Application Number

Available once the application is entered on Adviser Hub. Please complete these for your records.

Vitality
LIFE INSURANCE

PERSONAL PROTECTION APPLICATION FORM WITH STANDARD UNDERWRITING

This form is designed for **Personal Protection applications with Standard Underwriting.**

VitalityLife offer two forms of underwriting for Personal Protection:

1) Standard Underwriting – **INCLUDED** in this form
2) Optimiser Underwriting – **NOT** included in this form.

Optimiser Underwriting is speedy and smooth, designed for Personal Protection applications with Vitality Optimiser or Wellness Optimiser. It is NOT designed for applications including Income Protection or Education Cover and eligibility is dependent on product selection and answers to a few upfront questions. If you would like to complete the Personal Protection application form with Optimiser Underwriting, you can order or download it at adviser.vitality.co.uk/life.

IMPORTANT INFORMATION

This application form should be used with a financial adviser.

This form can be used for new applications for VitalityLife's personal protection products. It can also be used for data capture.

To enable us to quote, underwrite and administer your plan, we will collect, process, share and retain your personal, health and medical information, and that of any other members covered in your plan, as described in our Privacy Policy.

We will request a new application for any plans that are not in force within 6 months of submitting this application.

If you are reinstating an existing plan, please complete a Supplementary Health Questionnaire, available on adviser.vitality.co.uk/life/.

CONTENTS

HOW TO SUBMIT THIS APPLICATION

a) Submit online in Adviser Hub to receive an immediate underwriting decision

- Complete all information up to the end of section I, along with payment details on page 25
- Submit the application online in Adviser Hub at adviser.vitality.co.uk/life/
- Receive an immediate underwriting decision or details of further information we require
- Your client(s) must sign the Access to Medical Reports Act 1988 Declaration on page 29. Please detach this declaration only and post it to FREEPOST VitalityLife, Sheffield, S95 1BW.

b) Tele-underwriting submission

- Complete all information up to the end of section E, along with payment details on page 25
- Your client(s) must sign the Access to Medical Reports Act 1988 Declaration on page 29.
- Post this application form to FREEPOST VitalityLife, Sheffield, S95 1BW.

c) Paper submission

- Please note, you cannot submit an application for the VitalityLife Essentials Plan by post. It must be submitted using option a) or b).
- Complete all information, including payment details on page 25 and the client declaration, authority and consent starting on page 31
- Your client(s) must sign the Access to Medical Reports Act 1988 Declaration on page 29
- Post the paper application to FREEPOST VitalityLife, Sheffield, S95 1BW.

IMPORTANT INFORMATION FOR THE APPLICANT(S)

Please use black ink, BLOCK LETTERS and tick or complete answers as appropriate. If you make a mistake please initial your correction.

Please take care to answer the questions on this form honestly and fully. If you miss any information out, or give us misleading information, this may mean that a future claim will not be paid. If you are applying for Income Protection Cover, giving us misleading information might mean the amount of the benefit will be reduced or not paid. In addition, this could also delay the processing of your application. Please enclose all relevant information as we may not contact your GP to obtain a GP report.

If someone else fills this form in for you, such as your financial adviser, please check that all the details are correct before you sign the declaration. You are responsible for all the answers you or your financial adviser provide on this application.

If you prefer, you may complete the medical questions in private and return the Lifestyle and Health details in section G direct to our Chief Medical Officer. Please indicate on this form if you have done so.

It is also very important that you tell us if there is a change to any of the following information between completion of this form and your application being accepted:

- Your personal health
- Your family history
- Your occupation
- Your earnings
- Your participation in any hazardous leisure activities
- Your travel or residence
- Your lifestyle (such as smoking and alcohol consumption)

If you do not, the plan may be cancelled and will result in non-payment of a claim.

INFORMATION ABOUT GENETIC TESTS

If this application, taken together with any other insurance plans you already have, is for Life Cover up to a sum of £500,000, Serious Illness/Critical Illness Cover up to £300,000 or Income Protection Cover up to £30,000 per year, you do not need to disclose any genetic test you may have had. You do not need to disclose the result of any genetic test undertaken in the context of research. Genetic test results only need to be disclosed where the sum exceeds either £500,000 for Life Cover or £300,000 for Serious Illness/Critical Illness Cover, £30,000 per year for Income Protection Cover and their use by insurers has been independently approved. You may, of course, disclose any genetic test result which is in your favour. If you either have a family history of, are experiencing symptoms of, or are having treatment for, a genetic condition, you must tell us.

Further information is available on request which fully explains this policy and details the genetic tests which are approved for use by insurers.

A. YOUR DETAILS

IMPORTANT: If this is a joint application, Life 1 must be the person who has selected the highest level of Life Cover. If no Life Cover is selected, Life 1 must be the person who has selected the highest level of Serious Illness Cover or Income Protection.

PERSONAL INFORMATION	**Life 1**	**Life 2 (if applicable)**
Are you a UK resident? UK includes England, Scotland, Wales and Northern Ireland but EXCLUDES the Channel Islands, Isle of Man and Republic of Ireland	Yes ◯ No ◯ *NB. We reserve the right to request additional information and documentation to verify this.*	Yes ◯ No ◯

IMPORTANT: If you select 'No', you'll need to establish eligibility for your plan by discussing your residency status with our Financial Crime team. Please read the Eligibility Guidelines on adviser.vitality.co.uk/life/ for contact details.

Title	Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Other ◯	Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Other ◯
First name(s)		
Surname		
Date of birth	D D M M Y Y Y Y	D D M M Y Y Y Y
Marital status	Single ◯ Separated ◯ Married ◯ Civil partner ◯ Divorced ◯ Dissolved civil partnership ◯ Widowed ◯ Surviving partner of civil partnership ◯	Single ◯ Separated ◯ Married ◯ Civil partner ◯ Divorced ◯ Dissolved civil partnership ◯ Widowed ◯ Surviving partner of civil partnership ◯
Gender	Male ◯ Female ◯	Male ◯ Female ◯
Please confirm your smoker status Includes cigarettes, cigars, pipe, loose tobacco, herbal cigarettes, any nicotine replacement therapy and electronic cigarettes.	Occasional smoker ◯ Regular smoker ◯ Ex-smoker (stopped more than 12 months ago) ◯ Never smoked ◯ *We will carry out random tests to confirm non-smoker status.*	Occasional smoker ◯ Regular smoker ◯ Ex-smoker (stopped more than 12 months ago) ◯ Never smoked ◯
How many cigarettes (include roll-ups) do you, or did you, smoke per day?		
In an average week, how many alcoholic drinks do you have? Examples of drink include a pint of beer/ cider, an average sized glass of wine or a single measure of spirits.		

Occupation Only required if you're applying for Income Protection Cover or Disability Cover.		
Employment status	Employed ◯ Self-employed ◯ Unemployed ◯ Houseperson ◯	Employed ◯ Self-employed ◯ Unemployed ◯ Houseperson ◯
Have you been self-employed for 2 years or more? Complete only if self-employed is selected.	Yes ◯ No ◯	Yes ◯ No ◯
Annual Personal Pre-Tax Income Only required if you're applying for Income Protection Cover or Disability Cover.	£	£

CONTACT INFORMATION	**Life 1**	**Life 2 (if applicable)**
If our tele-underwriters and/or Vitality Nurses need to contact you, please choose your preferred contact time.	No Preference ◯ Mon - Fri 9am – 12pm ◯ Mon - Fri 12pm – 4pm ◯ Mon - Fri 4pm – 8pm ◯	No Preference ◯ Mon - Fri 9am – 12pm ◯ Mon - Fri 12pm – 4pm ◯ Mon - Fri 4pm – 8pm ◯
Contact telephone number(s)		
Email address		
Current address		

CLIENT CONSENT	**Life 1**	**Life 2 (if applicable)**
My client gives consent for their personal and medical information to be shared with the other life assured on the plan. Only applicable to a joint life plan.	Yes ◯ No ◯	Yes ◯ No ◯

IMPORTANT: If this is a joint life application and medical consent has not been provided to share medical and health information with both lives, please complete this application form for each Life Assured.

Marketing preferences - optional

Vitality Corporate Services Limited would like to send your client(s) information about our products and future products, which currently include health and life insurance, investments and general insurance. We are focused on bringing exciting new products to them and to enhance those already available by offering improved services and benefits as a Vitality member.

Please let us know how Life 1 would like to hear about the latest updates from us.

Email ☐ Post ☐ SMS/text ☐ Social media ☐ Telephone ☐ No contact ☐

Please let us know how Life 2 (if applicable) would like to hear about the latest updates from us.

Email ☐ Post ☐ SMS/text ☐ Social media ☐ Telephone ☐ No contact ☐

We will not share their personal data with any other companies for marketing purposes.

Your client(s) can change their mind about how they would like to receive marketing information about our products and services at any time. They can manage their preferences on our website, call our customer services team or they can unsubscribe, using the unsubscribe link on emails that we send to them. For SMS/text messages, follow the opt-out instructions on the message.

