ☐ No ☐

Had an abnormal cervical smear, abnormal mammogram or other gynaecological condition that has needed more than one consultation?

Yes ☐ No ☐ Yes ☐ No ☐

If your client has answered yes to any question, please complete section 16 which asks more questions about the specific illness.

If there isn't an exact match for your client's condition, you can use the generic questionnaire at the end of section 16 to gather more information.

10. FAMILY HISTORY

If you answer yes to any question, please provide details in the box below.

	FIRST LIFE		SECOND LIFE	
Have any of your natural parents, brother(s), sister(s) been diagnosed with or died from any of the following before age 65? *You don't need to answer this question if you are adopted or you do not know your family history.*				
Diabetes	Yes ☐	No ☐	Yes ☐	No ☐
Heart disease	Yes ☐	No ☐	Yes ☐	No ☐
Cardiomyopathy	Yes ☐	No ☐	Yes ☐	No ☐
MS (Multiple Sclerosis)	Yes ☐	No ☐	Yes ☐	No ☐
Stroke	Yes ☐	No ☐	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Yes ☐	No ☐
Polyposis of the colon	Yes ☐	No ☐	Yes ☐	No ☐
Huntington's disease	Yes ☐	No ☐	Yes ☐	No ☐
Motor neurone disease	Yes ☐	No ☐	Yes ☐	No ☐
Muscular dystrophy	Yes ☐	No ☐	Yes ☐	No ☐
Myotonic Dystrophy/ Myotonia Atrophica	Yes ☐	No ☐	Yes ☐	No ☐
Kidney disease (including polycystic kidney disease)	Yes ☐	No ☐	Yes ☐	No ☐
Parkinson's disease	Yes ☐	No ☐	Yes ☐	No ☐
Alzheimer's disease	Yes ☐	No ☐	Yes ☐	No ☐

Relationship to (mother, father, brother, sister)	Age of diagnosis	Condition

11. HAZARDOUS PURSUITS

Please answer the following questions about any hazardous pursuits.

Do you regularly take part in any of the following hazardous sports or activities?
You don't need to tell us about flying as a fare paying passenger or cabin crew on scheduled or charter aircraft, track or experience days, a one-off bungee, parachute jump or scuba dive.

	FIRST LIFE		SECOND LIFE	
Caving or potholing	Yes ☐	No ☐	Yes ☐	No ☐
Flying (other than as a fare paying passenger)	Yes ☐	No ☐	Yes ☐	No ☐
Hang gliding	Yes ☐	No ☐	Yes ☐	No ☐
Motor car sport	Yes ☐	No ☐	Yes ☐	No ☐
Motorcycle sport	Yes ☐	No ☐	Yes ☐	No ☐
Mountaineering or rock climbing	Yes ☐	No ☐	Yes ☐	No ☐
Parachuting or skydiving	Yes ☐	No ☐	Yes ☐	No ☐
Powerboat racing	Yes ☐	No ☐	Yes ☐	No ☐
Sailing, other than inland	Yes ☐	No ☐	Yes ☐	No ☐
Diving	Yes ☐	No ☐	Yes ☐	No ☐
Any extreme sport, for example bungee or BASE jumping, canyoning, white water rafting	Yes ☐	No ☐	Yes ☐	No ☐

If your client has answered yes to any of the hazardous pursuits questions we'll need further information.
You can find these questionnaires on our website at www.scottishwidows.co.uk/extranet

If a questionnaire is not available for your client's particular sport or activity, please tell us about it in the space above.

12. DECLARATION AND CONSENT

This is your client's declaration. It is important that you read/give this to your client.