MORE INFORMATION	**Life 1**	**Life 2 (if applicable)**
Do you have any Income Protection Cover with any other companies including any you are currently applying for? If 'Yes' please provide the cover amounts. You only need to complete this question if you are applying for Income Protection.	Yes ☐ No ☐ Total Income Protection Cover £	Yes ☐ No ☐ Total Income Protection Cover £
Will you be cancelling any of the insurance cover outlined above when your VitalityLife plan starts? If 'Yes' please provide the cover amounts. You only need to complete this question if you are applying for Income Protection.	Yes ☐ No ☐ Total Income Protection Cover £	Yes ☐ No ☐ Total Income Protection Cover £
Is this plan to be used in connection to a mortgage?	Yes ☐ No ☐	Yes ☐ No ☐
Is this plan to be used for Business Protection?	Yes ☐ No ☐	Yes ☐ No ☐
Are you currently pregnant? For females only.	Yes ☐ No ☐	Yes ☐ No ☐
Height	feet inches or centimetres	feet inches or centimetres
Weight	stones pounds or kilograms	stones pounds or kilograms

B. YOUR PLAN

Which plan would you like? An Essentials Plan application can only be submitted online.	VitalityLife Plan ◯ Essentials Plan ◯

C. YOUR CORE COVER

LIFE COVER - SECTION C1	**Life 1**	**Life 2 (if applicable)**
Would you like Life Cover?	Yes ◯ No, go to section C2 ◯	Yes ◯ No, go to section C2 ◯
Cover amount	£	£
Cover term When selecting 'Fixed Term', please choose the term.	Whole of life ◯ ☐ years fixed term	Whole of life ◯ ☐ years fixed term
Premium basis	Guaranteed ◯ Reviewable ◯	

IMPORTANT: If you choose the account basis to be indexed, the amount of cover will increase by Retail Prices Index (PRI) each year. Premiums will increase each year in line with RPI plus 1.5% to 3.5% up to the anniversary before your client's 80th birthday and RPI plus 5% after that. If this is a joint life plan, this will be based on the younger of the two lives covered.

Cover basis	Indexed ◯ Level ◯ Decreasing (only available with Fixed Term) ◯
Payment options Only applicable for joint life Whole of Life cover chosen for both lives.	As a result of the first death ◯ As a result of the second death ◯

SERIOUS ILLNESS COVER - SECTION C2	**Life 1**	**Life 2 (if applicable)**
Would you like Serious Illness Cover?	Yes ◯ No, go to section C3 ◯	Yes ◯ No, go to section C3 ◯

IMPORTANT: If Life Cover is selected, the amount of Serious Illness Cover cannot be higher than the amount of Life Cover.

Cover amount	£	£
Level of cover	Primary ◯ Comprehensive ◯	Primary ◯ Comprehensive ◯

IMPORTANT: If Life Cover is selected, the premium basis for Serious Illness Cover must to be the same as that for Life Cover.

Premium basis	Guaranteed ◯ Reviewable ◯

IMPORTANT: : If Life Cover is selected, the cover basis for Serious Illness Cover must to be the same as that for Life Cover.

If you choose the account basis to be indexed, the amount of cover will increase by Retail Prices Index (PRI) each year. Premiums will increase each year in line with RPI plus 1.5% to 3.5% up to the anniversary before your client's 80th birthday and RPI plus 5% after that. If this is a joint life plan, this will be based on the younger of the two lives covered.

Cover basis	Indexed ◯ Level ◯ Decreasing ◯	
IMPORTANT: If Life Cover is selected and cover basis is either Indexed or Level, the Serious Illness Cover term must be no longer than the Life Cover term. If Life Cover is selected and the cover basis is decreasing, the Serious Illness Cover term must be the same as the Life Cover term.		
Cover term	☐ years	☐ years
Would you like Dementia and FrailCare Cover to start after your Serious Illness Cover?	Yes ◯ No ◯	Yes ◯ No ◯

INCOME PROTECTION - SECTION C3	**Life 1**	**Life 2 (if applicable)**
Would you like Income Protection?	Yes ◯ No, go to section D. ◯	Yes ◯ No, go to section D. ◯
IMPORTANT: The maximum amount of the benefit is the monthly equivalent of 60% of the first £60,000 per annum of your earnings and 50% of earnings in excess of £60,000 per annum. For Short Term & Primary Income Protection Cover, this is subject to an overall maximum benefit of £10,000 per month. For Comprehensive Income Protection Cover, this is subject to an overall maximum benefit of £16,666.67 per month. If you have been self-employed for less than one year, your maximum benefit may be restricted.		
Level of cover	Short Term ◯ Primary ◯ Comprehensive ◯	Short Term ◯ Primary ◯ Comprehensive ◯
Do you wish to split your cover over two deferred periods?	Yes ◯ No ◯	Yes ◯ No ◯
What initial deferred period would you like? If you work as a teacher in the public sector, within the NHS or UK local councils and would like the public sector deferred period, please select a 12 month deferred period. This is only available with Primary and Comprehensive Cover. *Only available if you are self-employed.	7 days* ◯ 1 month ◯ 2 months ◯ 3 months ◯ 6 months ◯ 12 months ◯	7 days* ◯ 1 month ◯ 2 months ◯ 3 months ◯ 6 months ◯ 12 months ◯
What amount of monthly benefit would you like after the initial deferred period?	£	£
What additional deferred period would you like? Please choose one option only.	1 month ◯ 2 months ◯ 3 months ◯ 6 months ◯ 12 months ◯	1 month ◯ 2 months ◯ 3 months ◯ 6 months ◯ 12 months ◯
What additional amount of monthly benefit would you like after the additional deferred period?	£	£
Would you like us to verify the earnings that we use to calculate your maximum monthly benefit?	Yes ◯ No ◯	Yes ◯ No ◯

IMPORTANT: If you are employed, we require your three most recent payslips and P60. If you are self-employed, we require your three most recent HMRC tax computations and self-assessments, together with a copy of the accounts that relate to these. If you are a director of a limited company, we require your three most recent payslips, P60 and a copy of your most recent company accounts as submitted to HMRC and advise how many employees work in the company.

Cover term	☐ years Until age 60 ☐ Until age 65 ☐ Until age 70 ☐	☐ years Until age 60 ☐ Until age 65 ☐ Until age 70 ☐
Would you like your monthly benefit amount(s) selected above to increase in line with RPI (when not claiming)?	Yes ☐ No ☐	Yes ☐ No ☐
If you make a claim, would you like your benefit amount(s) during claim to: This question only applies if you have chosen Primary or Comprehensive Income Protection Cover.	Remain level ☐ Increase in line with RPI ☐ Increase in line with RPI +2% (Only available with Comprehensive Cover) ☐	Remain level ☐ Increase in line with RPI ☐ Increase in line with RPI +2% (Only available with Comprehensive Cover) ☐
Premium basis	Guaranteed ☐ Reviewable ☐	
At what level, and for how long, would your earnings continue from employment if you are unable to work due to sickness or accident? This may affect any benefit you receive from us	£ ☐ each month for ☐ months followed by £ ☐ each month for ☐ months	£ ☐ each month for ☐ months followed by £ ☐ each month for ☐ months

D. YOUR ADDITIONAL OPTIONS AND BENEFITS

PREMIUM AND INTEREST RATE OPTIMISER - SECTION D1

IMPORTANT: Available with Whole of Life Cover with Guaranteed premium benefits.

Would you like to add either Premium Optimiser or Interest Rate Optimiser?	Premium Optimiser ☐ Interest Rate Optimiser ☐ No ☐

IMPORTANT: These optimisers will give you an upfront premium discount, compared to standard Whole of Life products. With Premium Optimiser, your premium will increase at a fixed 2.5% annually. With Interest Rate Optimiser, the annual premium increase depends upon Long Term Interest Rates. The Long Term Interest Rate is defined as the 20 year rate from the Bank of England's UK government liability nominal spot rate curve. This is a publicly available rate and the current rate can be accessed at adviser.vitality.co.uk/wol.

LIFESTYLECARE COVER - SECTION D2

IMPORTANT: Available on Whole of Life Cover single life plans. Unavailable on Serious Illness Cover and Income Protection.

Would you like to include LifestyleCare Cover?	Yes ☐ No, please go to section D3. ☐
Cover amount This cannot exceed £250,000 and 100% of the Whole of Life Cover amount.	£ ☐
Would you like LifestyleCare Cover Protector?	Level 1 ☐ Level 1 & 2 ☐ No ☐

PROTECT YOUR COVER - SECTION D3	
IMPORTANT: Available with Serious Illness Cover.	
Would you like to protect your cover?	Yes, with Protected Life Cover ◯ Yes, with Protected Life and Serious Illness Cover ◯ No ◯
IMPORTANT: If you wish to place your plan into trust for Inheritance Tax planning purposes, you must protect your cover.	

SERIOUS ILLNESS COVER BOOSTER - SECTION D4	**Life 1**	**Life 2 (if applicable)**
IMPORTANT: Available with Serious Illness Cover.		
Would you like to add Serious Illness Cover Booster?	Yes ◯ No ◯	Yes ◯ No ◯

FAMILY INCOME COVER - SECTION D5	**Life 1**	**Life 2 (if applicable)**
IMPORTANT: Available on all our core covers.		
Would you like Family Income Cover?	Yes ◯ No, go to section D6 ◯	Yes ◯ No, go to section D6 ◯
Cover type	Primary ◯ Comprehensive ◯	Primary ◯ Comprehensive ◯
Monthly cover amount	£	£
Cover term Term must be shorter than the longest term of core cover selected.	years	years
Would you like your cover to be indexed?	Yes ◯ No ◯	Yes ◯ No ◯
Premium basis	Guaranteed ◯ Reviewable ◯	Guaranteed ◯ Reviewable ◯
Guaranteed payment term The standard is 1 year for Primary and 2 years for Comprehensive.	1 year / 2 years ◯ 5 years ◯ 10 years ◯	1 year / 2 years ◯ 5 years ◯ 10 years ◯
Payment options	On death or terminal illness ◯ On death, terminal illness or serious illness ◯	On death or terminal illness ◯ On death, terminal illness or serious illness ◯

EDUCATION COVER - SECTION D6	**Life 1**	**Life 2 (if applicable)**
IMPORTANT: Available on all our core covers.		
Would you like Education Cover?	Yes ◯ No ◯	Yes ◯ No ◯
Payment options	On death or terminal illness ◯ On death, terminal illness or serious illness ◯	On death or terminal illness ◯ On death, terminal illness or serious illness ◯

Please provide details of the children you would like to cover.
If you would like to cover more than four children, please continue on a separate sheet.

Child	First name(s)	Surname	Gender	Date of Birth
1			M F	D D M M Y Y Y Y
Type of school		State school ◯ Private school ◯	Private school with boarding ◯	
2			M F	D D M M Y Y Y Y
Type of school		State school ◯ Private school ◯	Private school with boarding ◯	
3			M F	D D M M Y Y Y Y
Type of school		State school ◯ Private school ◯	Private school with boarding ◯	
4			M F	D D M M Y Y Y Y
Type of school		State school ◯ Private school ◯	Private school with boarding ◯	

DISABILITY COVER - SECTION D7	Life 1	Life 2 (if applicable)
IMPORTANT: Available on all of our core covers.		
Would you like Disability Cover?	Yes ◯ No ◯	Yes ◯ No ◯
Monthly cover amount	£	£
Level of cover	Leve 1 ◯ Level 2 ◯ Level 3 ◯	Leve 1 ◯ Level 2 ◯ Level 3 ◯
Cover term	Until age 65 exactly ◯ Until age 70 exactly ◯ years	Until age 65 exactly ◯ Until age 70 exactly ◯ years

OPTIONAL SERIOUS ILLNESS COVER FOR CHILDREN - SECTION D8	
IMPORTANT: Available on all of our core covers.	
Would you like to add Optional Serious Illness Cover for Children?	Yes ◯ No, please go to section D9 ◯
Cover amount (per child) This cannot exceed the greater of your Life Cover or Serious Illness Cover amounts.	£

Cover type	Primary ◯ Comprehensive ◯

Please provide details of the children you would like to cover.
If you would like to cover more than four children, please continue on a separate sheet.

Child	First name(s)	Surname	Gender	Date of Birth
1			M F	D D M M Y Y Y Y
2			M F	D D M M Y Y Y Y
3			M F	D D M M Y Y Y Y
4			M F	D D M M Y Y Y Y

WAIVER OF PREMIUM OPTIONS - SECTION D9	Life 1	Life 2 (if applicable)
IMPORTANT: In the event of a claim, the benefits we pay under any of the Waiver of Premium options will cover all premiums for Life 1 and Life 2 (if applicable).		
Would you like Waiver of Premium on death? This benefit is only available on joint life plans, where the other life assured has selected Income Protection Cover.	Yes ◯ No ◯	Yes ◯ No ◯
Would you like Waiver of Premium on Serious Illness? This benefit is not available if Life Cover and/or Serious Illness Cover at 100% are the only benefits selected.	Yes ◯ No ◯	Yes ◯ No ◯
Would you like Waiver of Premium on Incapacity? If Comprehensive Income Protection Cover has been selected, then Waiver of Premium on Incapacity is also required.	Yes ◯ No ◯	Yes ◯ No ◯
What deferred period would you like for Waiver of Premium for Incapacity? Choose one option only.	7 days (self-employed only) ◯ 1 month ◯ 2 months ◯ 3 months ◯ 6 months ◯ 12 months ◯	7 days (self-employed only) ◯ 1 month ◯ 2 months ◯ 3 months ◯ 6 months ◯ 12 months ◯

E. YOUR HEALTHY LIVING OPTION

OPTIMISER - SECTION E1	Life 1	Life 2 (if applicable)
IMPORTANT: If you would like a Healthy Living Option, please only select one.		
Would you like Wellness Optimiser?	Yes ◯ No ◯	Yes ◯ No ◯
Would you like Vitality Optimiser?	Yes ◯ No ◯	Yes ◯ No ◯

Vitality Lite: If you have chosen Wellness Optimiser or Vitality Optimiser and your monthly premium is under £30 for single life plans or under £40 for joint life plans, before the Vitality fee is added, then Vitality Lite will automatically be added to your plan. This includes an upfront discount, the opportunity to control your future premiums and the opportunity to earn cashback. You also get access to a number of discounts and rewards.

Vitality Plus: If your monthly premium is £30 or over for single life plans or £40 or over for joint life plans, before the Vitality fee is added, you automatically get Vitality Plus with Vitality or Wellness Optimiser added to your plan. This includes all of the above and access to our extended range of rewards and discounts.

VITALITY PLUS - SECTION E2	Life 1	Life 2 (if applicable)
Would you like Vitality Plus?	Yes ◯ No ◯	Yes ◯ No ◯

This gives you a range of rewards and discounts to keep you motivated, including discounted gym membership, a cinema ticket and money off travel and accommodation. The higher your Vitality Status the bigger the rewards, and the higher the discount you'll receive. Please note, certain Vitality rewards and benefits are only available for those who are 18 years and over.

F. EXISTING COVER

EXISTING COVER	Life 1	Life 2 (if applicable)
Do you already have any Life Cover, Critical Illness / Serious Illness or Income Protection Cover with VitalityLife (formerly known as PruProtect)?	Yes ◯ No ◯ Plan number	Yes ◯ No ◯ Plan number
Within the last 12 months have you applied for any other cover with VitalityLife, regardless of whether a plan has been issued or not? If 'Yes' please provide full details of the cover and reason declined.	Yes ◯ No ◯	Yes ◯ No ◯
Including this application, will the total amount of Life cover you have for all purposes exceed £1.5 million or £500,000 for Serious Illness / Critical Illness cover? (Ignore cover that will be cancelled and applications that are for comparative purposes only, but include any further cover you intend to apply for in the next 6 months)	Yes ◯ No ◯	Yes ◯ No ◯

G. LIFESTYLE AND HEALTH DETAILS - STANDARD UNDERWRITING

OCCUPATION - SECTION G1	Life 1	Life 2 (if applicable)
What is your main occupation? Please enter an occupation with the closest match online. This will help us process your application as quickly as possible.		
IMPORTANT: Additional information may be required for specific occupations, such as percentage of time working at heights or whether working on oil rigs outside the North Sea or UK waters. Please capture these details if applicable.		
More information, if applicable		
Do you work in or with the Armed Forces or reserve forces? Even if you have already selected an armed forces occupation title, you must answer 'Yes' to this question if applicable.	Yes ◯ No ◯	Yes ◯ No ◯
Please indicate whether you work full time in the Armed Forces, are a Reservist or whether you work with or for the Armed Forces as a civilian: • Full time in the Armed Forces • As a civilian attached to the Armed Forces • As a Reservist. If 'Yes', do you work with the Reservists on a full time basis?	Yes ◯ No ◯ Yes ◯ No ◯ Yes ◯ No ◯	Yes ◯ No ◯ Yes ◯ No ◯ Yes ◯ No ◯
Are you currently on, or have you received confirmation / notification that you are due to go on, an Operational Tour of Duty outside of the UK to a hazardous country in the next 12 months? This includes an Operational Tour of Duty with the United Nations. Hazardous countries include Afghanistan, Burundi, Central African Republic, Chad, Congo, Cote d'Ivoire, Guinea, Haiti, Iraq, Kyrgyzstan, Libya, Mali, Pakistan, Somalia, Sudan, South Sudan, Syria, Yemen and Zimbabwe. If 'Yes', what is the nature of the tour of duty e.g. combat, peace keeping, training and support (self and others), humanitarian etc? Please give details When will your posting start and how long do you expect it to last? What regions within this country or countries will you be posted to during your tour?	Yes ◯ No ◯	Yes ◯ No ◯

IMPORTANT: You do not need to complete the following two questions if you work purely as a civilian attached to the Armed Forces.		
Do you work in any branch of the Special Forces (e.g. SAS, SBS, SFSG)?	Yes ☐ No ☐	Yes ☐ No ☐
Do your normal duties involve bomb disposal, mine clearance, diving, flying in helicopters (as aircrew) or fast jets? If 'Yes', please give a description of your duties.	Yes ☐ No ☐	Yes ☐ No ☐
IMPORTANT: If you have or you are applying for Life Cover only, please go to section G2 - Travel and Residency		
Do you work less than 16 hours per week? If you are unemployed, a student, a houseperson, retired or a pensioner then answer 'No' to this question.	Yes ☐ No ☐	Yes ☐ No ☐
Apart from commuting between your home and fixed place of work, does your job involve driving more than 25,000 miles per year?	Yes ☐ No ☐	Yes ☐ No ☐

TRAVEL AND RESIDENCY - SECTION G2	**Life 1**	**Life 2 (if applicable)**
In the next 12 months, do you intend spending more than 4 weeks overall (i.e. in total across all of these areas) in the Middle East, Africa, Central or South America, Asia (ignore Japan, Hong Kong and Singapore), Ukraine, Russia or New Guinea? If 'Yes', please provide details of country(s), whether currently living in that country, duration of stay (past and future), reason for stay, area (i.e. town/city).	Yes ☐ No ☐	Yes ☐ No ☐
In the last 5 years have you spent more than 3 consecutive months in Africa, India, Thailand or the Caribbean (includes Antigua, Bahamas, Barbados, Bermuda, Cuba, Dominican Republic, Grenada, Haiti, Jamaica, Trinidad and Tobago)? If 'Yes', please provide details of country(s), duration of stay, whether a UK citizen or have right to permanently stay in UK	Yes ☐ No ☐	Yes ☐ No ☐

HAZARDOUS PURSUITS/HOBBIES - SECTION G3	Life 1	Life 2 (if applicable)
Do you take part in or intend to start within the next 12 months any hazardous pastimes? E.g. water sports, diving, mountaineering, aviation sports including parachuting, motor sports, extreme sports etc. You can ignore one off experiences. If 'Yes' please complete the following questionnaire: • Name of activity(s) – include names of ALL aspects of the activity you take part in. If activity is skiing, please advise whether you ever go off piste, heli-skiing or ski mountaineering • Please list any qualification(s) • Where do you take part in this activity(s) i.e. venue type, area of the world etc? • How many times a year do you take part? • Do you ever take part alone? • If applicable, what heights/depths do you go to?	Yes ☐ No ☐ Yes ☐ No ☐ height depth	Yes ☐ No ☐ Yes ☐ No ☐ height depth