FIRST LIFE DECLARATION

- I confirm I have read the Important Notes consisting of:
  - Data Privacy Notice
  - Money Laundering Regulations
  - Genetic Testing
  - Medical Information
  - Your answers to our questions
- I declare that I understand my application will be completed online on my behalf by my financial adviser. Scottish Widows will send me an Application Summary which I will review to ensure I agree with the information provided and I will inform Scottish Widows within 30 days if any information is incorrect or has changed.
- I declare that, to the best of my knowledge and belief, the information given in this application is true and complete. **If any of the information or the answers provided are subsequently found to be incorrect or incomplete then I understand Scottish Widows may not pay any claim, amend the terms of my policy or at worst cancel my policy**.
- I need to let Scottish Widows know if the answer to a question in this application changes before the date we have agreed the terms for my cover. If I don't do this, you may not pay any claim, have to amend the terms of my policy or at worst cancel my policy. Scottish Widows will have agreed the terms once you have my confirmation that all my application answers are true and complete and you have written to me after that confirming your terms.
- I understand that you will rely on the answers I have given and you will not necessarily ask my doctor for information about my medical history to offer terms for this application.
- I understand that you may ask me to complete a consent form to obtain medical information from any doctor I have consulted and that I may not be covered if I do not agree to this.
- I agree that you may gather relevant information from other insurers about any other applications I have made to them and to you sharing my information with your reinsurer partners.
- I understand that I will not be able to claim under the policy until the policy start date and that the policy cannot be backdated to a start date which is on or before the date of any event which might lead to a claim.
- I agree that this application, together with any statements made to a medical examiner, makes up the contract between me and you.
- If this is a joint life application, by agreeing to this declaration, I am consenting to share all plan and policy information between both of us.
- I confirm I am a UK resident.

By agreeing to this Declaration I am allowing you to process this application using the information that I have given. You may also use this information to process any claim made on my policy.

SECOND LIFE DECLARATION

- I confirm I have read the Important Notes consisting of:
  - Data Privacy Notice
  - Money Laundering Regulations
  - Genetic Testing
  - Medical Information
  - Your answers to our questions
- I declare that I understand my application will be completed online on my behalf by my financial adviser. Scottish Widows will send me an Application Summary which I will review to ensure I agree with the information provided and I will inform Scottish Widows within 30 days if any information is incorrect or has changed.
- I declare that, to the best of my knowledge and belief, the information given in this application is true and complete. **If any of the information or the answers provided are subsequently found to be incorrect or incomplete then I understand Scottish Widows may not pay any claim, amend the terms of my policy or at worst cancel my policy**.
- I need to let Scottish Widows know if the answer to a question in this application changes before the date we have agreed the terms for my cover. If I don't do this, you may not pay any claim, have to amend the terms of my policy or at worst cancel my policy. Scottish Widows will have agreed the terms once you have my confirmation that all my application answers are true and complete and you have written to me after that confirming your terms.
- I understand that you will rely on the answers I have given and you will not necessarily ask my doctor for information about my medical history to offer terms for this application.
- I understand that you may ask me to complete a consent form to obtain medical information from any doctor I have consulted and that I may not be covered if I do not agree to this.
- I agree that you may gather relevant information from other insurers about any other applications I have made to them and to you sharing my information with your reinsurer partners.
- I understand that I will not be able to claim under the policy until the policy start date and that the policy cannot be backdated to a start date which is on or before the date of any event which might lead to a claim.
- I agree that this application, together with any statements made to a medical examiner, makes up the contract between me and you.
- If this is a joint life application, by agreeing to this declaration, I am consenting to share all plan and policy information between both of us.
- I confirm I am a UK resident.

By agreeing to this Declaration I am allowing you to process this application using the information that I have given. You may also use this information to process any claim made on my policy.

13. ACCESS TO MEDICAL REPORTS ACT (AMRA) – MEDICAL CONSENT FORM

FIRST LIFE

Plan / Policy reference number	
Name of First Life	
Date of Birth	

This consent form authorises Scottish Widows to request a medical report from your doctor under The Access to Medical Reports Act 1988, or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991, whichever is appropriate.

You have certain rights under the above Act/Order and have the right to withhold your consent. You can see any report from your doctor before it is sent or during the 6 months after that. You can ask the doctor to amend any part you consider misleading or incorrect and add comments if they don't agree to make the changes. The doctor does not have to show you any part of the report they feel might cause you harm. Without your consent Scottish Widows cannot apply for a medical report.

- You agree that a copy of this consent can be used to obtain medical information from your doctor.
- You agree to Scottish Widows asking any doctor about your physical or mental health to provide medical information so Scottish Widows may assess your application.
- You authorise people whom Scottish Widows ask to provide medical information to do so. You agree that Scottish Widows may gather medical records within six months of the start of the policy or to verify any claim made on the policy.

DECLARATION

I agree that Scottish Widows may obtain medical information from any doctor I have consulted.

Do you want to see any medical report on yourself before it is sent to Scottish Widows?