LIFESTYLE - SECTION G4	Life 1	Life 2 (if applicable)
Have you ever been advised to reduce your alcohol intake because you were drinking too heavily? If 'Yes' please provide full details of treatment or advice given.	Yes ☐ No ☐	Yes ☐ No ☐
In the last 10 years have you ever taken recreational drugs such as cannabis, ecstasy, cocaine, methadone, heroin, anabolic steroids or similar substances? If 'Yes' please provide details including, type of drugs used, dates, how often (i.e. regularly or as an experiment) and circumstances (i.e. party, university etc).	Yes ☐ No ☐	Yes ☐ No ☐

IMPORTANT: This information may be sent in confidence to our Chief Medical Officer

FAMILY MEDICAL HISTORY - SECTION G5	Life 1	Life 2 (if applicable)
Before the age of 60, have any members of your immediate family (natural parents, brothers or sisters) had any of the following medical conditions: Breast, Ovarian, Colon or Bowel Cancer, Heart Attack, Angina, Cardiomyopathy, Diabetes, Multiple Sclerosis, Muscular Dystrophy, Parkinson's, Dementia / Alzheimer's Disease, Huntington's, Motor Neurone Disease or Polycystic Kidney Disease? If 'Yes' please provide details of age of relative at the time they were diagnosed, relationship to you and whether you have had any screening or investigations for this condition yourself.	Yes ☐ No ☐	Yes ☐ No ☐

YOUR HEALTH - SECTION G6	Life 1	Life 2 (if applicable)
Have you ever had or do you currently have any of the following: If 'Yes', please complete the relevant Medical Disclosure questionnaire with full details on page 35.		
Cancer, leukaemia, Hodgkin's disease, lymphoma, brain or spinal tumour?	Yes ☐ No ☐	Yes ☐ No ☐
Heart disease or disorder, including heart attack, angina, cardiomyopathy, heart murmur, heart surgery or procedure, palpitations, irregular heart beat or chest pain?	Yes ☐ No ☐	Yes ☐ No ☐
Stroke, transient ischaemic attack (TIA), brain haemorrhage or permanent brain injury through an accident?	Yes ☐ No ☐	Yes ☐ No ☐
Multiple sclerosis, optic neuritis, epilepsy, paralysis, muscular dystrophy, Parkinson's disease, dementia or Alzheimer's disease, cerebral palsy, motor neurone disease or any disorders of the brain or nerves?	Yes ☐ No ☐	Yes ☐ No ☐
Diabetes, sugar in the urine, blood sugar or thyroid problems?	Yes ☐ No ☐	Yes ☐ No ☐
Schizophrenia, bipolar disorder / manic depression or have you ever required hospital treatment as an inpatient for any mental illness?	Yes ☐ No ☐	Yes ☐ No ☐
Have you ever tested positive for HIV, Hepatitis B or Hepatitis C or are you awaiting the results of such a test? Note: if the result is negative, the fact of having an HIV test will not, in itself, have any effect on your acceptance terms for insurance.	Yes ☐ No ☐	Yes ☐ No ☐

IMPORTANT: Please complete the additional medical questionnaire(s) for each disclosure and provide as much information as possible.

YOUR HEALTH IN THE LAST 5 YEARS - SECTION G7	**Life 1**	**Life 2 (if applicable)**
Apart from any condition you have already told us about, have you had any of the following in the last 5 years: If 'Yes', please complete the relevant Medical Disclosure questionnaire with full details on page 35.		
Lump, cyst, growth or skin lesion of any kind, or a mole or freckle that has bled, become painful, itchy, changed colour, increased in size or that you have been advised to monitor (including photographic surveillance)?	Yes ☐ No ☐	Yes ☐ No ☐
Raised blood pressure or raised cholesterol, Deep Vein Thrombosis, disease or disorder of the blood vessels including the aorta and arteries of the leg or neck or any condition affecting the blood such as anaemia or thalassaemia?	Yes ☐ No ☐	Yes ☐ No ☐
Numbness, tremor, tingling, pins and needles, dizziness, facial pain or visual disturbance including blurred or double vision?	Yes ☐ No ☐	Yes ☐ No ☐
Seizures, fits, fainting, blackouts or memory loss?	Yes ☐ No ☐	Yes ☐ No ☐
Any disorder of the digestive system, liver, stomach, oesophagus, pancreas, colon or bowel, including hepatitis, colitis or Crohn's disease? Please ignore minor indigestion, heartburn, appendicitis (operated and fully recovered) or irritable bowel syndrome (IBS) that only cause occasional mild discomfort and for which you have not required investigation or hospital referral and none are planned.	Yes ☐ No ☐	Yes ☐ No ☐
Any disorder of the kidneys, bladder or prostate, including blood or protein in the urine or urinary tract infection?	Yes ☐ No ☐	Yes ☐ No ☐
Any mental disorder, including stress, anxiety, panic attacks, depression or continuous fatigue, tiredness, fibromyalgia or eating disorders?	Yes ☐ No ☐	Yes ☐ No ☐
Any respiratory or lung disorder, including asthma, bronchitis, COPD (COAD), emphysema or sleep apnoea?	Yes ☐ No ☐	Yes ☐ No ☐

Any pain or other problems relating to your back, neck, joints, bones or muscles, including arthritis, ankylosing spondylitis, rheumatism or gout. Simple muscle strain, sprains or fractures of limbs that you have fully recovered from can be ignored. There is no need to answer this question if the application is life cover only.	Yes ☐ No ☐	Yes ☐ No ☐
Any disorder of the eyes or ears, including blindness or deafness, or problems with your sight or difficulty hearing? Conjunctivitis, sight problems fully corrected by glasses, contact lenses or laser eye treatment for short/long sight or cosmetic reasons, or simple earache or ear infections that have cleared up with no ongoing hearing loss can be ignored. There is no need to answer this question if the application is life cover only.	Yes ☐ No ☐	Yes ☐ No ☐
Any gynaecological disorder including abnormal cervical smears or breast conditions which have required investigations, referral to a specialist or treatment? Infertility treatment, miscarriage/ termination, uncomplicated pregnancy/ caesarean section, thrush, routine scan/blood test for pregnancy, routine cervical smear (normal result), HRT (no investigations involved) can be ignored. Only applicable where the life assured is Female. There is no need to answer this question if the application is life cover only.	Yes ☐ No ☐	Yes ☐ No ☐
In the last 5 years have you required more than 2 weeks off work for any medical condition, illness or injury not already mentioned. Please ignore flu or colds from which you've fully recovered and pregnancy where no complications were present.	Yes ☐ No ☐	Yes ☐ No ☐

IMPORTANT: If answered 'Yes' to any of these questions please complete the additional medical questionnaire(s) for each disclosure and provide as much information as possible.

YOUR HEALTH IN THE LAST 5 YEARS - SECTION G8	**Life 1**	**Life 2 (if applicable)**

IMPORTANT: For question 8, please see the list of minor conditions and treatments that can be ignored below.

Acne	Haemorrhoids/piles	Routine wellman/woman check (normal results)
Appendicitis (operated and fully recovered)	Hay fever	Shingles

Athletes foot	HRT (no investigations involved)	Simple fracture of limbs (fully recovered)
Bunion	Indigestion/heartburn/IBS (no investigations required)	Sprains (fully recovered)
Cold sore	Infertility treatment	Thrush
Cold/flu	In growing toe nail	Tonsillitis
Common childhood diseases (fully recovered)	Miscarriage/termination	Uncomplicated pregnancy / caesarean
Conjunctivitis	Muscle strain (fully recovered)	Vasectomy
Ear syringing	Routine cervical smear (normal result)	Verruca
Food poisoning (fully recovered)	Routine scan/blood test for pregnancy	Wisdom teeth removed

In the last 6 months have you experienced any unintentional or unexplained weight loss?	Yes ☐ No ☐	Yes ☐ No ☐
Apart from anything you have already told us about in this form, within the last 2 years have you had any medical condition, illness or injury that you have received treatment for over a continuous period of 2 weeks or more?	Yes ☐ No ☐	Yes ☐ No ☐
Apart from anything you have already told us about in this form, within the last 2 years have you undergone any investigation such as blood tests, scans or biopsies? If so, for what condition, or suspected condition?	Yes ☐ No ☐	Yes ☐ No ☐
Apart from anything you have already told us about in this form, do you have any impairment or medical complaints that you intend seeking medical advice for, or are you currently awaiting the results of any investigations? If 'Yes", please provide as much information as possible.	Yes ☐ No ☐	Yes ☐ No ☐

H. YOUR DOCTOR'S DETAILS

DOCTOR'S DETAILS	**Life 1**	**Life 2 (if applicable)**
IMPORTANT: If applicable, please tick here if the Life 1 and Life 2 have the same doctor. ☐		
Doctor's name		

Clinic/surgery address		
Telephone number		
I give permission for VitalityLife to share my personal and medical information with my named GP for the purpose of this application	Yes ☐ No ☐	Yes ☐ No ☐

I. PLAN OWNER DETAILS

PLAN OWNER DETAILS - SECTION I1	**Plan owner**
Plan owner's name	
Plan owner type	Life Assured ☐ Company ☐ Individual ☐ Trustee(s) ☐ Group of Individuals ☐

IMPORTANT: If you have selected Individual/Trustee(s)/Group of Individuals as the plan owner type, please complete section I2, section I3 and section I4 (if applicable).

If you have selected Life Assured, please complete section I3.