Yes ☐ No ☐

Signature

Date (DD MM YYYY)

Please email this to our servicing team at **Protect@scottishwidows.co.uk**

Alternatively you can post a copy to the Scottish Widows servicing team at the following address: Scottish Widows Protect Servicing Team, 15 Dalkeith Road, Edinburgh EH16 5BU.

SECOND LIFE

Plan / Policy reference number	
Name of Second Life	
Date of Birth	

This consent form authorises Scottish Widows to request a medical report from your doctor under The Access to Medical Reports Act 1988, or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991, whichever is appropriate.

You have certain rights under the above Act/Order and have the right to withhold your consent. You can see any report from your doctor before it is sent or during the 6 months after that. You can ask the doctor to amend any part you consider misleading or incorrect and add comments if they don't agree to make the changes. The doctor does not have to show you any part of the report they feel might cause you harm. Without your consent Scottish Widows cannot apply for a medical report.

- You agree that a copy of this consent can be used to obtain medical information from your doctor.
- You agree to us asking any doctor about your physical or mental health to provide medical information so Scottish Widows may assess your application.
- You authorise people whom Scottish Widows ask to provide medical information to do so. You agree that Scottish Widows may gather medical records within six months of the start of the policy or to verify any claim made on the policy.

DECLARATION

I agree that Scottish Widows may obtain medical information from any doctor I have consulted.

Do you want to see any medical report on yourself before it is sent to Scottish Widows?

Yes ☐ No ☐

Signature

Date (DD MM YYYY)

Please email this to our servicing team at **Protect@scottishwidows.co.uk**

Alternatively you can post a copy to the Scottish Widows servicing team at the following address: Scottish Widows Protect Servicing Team, 15 Dalkeith Road, Edinburgh EH16 5BU.

14. BANK DETAILS OF PAYER

Account name	
Account number	
Sort code	
Preferred payment date	

The chosen payment date should be between 1st and 28th of each month

If it's a company paying the premium please also complete the information below.

Company name	
Company contact name	
Phone number	
Building name	
Address	
Postcode	

15. START DATES AND TRUSTS

15.1 Personal and Business Protection

For personal and business protection, please complete the table below:

Lives assured	Type of cover (Policy type)	Cover amount £	Start Date (dd/mm/yyyy)	Are these policy(ies) being held in trust at outset? (delete as appropriate)
				Yes/No
				Yes/No
				Yes/No
				Yes/No

15.2 Relevant Life Cover

This plan must be set up in trust. Please complete the table below and make sure the correct trust form is completed by your client and sent to Scottish Widows.

Life assured	Type of cover (Policy type)	Cover amount £	Start Date (dd/mm/yyyy)	This policy will be held in trust at outset	Has the correct trust form been completed?
	Relevant Life Cover			Yes	

16. ADDITIONAL HEALTH QUESTIONS

If your client(s) has answered 'yes' to any of the health questions in the previous pages, we'll probably need to ask a few more questions on the specific illness. To save you having to contact your client(s) again, there are some additional health questions in this section.

We've only listed the most common conditions so if you can't find an illness that matches exactly, you can ask your client(s) questions from the generic questionnaire at the end of this section.

You don't have to complete this section but it will help your client(s) get a quicker decision as we'll ask for this information when you apply online on their behalf.

FIRST LIFE | SECOND LIFE

ASTHMA

When did you last experience symptoms for this condition or take treatment?

(MM YYYY) (MM YYYY)

Which of the following best describes the frequency of your symptoms?

a) regularly have days with no symptoms or breathlessness

b) symptoms of breathlessness each day, but with periods of respite

c) continuous or most of the day

Which of the following best describes the duration and effect of your symptoms you have from an episode of the condition?

a) for a short period with less than 2 hours effect per day on ability to work or do daily activities

b) more than 2 hours but less than 12 hours effect per day on ability to work or do daily activities

c) more than 12 hours effect per day on ability to work or do daily activities

How many courses of steroid tablets have you taken in the last 2 years? (e.g. prednisolone)

a) 0

b) 1-2

c) more than 2

d) continuous

End of section

FIRST LIFE | SECOND LIFE

BACK AND JOINTS

You should complete this section for all back and joints problems, then the relevant section for either back pain below, or joint pain below.

Have you had surgery/awaiting surgery or are you having/awaiting tests or investigations?

Surgery	Yes ☐ No ☐ awaiting ☐	Yes ☐ No ☐ awaiting ☐
Tests	Yes ☐ No ☐ awaiting ☐	Yes ☐ No ☐ awaiting ☐

If waiting for surgery, please provide the date

(MM YYYY) (MM YYYY)

In the last 5 years how many days in total have you been unable to perform the core duties of your occupation or experienced limitations in performing daily activities?

☐ days ☐ days

How many times have you suffered from this condition?

☐ times ☐ times

Are you currently experiencing ongoing symptoms or treatment (delete as appropriate)?

Ongoing symptoms/ treatment/both	Yes ☐ No ☐	Ongoing symptoms/ treatment/both Yes ☐ No ☐

If no, provide the date of last symptoms or treatment.

Last symptoms

(MM YYYY) (MM YYYY)

Last treatment

(MM YYYY) (MM YYYY)

Have you made a full recovery with no limitation in performing your core duties of your occupation or your normal daily activities?

Yes ☐ No ☐ Yes ☐ No ☐

BACK ONLY

How many days have you ever had off work with this condition?

☐ days ☐ days

In addition, do you suffer with any mental illness, anxiety or stress as a result of this condition?

Yes ☐ No ☐ Yes ☐ No ☐

Section continues on page 27

	FIRST LIFE	SECOND LIFE

JOINTS ONLY

Which joint/joints are affected? If this affects your back/neck please complete the previous section for backs.

Please confirm if your condition is related to another medical condition.

Yes ☐ No ☐ Yes ☐ No ☐

If yes, what?

Please describe your condition e.g. – dislocation, fracture, break.

End of section

FIRST LIFE

SECOND LIFE

BLOOD PRESSURE AND/OR CHOLESTEROL

When did you start treatment?

Blood pressure	Cholesterol
(MM YYYY)	(MM YYYY)

Blood pressure	Cholesterol
(MM YYYY)	(MM YYYY)

When is your next follow up due?

Blood pressure	Cholesterol
(MM YYYY)	(MM YYYY)

Blood pressure	Cholesterol
(MM YYYY)	(MM YYYY)

Have you ever had an abnormal ECG or heart investigation?

Yes ☐ No ☐ Yes ☐ No ☐

When was the date of your last check up?

(MM YYYY) (MM YYYY)

Are you still on treatment? Yes ☐ No ☐ Yes ☐ No ☐

If 'no', please move on to the 'not on treatment' section further down the page.

How many medications do you take for each condition?

Was your condition described as well controlled at your last review?

Yes ☐ No ☐ Yes ☐ No ☐

Provide your last reading

Blood pressure ☐ Cholesterol ☐ Blood pressure ☐ Cholesterol ☐

Did you need any of the following at your last review?

Referral for investigations or specialist treatment

Yes ☐ No ☐ Yes ☐ No ☐

Change in medication or increase your current dosage

Yes ☐ No ☐ Yes ☐ No ☐

If you are not on treatment, please answer the following questions:

Never required treatment Yes ☐ No ☐ Yes ☐ No ☐

Required treatment, but stopped following medical advice

Yes ☐ No ☐ Yes ☐ No ☐

Required treatment, but stopped without medical advice

Yes ☐ No ☐ Yes ☐ No ☐

When was your condition last noted to be raised?

(MM YYYY) (MM YYYY)

End of section

FIRST LIFE | SECOND LIFE

CANCER/TUMOUR

Please confirm the area affected

Have all tests, investigations and treatment been completed?

Yes ☐ No ☐ | Yes ☐ No ☐

Has your cancer spread to your lymph nodes or other parts of your body?

Yes ☐ No ☐ Not known ☐ | Yes ☐ No ☐ Not known ☐

Has there been a recurrence of the cancer/tumour?

Yes ☐ No ☐ | Yes ☐ No ☐

When was your last treatment (chemotherapy, radiotherapy or surgery)?

Please don't include drugs such as tamoxifen which are prescribed to prevent recurrence.

(MM YYYY) | (MM YYYY)

End of section

GROWTHS/LUMPS/MOLES

Have you consulted a doctor or specialist?

Yes ☐ No ☐ | Yes ☐ No ☐

Have you had investigations which have confirmed the condition to be simple or benign and cancer ruled out? If no please complete cancer section.

Yes ☐ No ☐ | Yes ☐ No ☐

Have all tests, investigations and treatment been completed?