If you have selected Company, please complete the information in section I5.

IMPORTANT: If you have selected Individual/Trustee(s)/Group of Individuals as the plan owner type, please complete the information below.

INDIVIDUAL/TRUSTEE(S)/GROUP OF INDIVIDUALS PLAN OWNER DETAILS – SECTION I2	
Title	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐
First name(s)	
Surname	
Date of birth	D D M M Y Y Y Y
Contact telephone number(s)	
Email address	
Address for correspondence	
Postcode	
Relationship to the life(s) assured	

Would you like us to correspond with this plan owner in relation to the plan?	Yes ◯ No ◯	
	Life 1	**Life 2 (if applicable)**
I confirm that consent has been given by the life assured to share the medical information and plan documents with the plan owner(s) in relation to this plan	Yes ◯ No ◯	Yes ◯ No ◯

PLAN INFORMATION FURTHER DETAILS – SECTION I3	
Do you have a Property and Financial Affairs Lasting Power of Attorney (LPA) or an Enduring Power of Attorney (EPA)?	Yes ◯ No ◯ If 'Yes', you can send us a certified true copy of the registered LPA or EPA and we can keep a copy on file to expedite the process in the event of your attorney(s) needing to correspond with us on your behalf.

IMPORTANT: For more information about LPAs, please visit https://www.gov.uk/power-of-attorney. For more information about EPAs please visit https://www.gov.uk/use-or-cancel-an-enduring-power-of-attorney.

Marketing preferences – optional

Vitality Corporate Services Limited would like to send the plan owner information about our products and future products, which currently include health and life insurance, investments and general insurance. We are focused on bringing exciting new products to them and to enhance those already available by offering improved services and benefits as a Vitality member.

Please let us know how they'd like to hear about the latest updates from us.

Email ◯ Post ◯ SMS/text ◯ Social media ◯ Telephone ◯ No contact ◯

We will not share their personal data with any other companies for marketing purposes.

They can change their mind about how they would like to receive marketing information about our products and services at any time. They can manage their preferences on our website, call our customer services team or they can unsubscribe, using the unsubscribe link on emails that we send to them. For SMS/text messages, follow the opt-out instructions on the message.

IMPORTANT: If you have selected Individual/Trustee(s)/Group of Individuals as the plan owner type and there is more than one plan owner please also complete the information below.

INDIVIDUAL/TRUSTEE(S)/GROUP OF INDIVIDUALS PLAN OWNER DETAILS – SECTION I4	
Title	Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Other ◯
First name(s)	
Surname	
Date of birth	D D M M Y Y Y Y
Contact telephone number(s)	
Email address	

Address for correspondence		
Postcode		
Relationship to the life(s) assured		
Would you like us to correspond with this plan owner in relation to the plan?	Yes ◯ No ◯	
	Life 1	**Life 2 (if applicable)**
I confirm that consent has been given by the life assured to share the medical information and plan documents with the plan owner(s) in relation to this plan	Yes ◯ No ◯	Yes ◯ No ◯
Do you have a Property and Financial Affairs Lasting Power of Attorney (LPA) or an Enduring Power of Attorney (EPA)?	Yes ◯ No ◯ If 'Yes', you can send us a certified true copy of the registered LPA or EPA and we can keep a copy on file to expedite the process in the event of your attorney(s) needing to correspond with us on your behalf.	

IMPORTANT: For more information about LPAs, please visit https://www.gov.uk/power-of-attorney. For more information about EPAs please visit https://www.gov.uk/use-or-cancel-an-enduring-power-of-attorney.

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Please let us know how they'd like to hear about the latest updates from us.

Email ◯ Post ◯ SMS/text ◯ Social media ◯ Telephone ◯ No contact ◯

We will not share their personal data with any other companies for marketing purposes.

They can change their mind about how they would like to receive marketing information about our products and services at any time. They can manage their preferences on our website, call our customer services team or they can unsubscribe, using the unsubscribe link on emails that we send to them. For SMS/text messages, follow the opt-out instructions on the message.

COMPANY DETAILS – SECTION I5

Address for correspondence	
Postcode	
Relationship to the life assured e.g. employer	

COMPANY CONTACT DETAILS

IMPORTANT: We will correspond with the person named below in relation to the plan.

Title	Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Other ◯	
First name		
Surname		
Date of birth	D D M M Y Y Y Y	
Job title		
Contact telephone number(s)		
Email address		
Address for correspondence		
Postcode		
	Life 1	**Life 2 (if applicable)**
I confirm that consent has been given by the life assured to share the medical information and plan documents with the plan owner(s) in relation to this plan	Yes ◯ No ◯	Yes ◯ No ◯
Do you have a Property and Financial Affairs Lasting Power of Attorney (LPA) or an Enduring Power of Attorney (EPA)?	Yes ◯ No ◯ If 'Yes', you can send us a certified true copy of the registered LPA or EPA and we can keep a copy on file to expedite the process in the event of your attorney(s) needing to correspond with us on your behalf.	

IMPORTANT: For more information about LPAs, please visit https://www.gov.uk/power-of-attorney. For more information about EPAs please visit https://www.gov.uk/use-or-cancel-an-enduring-power-of-attorney.

Marketing preferences – optional

Vitality Corporate Services Limited would like to send the plan owner information about our products and future products, which currently include health and life insurance, investments and general insurance. We are focused on bringing exciting new products to them and to enhance those already available by offering improved services and benefits as a Vitality member.

Please let us know how they'd like to hear about the latest updates from us.

Email ◯ Post ◯ SMS/text ◯ Social media ◯ Telephone ◯ No contact ◯

We will not share their personal data with any other companies for marketing purposes.

They can change their mind about how they would like to receive marketing information about our products and services at any time. They can manage their preferences on our website, call our customer services team or they can unsubscribe, using the unsubscribe link on emails that we send to them. For SMS/text messages, follow the opt-out instructions on the message.

J. PLAN INFORMATION

IMPORTANT: This section is for the Financial Adviser, please ensure all questions are completed.

ADVISER DETAILS - SECTION J1

FCA Regulatory Number	
Adviser's first name(s)	
Adviser's surname	
Agency details – VitalityLife Agency Number	

IMPORTANT: Advisers that only have permissions to carry out insurance mediation on non-investment insurance contracts (i.e. pure protection business under the Insurance Conduct of Business "ICOBS" regime) will only be able to answer question 1 as 'No', since they will not have regulatory permissions to advise or arrange investment business.

Advisers who hold permissions to advise or arrange investment business as well as non-investment insurance contracts will need to consider whether this quote/application for VitalityLife is associated with advice on investment business and answer question 1 as 'Yes' or 'No' as appropriate.

1. Is the protection sale associated with advice on investment business as per the FCA Retail Distribution Review?	Yes ☐ No ☐
2. How would you like to be remunerated on this VitalityLife business?	Commission ☐ Fee or other adviser charge ☐ Mix of commission and fee or other adviser charge ☐
3. If you are being remunerated by commission (whether in full or in part), are you intending to rebate/sacrifice a proportion of commission? If so, what percentage of commission is to be discounted (rebated)?	Yes ◯ No ◯ %

IMPORTANT: Advisers who answered question 1 as 'Yes' and are being remunerated for any subsequent VitalityLife plan by commission in question 2 are required under FCA rules to disclose the commission on the illustration. Therefore, in this circumstance question 4 should be answered as "Yes".

4. Do you want to disclose the commission on the illustration?	Yes ◯ No ◯

PLAN CORRESPONDENCE AND OPTIONS - SECTION 2

Please provide us with your client's email address so we can send them information about their plan. We will send your client correspondence regarding their plan via email or via a secure online inbox located on our Member Zone.	First (or only) life email address: Second life (if applicable) email address:

Does they wish to receive plan correspondence via post only?	Only by post ◯
Who shall we send the acceptance letter to?	Direct to the plan owner, with copy to you ◯ Both to you ◯
Who shall we send the plan documents to?	Direct to the plan owner, with copy to you ◯ Both to you ◯

K. PAYMENT DETAILS

IMPORTANT: : If your client has selected monthly, premiums must be paid by Direct Debit. If your client has selected annual, the plan premium can be paid for by either Direct Debit or Electronic Fund Transfer (EFT). Electronic Fund Transfers (EFT) must be made into the following account. Please ensure you include the plan number as the reference to avoid delays in allocating the payment to the plan.

Bank account name: VitalityLife
Bank: HSBC
Sort Code: 400250
Bank account number: 81359118
Reference number: Your plan number followed by AB

How does your client wish to pay their premiums?	Monthly ◯ Annually ◯

IMPORTANT: Please only complete the following information if your clients are paying by Direct Debit.

How does your client wish to complete their direct debit instruction?	Paperless ◯ Paper with client signature ◯
I have chosen to obtain client signatures on direct debit:	Yes ◯ No ◯
First (or only) life assured name or payer name To be completed by the Financial Adviser.	
Date of Birth To be completed by the Financial Adviser.	☐☐☐☐☐☐☐☐
On what date of the month would you like us to collect the premiums? This must be between the 1st and 28th of the month.	☐ of the month

IMPORTANT: If your client has elected to pay via Direct Debit, please complete the Direct Debit form on page 27.

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INSTRUCTION TO YOUR BANK OR BUILDING SOCIETY TO PAY BY DIRECT DEBIT

i **NOTE:** Please fill in the form and send to: **FREEPOST VitalityLife, Sheffield, S95 1BW.**

Name(s) of account holder(s)

Reference number (please complete)

Bank/Building Society account number

Service user number

2	9	8	4	9	7

Branch Sort Code

__ - __ - __

Instruction to your Bank or Building Society

Please pay VitalityLife 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 VitalityLife and, if so, details will be passed electronically to my Bank/Building Society.