Yes ☐ No ☐ | Yes ☐ No ☐

When was your last investigation or treatment?

(MM YYYY) | (MM YYYY)

Has this been completely removed?

Yes ☐ No ☐ | Yes ☐ No ☐

Has there been any recurrence?

Yes ☐ No ☐ | Yes ☐ No ☐

Are you still being followed up?

Yes ☐ No ☐ | Yes ☐ No ☐

Do you have any other growths or lumps?

Yes ☐ No ☐ | Yes ☐ No ☐

Have you been advised to check other moles etc or to limit sun exposure?

Yes ☐ No ☐ | Yes ☐ No ☐

Has your mole bled, changed colour or changed size? (moles/naevi only)

Yes ☐ No ☐ | Yes ☐ No ☐

Breast lump only – Was this diagnosed as a fibroadenoma?

Yes ☐ No ☐ | Yes ☐ No ☐

End of section

	FIRST LIFE	SECOND LIFE

DIABETES

Type of diabetes

Type 1	☐	Type 2	☐	Type 1	☐	Type 2	☐
Gestational	☐	Don't know	☐	Gestational	☐	Don't know	☐

Please provide the date you were diagnosed or age at diagnosis

(MM YYYY)	(MM YYYY)

Do you have any kidney complication from diabetes or any heart disease?

Yes	☐	No	☐	Yes	☐	No	☐

Have you been admitted to hospital for any complications of diabetes including a coma?

Yes – date of admission (DD MM YYYY)				Yes – date of admission (DD MM YYYY)			
No	☐			No	☐		

Do you take insulin?

Yes	☐	No	☐	Yes	☐	No	☐

When did you last attend the doctor or clinic for review?

(MM YYYY)	(MM YYYY)

Has your diabetes caused any damage to your eyes, nerves or has protein (albumin) been found in your urine?

Yes – all	☐	Yes – all	☐
Yes – eyes/nerves/protein	☐	Yes – eyes/nerves/protein	☐
No/don't know	☐	No/don't know	☐

Latest Hba1c reading

GESTATIONAL ONLY (PREGNANCY RELATED)

Are you pregnant?

Yes	☐	No	☐	Yes	☐	No	☐

When did you last experience symptoms or take treatment?

(MM YYYY)	(MM YYYY)

Have you fully recovered?

Yes	☐	No	☐	Yes	☐	No	☐

End of section

	FIRST LIFE	SECOND LIFE

MENTAL ILLNESS

Have you fully recovered? Yes ☐ No ☐ Yes ☐ No ☐

If no, please provide date of last symptoms

(MM YYYY) (MM YYYY)

Are you still on treatment? Yes ☐ No ☐ Yes ☐ No ☐

If no, please provide date last taken

(MM YYYY) (MM YYYY)

Does this condition affect your ability to perform your normal occupation?

Yes ☐ No ☐ Yes ☐ No ☐

Please give the length of any continuous periods you have been off work or been unable to do your normal activities because of the condition in the last 5 years

0 days ☐ 1-14 days ☐ 0 days ☐ 1-14 days ☐

15-28 days ☐ More than 28 days ☐ 15-28 days ☐ More than 28 days ☐

How many of those have been in the last 2 years?

days days

Please indicate which of the following best describes the number of episodes and length of symptoms you have had in the last 5 years

No symptoms in the last 5 years ☐ ☐

1 or 2 episodes but none for longer than 1 month ☐ ☐

More than 2 or any episode longer than 1 month ☐ ☐

Have you been treated by a psychiatrist at a hospital or clinic as an in-patient or as an out-patient in the last 5 years?

Yes – in-patient and/or out-patient ☐ ☐

Yes – out-patient only ☐ ☐

No – neither ☐ ☐

When did you last receive in-patient care?

(MM YYYY) (MM YYYY)

Have you ever taken an overdose of drugs, attempted suicide or self harm in the last 10 yrs?

Yes ☐ No ☐ Yes ☐ No ☐

Section continues on page 32

FIRST LIFE | SECOND LIFE

MENTAL ILLNESS (CONTINUED)

How many attempts at suicide or self-harm have you had in the past?

When did this/they take place?

(MM YYYY)

When did you last experience suicidal thoughts or symptoms?

(MM YYYY)

Have you made a full recovery, been discharged from review and are no longer on treatment?

Yes ☐ No ☐

Yes ☐ No ☐

End of section

FIRST LIFE | SECOND LIFE

OSTEOARTHRITIS

Have you had joint replacement surgery?

Yes ☐ No ☐ | Yes ☐ No ☐

Date _____ (MM YYYY) | _____ (MM YYYY)

Did you suffer from any of these complications? (delete as appropriate)

DVT/stroke/infection/N/A | DVT/stroke/infection/N/A

If infection, has it been treated and eradicated?

Yes ☐ No ☐ | Yes ☐ No ☐

Describe your symptoms:

Minor symptoms only for a few hours a day, with no limitation in performing the core duties of your occupation or daily activities ☐ ☐

More frequent symptoms but with minor or occasional limitation in performing the core duties of your occupation or daily activities ☐ ☐

Regular or persistent pain and use of aids for walking such as a stick ☐ ☐

Which joint/joints are affected?

_____ | _____

End of section

RHEUMATOID ARTHRITIS

Are you awaiting any operation or investigations?

Yes ☐ No ☐ | Yes ☐ No ☐

Describe your symptoms:

Minimal/slight pain, stiffness or swelling in hands or feet only. Able to carry out usual daily activities. ☐ ☐

Involvement of other joints (wrist, spine, knees). More pain/stiffness/swelling. Able to carry out usual daily activities. ☐ ☐

Involvement of major joints. No freedom from pain. Inability to carry out daily activities. ☐ ☐

In the last 2 years have you required treatment with oral steroids, methotrexate or anti-TNF agents?

Yes ☐ No ☐ | Yes ☐ No ☐

When did you last have symptoms or take treatment?

_____ (MM YYYY) | _____ (MM YYYY)

End of section

	FIRST LIFE	SECOND LIFE

TRAVEL (This covers all types of travel)

Past Travel

Please state the country/countries you have visited.

Have you had any health problems, surgery, acupuncture, body piercing or tattooing in any such countries?

Please state how many days you have spent in each country during the past 5 years.

Do you have any intention of returning to any of these countries?

Please give reason for visit, exact destinations, length of stay in each country and frequency of trips.

Future Travel

Please state the country/countries you intend to visit.

For how many days will you travel to each country in the next year?

Please give reason for visit, exact destinations, length of stay in each country and frequency of trips.

End of section

FIRST LIFE | SECOND LIFE

THYROID (This covers all types of thyroid)

Please complete this section first before completing the specific overactive thyroid section below (if applicable).

Are you waiting for any of the following; surgery, investigations, results of tests or a diagnosis?

Yes ☐ No ☐ | Yes ☐ No ☐

Has your diagnosis been confirmed?

Yes ☐ No ☐ | Yes ☐ No ☐

Has the diagnosis confirmed any of the following?

Over activity ☐ Under activity ☐ | Over activity ☐ Under activity ☐

Goitre ☐ Nodule ☐ | Goitre ☐ Nodule ☐

Thyroid eye disease ☐ | Thyroid eye disease ☐

Have the investigations shown any cancer, malignancy or tumour?

Yes ☐ No ☐ | Yes ☐ No ☐

Please advise when your treatment started and if relevant when it finished

Started _____ (MM YYYY) | _____ (MM YYYY)

Finished _____ (MM YYYY) | _____ (MM YYYY)

Please describe your current control and thyroid function

Not controlled ☐ | Not controlled ☐

Well controlled ☐ | Well controlled ☐

Fully recovered ☐ | Fully recovered ☐

Please confirm the number of days off work you have had in the last 2 years

_____ days | _____ days

OVERACTIVE/Hyperthyroid only

When did you begin to suffer with this condition?

_____ (MM YYYY) | _____ (MM YYYY)

Is your thyroid gland now underactive?

Yes ☐ No ☐ | Yes ☐ No ☐

End of section

If you can't find a section that matches an illness, please complete this generic questionnaire.