Name and full postal address of your Bank or Building Society

To: The manager

Bank/Building Society

Bank or Building Society address

Postcode

Signature(s)

✕

✕

Date D D M M Y Y Y Y

Banks and Building Societies may not accept Direct Debit Instructions from 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 VitalityLife will notify you at least 5 working days in advance of your account being debited or as otherwise agreed. If you request VitalityLife 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 VitalityLife 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 VitalityLife 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.

THE DIRECT DEBIT GUARANTEE

L. ACCESS TO MEDICAL REPORTS ACT 1988

IMPORTANT: Please read and sign this declaration relating to your medical records.

We may need to get medical reports to support your claim, Before we can ask any doctor that you have consulted to fill in a report, we need your permission under the Access to Medical Reports Act 1988. Your rights under the Act are as follows:

You do not need to give your permission, but if you do not, we may not be able to go ahead with your claim.

You can ask to see the report before the doctor returns it to us. If this is the case, we will tell the doctor to keep the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.

If you choose not to see the report at this stage, you may ask the doctor for a copy within six months of it being 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 think that any part of the report is not correct or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him or her to attach a statement outlining your views, which will then accompany the report.

Your doctor can withhold access to the report if he or she feels that it would cause physical or mental harm to you or others.

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

- Your current health
- Any care, medication or treatment you are currently receiving
- The results of referrals or tests you are 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, consultations 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;
  - musculo-skeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles;
- 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 have told your doctor about

We have asked your doctor not to reveal information about:

- Negative tests for 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 have not inherited a condition your family suffers from

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

- Refusing to provide insurance;
- Increasing premiums above standard rates; or
- Setting premiums at standard rates

If you have any questions about your rights under the Act or questions relating to the process of getting, assessing or storing medical information, please write to:

Chief Medical Officer, VitalityLife, Sheffield, S95 1BW.

IMPORTANT NOTES

Claim payments will not start until we have assessed and accepted your claim. During this period, premiums must be kept up to date.

We may ask you to contact your doctor if we are waiting for reports which we have asked for.

If we ask you to come for a medical examination, we will need to share the application information with another company we have authorised. They will make the arrangements for the examination to take place.

We may need to send your claim form and relevant medical reports and financial information to our reinsurers for their opinion. Or, we may need to send them at a later stage for purposes relating to managing the claim. You can get details of general reassurance principles and details of any company we use to assess your claim, from our head office:

Claims, VitalityLife, Sheffield, S95 1BW.

We have a confidentiality policy in place which means we hold your medical information securely and access is limited to authorised individuals who need to see it.

L. ACCESS TO MEDICAL REPORTS ACT 1988 - CONTINUED

DECLARATION

How we use your personal data

You are entitled to ask for a copy of our standard terms and conditions and a copy of your application form at any time. It is our policy to obtain a random sample of medical reports shortly after acceptance of insurance contracts to monitor the accuracy and completeness of the information given. By signing this declaration you will be giving us the right to request a medical report. We will write to tell you if we require such a report. Your rights under the Access to Medical Reports Act 1988 remain the same. In the event that the medical report shows that you failed to disclose a fact that it would be reasonable to expect you to disclose, we reserve the right to reconsider the terms offered to you or cancel the policy.

Please refer to page 29 for the data protection notice. If you have any questions about this please write to:

Data Protection Officer, VitalityLife, 4th Floor, 70 Gracechurch Street, London, EC3V 0XL

For certain products we will need to process sensitive personal information such as health information.

By signing and returning this form, you consent to us processing your sensitive information.

- I/We agree to you asking any doctor I /we have consulted about my/our physical or mental health to provide medical information so you may assess my/our proposal. You may gather relevant information from other insurers about any other applications for life, critical illness, sickness, disability, accident or private medical insurance that I/we have applied for. I/We authorise those asked to provide medical information when they see a copy of this consent form. This form allows you to gather medical reports within six months of the start of the Plan, or after my/our death, to support any claim made on the Plan proceeds.
- This information can also be used to maintain management information for business analysis.
- I/We have read the declaration, important notes and information relating to my rights under the Access to Medical Reports Act 1988.

SIGNATURE OF FIRST (OR ONLY) LIFE ASSURED	
Full name	Date of birth D D M M Y Y Y Y
I **do not** want to see the report before it is sent to the company. ☐	I **do** want to see the report before it is sent to the company. ☐
Signature ✕	Date D D M M Y Y Y Y

SIGNATURE OF SECOND LIFE ASSURED (IF APPLICABLE)	
Full name	Date of birth D D M M Y Y Y Y
I **do not** want to see the report before it is sent to the company. ☐	I **do** want to see the report before it is sent to the company. ☐
Signature ✕	Date D D M M Y Y Y Y

TO BE COMPLETED BY THE FINANCIAL ADVISER
If you are submitting this application online in Adviser Hub, please record the application number below.
Application number:

Please fax this completed form to VitalityLife at **0870 240 0937** or post to **VitalityLife, New Business, Sheffield, S95 1BW.**

CHANGING THIS DATA PROTECTION NOTICE

This Data Protection Notice may change from time to time and you should review the contents regularly. We will notify you of any changes where we are required to do so by law.

M. FULL PAPER APPLICATION CLIENT DECLARATION, AUTHORITY AND CONSENT DECLARATION

How we use your personal data

I/We hereby certify that the answers given have been accurately re-produced, that I/we have disclosed all material facts and I/We verify the truth of the answers. Moreover, I/we authorise that they form the basis of the contract applied for. I/We understand that the nurse is bound by and will adhere to the NMC Code of Conduct at all times. In accordance with applicable Data Protection Laws (including, but not limited to all laws and regulations in the United Kingdom including the General Data Protection Regulation and the Data Protection Act 2018 and laws and regulations of the European Union, the European Economic Area and their member states, applicable to the processing of personal data and the interception of communications in place from time to time), the medical collections agent will hold information about me on their computer systems.

I/We the applicant(s) declare that, to the best of my/our knowledge and belief, the information on this form is true and complete and agree that the terms of this application and declaration and any statements made by the life or lives to be assured to VitalityLife's medical examiner together with VitalityLife's letter of acceptance will be deemed to form part of any resultant contracts.

I/We will inform you immediately of any changes that occur before the application is accepted. I/We understand that failure to do so may result in the contract being declared void, and that a claim for the proceeds may not be paid.

*I/We authorise my/our financial adviser to act on my/our behalf to amend the sum(s) to be assured or term of the assurance applied for to correspond with any alteration in detail of the mortgage from that set out in this application and to agree the commencement date of the plan with VitalityLife.

☐ *** Tick this box if you do NOT wish your Financial Adviser to act on your behalf to make changes or start the Plan**

I/We consent to VitalityLife seeking details of the mortgage from the lender.

I/We am/are aware that the income benefits I/we receive could affect the amount of any income support/income based Jobseekers Allowance, should I/We be eligible for state help.

General information

1. By returning this form to us you consent to our processing sensitive personal data about you where this is necessary.
2. Copies of the plan provisions, and the completed application form are available on request.
3. If anyone else fills in this Application on your behalf, He/She does so as your agent and not as an agent of VitalityLife. He/She does not have the authority to accept this Application on behalf of VitalityLife.
4. Completion of the direct debit instruction does NOT imply commencement of your plan assurance risk. VitalityLife's letter of acceptance will indicate when the plan will commence. In most instances your payments will be as originally quoted.
   Revised terms may be offered to you, for example if you have a birthday while your application is being processed but occasionally we may be unable to offer any terms.
5. The direct debit instruction attached is designed to enable you to pay premiums to VitalityLife with the minimum of inconvenience as and when they fall due. If the amount payable under your instruction is due to be altered, VitalityLife will advise you of details of the new amount shortly before your account is due for debiting. Direct debits under this Instruction will be originated only in respect of premiums payable in accordance with the terms of the plan for which it is drawn.
6. If the Applicant is not the life or lives to be assured, you must have sufficient insurable interest to be able to apply for the plan on this basis. If in doubt, please check with your financial adviser that sufficient insurable interest exists.

Data Protection Notice

Why should you read this notice?

We think it is important for all of our members to be made aware of what information Vitality holds about them and to have the reassurance of knowing that we comply with the data protection legislations. The following is a summary of our Privacy Policy. For details of the full Privacy Policy (effective from 25 May 2018) please visit vitality.co.uk/ privacy.

Who Vitality are?

Vitality is part of the Discovery Group of companies and is owned by Discovery Limited, a financial services firm based in South Africa.

Vitality Corporate Services Limited is an authorised intermediary of Vitality Health Limited ("VitalityHealth"), Vitality Life Limited ("VitalityLife") and ("VitalityInvest"). Together Vitality arranges and administers products provided by VitalityHealth, VitalityLife and VitalityInvest. Vitality Corporate Services Limited is the data controller for the management of interactions between us and you; VitalityHealth and VitalityLife and VitalityInvest respectively are the data controllers for the personal data and special category data that you or your representative provide to us.

M. FULL PAPER APPLICATION CLIENT DECLARATION, AUTHORITY AND CONSENT - CONTINUED

Sharing your personal data

We may need to share your personal data for legal or regulatory purposes, with your authorised representative where you have appointed an insurance or financial adviser or with other companies in order to provide our products and services.

Processing claims

In the event of a claim we may require a medical report from your GP. Such a report will only be requested with your consent and will be in compliance with the Access to Medical Reports Act 1988 ('AMRA'). The information requested from your GP will be limited to only the information relevant to your claim. You have the right to request to see the GP's report and to request any amendments be made by the GP where you consider the data to be inaccurate. The GP may agree to this at his/her discretion. You will be informed about the AMRA process at the time we request your consent to enable us to ask your GP for a report.

We may have to give some information about your plan and about your health or medical status to those involved in your treatment or care, (and/or your representative if you have consented to us doing this). Any such disclosure will be done confidentially unless you specifically instruct us otherwise.

If the claimant is aged 13 or over we will address any correspondence to the claimant in order to protect their right to confidentiality. The planholder will be informed only that a claim has been made and the value of the payment we have made; no details about the medical condition or treatment provided will be disclosed to them. If the claimant wishes to waive their right to confidentiality they should inform us at the time the claim is made.

If you have another insurance plan that covers the same costs that you are claiming from us then we may also disclose your relevant personal data to that other insurer so that we can ensure we only pay our proportion of the claim.

Your information, and that of others also covered by the plan, may be disclosed to other parties (for example other insurance companies) with a view to preventing fraudulent or improper claims.

Marketing

Vitality Corporate Services Limited would like to send you information about our products and future products, which currently include health and life insurance, investments and general insurance. We are focused on bringing exciting new products to you and to enhance those already available by offering improved services and benefits as a Vitality member.

When you purchase a product from Vitality you will be provided with access to the Member Zone where you can manage your marketing preferences and choose your preferred method of receiving information about our products, services and the benefits at any time.

You can manage your marketing preferences and choose your preferred method of receiving information about our products, services and the benefits at any time by calling our customer services team.

Data protection complaints

We want all of our members to be happy with the way their personal data, health data and medical information has been processed by us. If you are unhappy about the way we have managed your personal data we would like to know about it as we are constantly striving to ensure we do the right thing and we would like to be able to put things right.

You'll find the contact details for our complaints teams at: vitality.co.uk/legal/complaints

However, if you are still dissatisfied you have the right to contact the Information Commissioner, who regulates compliance with data protection regulation and laws at: ico.org.uk

You can also call the ICO on 0303 123 1113 or 01625 545 745, or write to them at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

If you have any queries in respect of your data protection rights or the way your personal data is processed by Vitality, please call us on 0207 133 8600, or write to us at:

Data Protection Officer
Vitality
70 Gracechurch Street
London
EC3V 0XL

All information about data protection and privacy can be found at vitality.co.uk/privacy.

M. FULL PAPER APPLICATION CLIENT DECLARATION, AUTHORITY AND CONSENT - CONTINUED

IMPORTANT: Please complete this section with your client(s) if you are using this document as a full paper application form

DECLARATION

I/We have read the information relating to My/Our rights under the General Data Protection Regulation and the Data Protection Act 2018, the declaration, important notes and general information.

I/We hereby certify that the answers given have been accurately re-produced, that I/We have disclosed all material facts and I/We verify the truth of the answers. Moreover, I/We authorise that they form the basis of the contract applied for. In accordance with applicable Data Protection Laws (including, but not limited to all laws and regulations in the United Kingdom including the General Data Protection Regulation and the Data Protection Act 2018 and laws and regulations of the European Union, the European Economic Area and their member states, applicable to the processing of personal data and the interception of communications in place from time to time), the medical collections agent will hold information about me on their computer systems.

SIGNATURE OF FIRST (OR ONLY) LIFE ASSURED	
Signature ✕	Date D D M M Y Y Y Y

SIGNATURE OF APPLICANT IF DIFFERENT	
Signature ✕	Date D D M M Y Y Y Y

WHAT ARE THE NEXT STEPS IN THE APPLICATION PROCESS?

IMPORTANT: Please follow this information if you are submitting this application online in Adviser Hub at adviser.vitality.co.uk/life/.

1) Many applications can be approved without further underwriting. However if further underwriting is required, your client will be issued a letter keeping them informed.

2) Send us the appropriate documents
   a) Detach the Access to Medical Reports Act 1988 form on pages 27-28 and return to us as indicated
   b) If you are not completing the Direct Debit instruction online, please complete the paper version and and obtain your client's signature. Please post the form to VitalityLife, Sheffield, S95 1BW.

3) If you find any errors or omissions, please call us and let us know on 0345 601 0072. You can notify us in writing on the form at the end of the confirmation schedule. If you are happy that the information in the confirmation schedule is complete and correct, you do not need to do anything further.

4) Once we have reached our underwriting decision your client will receive an acceptance letter. In some instances where special terms have been offered, we will need the client's signature before we can proceed.

5) Your client will receive their Welcome Pack including a plan schedule, plan summary and plan provisions, plus details about Vitality and how they can log into their Member Zone.

USEFUL TIP: As advisers, you can choose to receive your correspondence about the application from VitalityLife electronically via a secure inbox. In order to do so, you can update your settings in Adviser Hub. Simply click on Account Settings and update your answer for the question 'You can be kept informed of each application as it progresses through email alerts'.

MEDICAL DISCLOSURE QUESTIONNAIRES

IMPORTANT: If you provided a disclosure earlier in this form, please complete the relevant medical questionnaire and give us as much information as possible.

MEDICAL QUESTIONNAIRE – FOR DIABETES ONLY

PLEASE COMPLETE THE FOLLOWING QUESTIONS

DIABETES ONLY	**Life 1**	**Life 2 (if applicable)**
What type of diabetes do you have?	Type 1 ◯ Type 2 ◯	Type 1 ◯ Type 2 ◯
When was your diabetes first diagnosed?	D D M M Y Y Y Y	D D M M Y Y Y Y
Have you ever had a heart attack, angina, stroke, blood vessel disease, circulation problems in your legs or feet, or kidney problems? If 'Yes' please provide as much information as possible.	Yes ◯ No ◯	Yes ◯ No ◯
Have you been admitted to hospital with hyperglycaemia, hypoglycaemia, diabetic coma or any other reason related to your diabetes? If 'Yes' please provide as much information as possible, including date(s).	Yes ◯ No ◯	Yes ◯ No ◯
When was your last diabetic review, either with your GP or clinic/hospital?	D D M M Y Y Y Y	D D M M Y Y Y Y
If known, what was the result of your last HbA1c?		
If known, what was the result of your last blood pressure reading?		
Are you on medication to either treat high blood pressure, or as a preventative measure to maintain your blood pressure at acceptable levels?		
If known, what was the result of your last cholesterol level?		
Are you on medication to either treat raised cholesterol, or as a preventative measure to maintain your cholesterol at acceptable levels?		
Have you ever had any ulcers, numbness, tingling or loss of sensation in your fingers, toes, feet or legs? If 'Yes' please provide as much information as possible.	Yes ◯ No ◯	Yes ◯ No ◯
Have you ever had protein in your urine?		
Have you ever had any diabetic eye problems? If 'Yes' please provide as much information as possible, including nature of any treatment received or planned.	Yes ◯ No ◯	Yes ◯ No ◯

If you need to advise us of any other disclosures please do so below.

MEDICAL QUESTIONNAIRE – FOR HIGH BLOOD PRESSURE AND RAISED CHOLESTEROL ONLY

PLEASE COMPLETE THE FOLLOWING QUESTIONS

HIGH BLOOD PRESSURE AND RAISED CHOLESTEROL ONLY	**Life 1**	**Life 2 (if applicable)**
Please confirm whether you have been diagnosed with high blood pressure, raised cholesterol or both.		
Apart from routine follow up appointments, are you awaiting medical tests or investigations, test results, referral to a specialist, clinic or hospital for high blood pressure and/or raised cholesterol? If 'Yes' please provide details including when you were first diagnosed with your condition, any consultations or treatment you've had to date and when your next appointment or test results are due.	Yes ◯ No ◯	Yes ◯ No ◯
If you are taking medication, has this changed or increased to improve control of your condition within the last 6 months? If you are not on medication for either blood pressure or cholesterol, please select No.	Yes ◯ No ◯	Yes ◯ No ◯
For the following questions, please answer those which are relevant to your condition(s) as disclosed above:		
When did you last have your blood pressure checked by a medical professional?	D D M M Y Y Y Y	D D M M Y Y Y Y

HIGH BLOOD PRESSURE AND RAISED CHOLESTEROL ONLY	Life 1	Life 2 (if applicable)
Do you know your most recent blood pressure reading? If 'Yes' please provide your most recent reading.	Yes ◯ No ◯	Yes ◯ No ◯
If 'No', how was your latest blood pressure reading described by your doctor or nurse? · High or resistant to control · Fluctuating / variable blood pressure · Slightly higher than normal · Normal · None of the above	 Yes ◯ No ◯ Yes ◯ No ◯ Yes ◯ No ◯ Yes ◯ No ◯ Yes ◯ No ◯	 Yes ◯ No ◯ Yes ◯ No ◯ Yes ◯ No ◯ Yes ◯ No ◯ Yes ◯ No ◯
Have you had any complications of raised blood pressure, such as eye or kidney problems, or abnormal urine test results (e.g. protein or blood in the urine)?	Yes ◯ No ◯	Yes ◯ No ◯
When did you last have your cholesterol checked by a medical professional?	D D M M Y Y Y Y	D D M M Y Y Y Y
Do you know your most recent cholesterol reading? If 'Yes' please provide your most recent reading. If 'No', how was your latest cholesterol reading described by your doctor or nurse? · Raised or resistant to control · Fluctuating / variable cholesterol · Slightly higher than normal · Normal · None of the above	Yes ◯ No ◯ Yes ◯ No ◯ Yes ◯ No ◯ Yes ◯ No ◯ Yes ◯ No ◯ Yes ◯ No ◯	Yes ◯ No ◯ Yes ◯ No ◯ Yes ◯ No ◯ Yes ◯ No ◯ Yes ◯ No ◯ Yes ◯ No ◯

If you need to advise us of any other disclosures please do so below.