	FIRST LIFE	SECOND LIFE
GENERIC QUESTIONNAIRE 1		
Name of condition		
Please provide dates for:		
Symptoms or diagnosis	(MM YYYY)	(MM YYYY)
Treatment: first	(MM YYYY)	(MM YYYY)
Treatment: last	(MM YYYY)	(MM YYYY)
Time off work:		
Last 12 months	Number of days/weeks	Number of days/weeks
Last 5 years	Number of days/weeks	Number of days/weeks
Last 10 years	Number of days/weeks	Number of days/weeks
Does this condition restrict your mobility or your ability to perform your normal daily activities?	Yes ☐ No ☐	Yes ☐ No ☐
Is this caused by any other condition?	Yes ☐ No ☐	Yes ☐ No ☐
If so, please give details		
Are you awaiting any tests/investigations or surgery?	Yes ☐ No ☐	Yes ☐ No ☐
Please confirm the results of any investigations		
Have you consulted a doctor/specialist regarding this?	Yes ☐ No ☐	Yes ☐ No ☐
Has there been any recurrence?	Yes ☐ No ☐	Yes ☐ No ☐
Have you made a full recovery?	Yes ☐ No ☐	Yes ☐ No ☐

End of section

If you can't find a section that matches an illness, please complete this generic questionnaire.

	FIRST LIFE	SECOND LIFE
GENERIC QUESTIONNAIRE 2		
Name of condition		
Please provide dates for:		
Symptoms or diagnosis	(MM YYYY)	(MM YYYY)
Treatment: first	(MM YYYY)	(MM YYYY)
Treatment: last	(MM YYYY)	(MM YYYY)
Time off work:		
Last 12 months	Number of days/weeks	Number of days/weeks
Last 5 years	Number of days/weeks	Number of days/weeks
Last 10 years	Number of days/weeks	Number of days/weeks
Does this condition restrict your mobility or your ability to perform your normal daily activities?		
	Yes ☐ No ☐	Yes ☐ No ☐
Is this caused by any other condition?		
	Yes ☐ No ☐	Yes ☐ No ☐
If so please provide details		
Are you awaiting any tests/investigations or surgery?		
	Yes ☐ No ☐	Yes ☐ No ☐
Please confirm the results of any investigations		
Have you consulted a doctor/specialist regarding this?		
	Yes ☐ No ☐	Yes ☐ No ☐
Has there been any recurrence?		
	Yes ☐ No ☐	Yes ☐ No ☐
Have you made a full recovery?		
	Yes ☐ No ☐	Yes ☐ No ☐

End of section

17. FINANCIAL QUESTIONNAIRE – FIRST LIFE

Please complete for all existing cover that is staying in force.

	Family	Mortgage	IHT	Business Loan	Key person	Shareholder protection	Relevant Life Cover
Life Cover							
Critical Illness Cover							

PERSONAL COVER

Please complete the relevant section only

Family/Personal Cover: Salary/other earned income	£
Mortgage/Loan Cover: Total amount of loan(s)	£
IHT Cover: IHT liability	£

BUSINESS COVER

Total remuneration of life assured	£

Please complete the relevant section below

SHAREHOLDER

Please input the most recent in the top box

Tax year	Net Profit	Net Assets	% Shareholding

Please confirm how the business has been valued	

BUSINESS LOAN COVER

Total amount of all loans being covered	£
Term of each loan being covered	
How many people are to be covered to protect this loan?	

KEY PERSON

How was the sum assured calculated?	Multiple of Salary/Loss of profits (Delete as appropriate)
Average net profit for the last 2-3 years	£
% of profit attributable to this key person	
How many other key people are being insured?	

ANY OTHER SUPPORTING INFORMATION

17. FINANCIAL QUESTIONNAIRE – SECOND LIFE

Please complete for all existing cover that is staying in force.

	Family	Mortgage	IHT	Business Loan	Key person	Shareholder protection	Relevant Life Cover
Life Cover							
Critical Illness Cover							

PERSONAL COVER

Please complete the relevant section only

Family/Personal Cover: Salary/other earned income	£
Mortgage/Loan Cover: Total amount of loan(s)	£
IHT Cover: IHT liability	£

BUSINESS COVER

Total remuneration of life assured	£

Please complete the relevant section below

SHAREHOLDER

Please input the most recent in the top box

Tax year	Net Profit	Net Assets	% Shareholding

Please confirm how the business has been valued	

BUSINESS LOAN COVER

Total amount of all loans being covered	£
Term of each loan being covered	
How many people are to be covered to protect this loan?	

KEY PERSON

How was the sum assured calculated?	Multiple of Salary/Loss of profits (Delete as appropriate)
Average net profit for the last 2-3 years	£
% of profit attributable to this key person	
How many other key people are being insured?	

ANY OTHER SUPPORTING INFORMATION

54576 03/18

SCOTTISH WIDOWS