MEDICAL QUESTIONNAIRE – FOR MENTAL HEALTH ONLY

PLEASE COMPLETE THE FOLLOWING QUESTIONS

MENTAL HEALTH ONLY	Life 1	Life 2 (if applicable)
What symptoms did you experience and when did they start?	D D M M Y Y Y Y	D D M M Y Y Y Y
Did your condition start in reaction to a major life event such as pregnancy, bereavement, unemployment or divorce?	Yes ◯ No ◯	Yes ◯ No ◯
Have you had more than one distinct episode of this condition (i.e. recurrent episodes)?	Yes ◯ No ◯	Yes ◯ No ◯
What diagnosis was given?		
Within the last 3 years, what is the longest duration that your daily activities been restricted due to this condition (e.g. causing time off work, confinement to the house, bed rest etc)? Please answer in total days.	D D D	D D D
Please give details of medication and/or treatment taken past and present, including dates and dosage.		
Have you required any of the following to treat this condition: hospital admission, referral to a psychiatrist, Lithium medication or ECT (electroconvulsive therapy)?		
Have you ever attempted: suicide, overdose, self-harm or had suicidal thoughts If 'Yes' please provide number of occasions and when last did this occur?		
Do you have any current symptoms? If 'Yes' please provide details? If 'No' please advise when last did you experience symptoms?	Yes ◯ No ◯	Yes ◯ No ◯

If you need to advise us of any other disclosures please do so below.

MEDICAL QUESTIONNAIRE – FOR MOLES, LUMPS, CYSTS AND SKIN LESIONS ONLY

PLEASE COMPLETE THE FOLLOWING QUESTIONS

MOLES, LUMPS, CYSTS AND SKIN LESIONS ONLY	Life 1	Life 2 (if applicable)
What type of lesion does this disclosure relate to (for example, mole, freckle, cyst, lump, lipoma, growth etc)?		
Does your disclosure relate to a single occurrence or multiple occurrences?		
Please describe the area(s) of the body this disclosure relates to.		
Have you consulted your doctor about this condition?	Yes ☐ No ☐	Yes ☐ No ☐
Are you awaiting any medical tests or investigations, test results, referral to hospital or surgery for this disclosure?	Yes ☐ No ☐	Yes ☐ No ☐
If 'Yes' please provide details including all investigations performed so far, dates, results and further appointments due		
Have you ever been told any mole, growth, lump, cyst or other lesion was any of the following: cancerous, pre-cancerous, malignant, pre-malignant, BCC (Basal Cell Carcinoma) or SCC (Squamous Cell Carcinoma)?	Yes ☐ No ☐	Yes ☐ No ☐
If 'Yes' please provide details of the diagnosis including when and where this was given.		

Have you had any treatment (surgery, radiotherapy, chemotherapy, hormone therapy or tablets (other than painkillers)) for this condition? If 'Yes' please provide details, including type of treatment, whether any follow up checks were required (except to remove stitches or check wound healing following any surgery) and relevant dates.	Yes ☐ No ☐	Yes ☐ No ☐
Do you have any moles, cysts, lumps, growths or lesions still present?	Yes ☐ No ☐	Yes ☐ No ☐
Have you now been discharged from follow up, with no further consultations, investigations, treatment or monitoring due? If 'No'please provide details of all planned tests, investigations or appointments, along with all relevant dates	Yes ☐ No ☐	Yes ☐ No ☐

If you need to advise us of any other disclosures please do so below.

MEDICAL QUESTIONNAIRE – ADDITIONAL DISCLOSURE 1

ADDITIONAL DISCLOSURE 1	Life 1	Life 2 (if applicable)
What is the medical condition?		
Has the diagnosis been confirmed?	Yes ◯ No ◯	Yes ◯ No ◯
Are you having any investigations into the cause of your symptoms? When did symptoms of this condition first occur? When did you last have symptoms?	Yes ◯ No ◯	Yes ◯ No ◯
Do you have recurrent symptoms? If 'Yes', please give details of how many episodes or attacks of symptoms you have had since onset of condition and describe the nature and severity of the symptoms	Yes ◯ No ◯	Yes ◯ No ◯
Do they restrict you in any way? If 'Yes', please give details of the problems experienced	Yes ◯ No ◯	Yes ◯ No ◯
Have you seen a specialist for the condition? If 'Yes', please give their name and address, the last date you attended and whether you are still attending them or not.	Yes ◯ No ◯	Yes ◯ No ◯
What medical investigations have been performed?		
What were the results (if known) and the dates they were done?		
Have all investigations now been completed?		
Are you waiting for any follow-ups or reviews? When did you last see your GP with this condition?	Yes ◯ No ◯	Yes ◯ No ◯
How many times have you been admitted to hospital for this condition and when was the last time?	N N N	N N N
When was the last time you went to hospital as an outpatient for investigations or check-ups for this condition?		

ADDITIONAL DISCLOSURE 1	**Life 1**	**Life 2 (if applicable)**
What treatment has been prescribed? (This should include details of all oral steroid prescriptions, e.g. prednisolone.) Please continue on a separate sheet if necessary Is the treatment continuing? If 'No', when did it stop?	Yes ☐ No ☐	Yes ☐ No ☐
Is any operation planned or being considered? What type of operation? If 'Yes', when is it planned?	Yes ☐ No ☐	Yes ☐ No ☐
Have you required time off work? If 'Yes', please give the date you were first absent from work. The date you returned to work.	Yes ☐ No ☐	Yes ☐ No ☐

If you need to advise us of any other disclosures please do so below.

MEDICAL QUESTIONNAIRE – ADDITIONAL DISCLOSURE 2

ADDITIONAL DISCLOSURE 2	Life 1	Life 2 (if applicable)
What is the medical condition?		
Has the diagnosis been confirmed?	Yes ◯ No ◯	Yes ◯ No ◯
Are you having any investigations into the cause of your symptoms? When did symptoms of this condition first occur? When did you last have symptoms?	Yes ◯ No ◯ D D M M Y Y Y Y D D M M Y Y Y Y	Yes ◯ No ◯ D D M M Y Y Y Y D D M M Y Y Y Y
Do you have recurrent symptoms? If 'Yes', please give details of how many episodes or attacks of symptoms you have had since onset of condition and describe the nature and severity of the symptoms	Yes ◯ No ◯	Yes ◯ No ◯
Do they restrict you in any way? If 'Yes', please give details of the problems experienced	Yes ◯ No ◯	Yes ◯ No ◯
Have you seen a specialist for the condition? If 'Yes', please give their name and address, the last date you attended and whether you are still attending them or not.	Yes ◯ No ◯	Yes ◯ No ◯
What medical investigations have been performed?		
What were the results (if known) and the dates they were done?		
Have all investigations now been completed?		
Are you waiting for any follow-ups or reviews? When did you last see your GP with this condition?	Yes ◯ No ◯ D D M M Y Y Y Y	Yes ◯ No ◯ D D M M Y Y Y Y
How many times have you been admitted to hospital for this condition and when was the last time?	N N N D D M M Y Y Y Y	N N N D D M M Y Y Y Y
When was the last time you went to hospital as an outpatient for investigations or check-ups for this condition?	D D M M Y Y Y Y	D D M M Y Y Y Y

ADDITIONAL DISCLOSURE 2	Life 1	Life 2 (if applicable)
What treatment has been prescribed? (This should include details of all oral steroid prescriptions, e.g. prednisolone.) Please continue on a separate sheet if necessary Is the treatment continuing? If 'No', when did it stop?	Yes ◯ No ◯	Yes ◯ No ◯
Is any operation planned or being considered? What type of operation? If 'Yes', when is it planned?	Yes ◯ No ◯	Yes ◯ No ◯
Have you required time off work? If 'Yes', please give the date you were first absent from work. The date you returned to work.	Yes ◯ No ◯	Yes ◯ No ◯

If you need to advise us of any other disclosures please do so below.

MEDICAL QUESTIONNAIRE – ADDITIONAL DISCLOSURE 3

ADDITIONAL DISCLOSURE 3	Life 1	Life 2 (if applicable)
What is the medical condition?		
Has the diagnosis been confirmed?	Yes ◯ No ◯	Yes ◯ No ◯
Are you having any investigations into the cause of your symptoms? When did symptoms of this condition first occur? When did you last have symptoms?	Yes ◯ No ◯	Yes ◯ No ◯
Do you have recurrent symptoms? If 'Yes', please give details of how many episodes or attacks of symptoms you have had since onset of condition and describe the nature and severity of the symptoms	Yes ◯ No ◯	Yes ◯ No ◯
Do they restrict you in any way? If 'Yes', please give details of the problems experienced	Yes ◯ No ◯	Yes ◯ No ◯
Have you seen a specialist for the condition? If 'Yes', please give their name and address, the last date you attended and whether you are still attending them or not.	Yes ◯ No ◯	Yes ◯ No ◯
What medical investigations have been performed?		
What were the results (if known) and the dates they were done?		
Have all investigations now been completed?		
Are you waiting for any follow-ups or reviews? When did you last see your GP with this condition?	Yes ◯ No ◯	Yes ◯ No ◯
How many times have you been admitted to hospital for this condition and when was the last time?	N N N	N N N
When was the last time you went to hospital as an outpatient for investigations or check-ups for this condition?		

ADDITIONAL DISCLOSURE 3	Life 1	Life 2 (if applicable)
What treatment has been prescribed? (This should include details of all oral steroid prescriptions, e.g. prednisolone.) Please continue on a separate sheet if necessary		
Is the treatment continuing?	Yes ◯ No ◯	Yes ◯ No ◯
If 'No', when did it stop?		
Is any operation planned or being considered?	Yes ◯ No ◯	Yes ◯ No ◯
What type of operation?		
If 'Yes', when is it planned?		
Have you required time off work?	Yes ◯ No ◯	Yes ◯ No ◯
If 'Yes', please give the date you were first absent from work.		
The date you returned to work.		

If you need to advise us of any other disclosures please do so below.

Positively different.

Vitality LIFE INSURANCE

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