Protection

Business Menu Plan

Application form

You should use this form to capture the information you'll need from your client to use our online quote and apply system or submit as a paper application form.

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

Important information for each person covered

How we use your data

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

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

ABI Policy on genetic testing

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

Obtaining Medical Reports

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

Impact of misrepresentation

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

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

Important information for the plan owner

How we use your data

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

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

Key Facts documentation

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

Important information for the plan owner continued

Obtaining Medical Reports

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

Impact of misrepresentation

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

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

If your plan is not in force twelve months after the date you sign this form, we'll request a new application form.

Further help and support

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

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

Adviser use only

Adviser name	
Company name This is the company we'll process this application for.	
Account number If you know your Royal London agency account number please tell us.	
Special commission instructions Please tell us any special commission instructions such as non-indemnity.	
Company address	
Postcode	
Phone number	
Fax	
Email	
Your unique reference If you'd like us to use a reference for future correspondence, please write your unique reference here.	

Completed forms should be returned to Royal London, 22 Haymarket Yards, Edinburgh EH12 5BH.

Important information about this application form

Please tell us what this application form is for by ticking the relevant box(es).

A new Business Menu Plan only		Quote number
	Please give us the quote number and attach the quote. The quote must be attached or we won't be able to process the application.	
Replacing an existing application form that is out of date (i.e. completed over six months ago)		Application number
Alteration to an existing plan		Plan number

1 Other applicant details

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

If someone other than a person covered is to own one or more of the covers under this application, please enter their details here. Otherwise, please go to section 2.

You can only add one other person as an applicant using this application form. If more than one person wants to apply for cover on the life of the same person covered, each person must have their own quote and complete a separate application form.

If you choose Employer in the following section please make sure you complete the company payment details in section 16.

Title	Mr Mrs Miss Ms Other (please give details)
First name(s)	
Surname	
Addressee name If the other applicant is a company, please give the addressee name within the company.	
Date of birth	D D M M Y Y Y Y
What is the other applicant's relationship to the person or people covered? If you choose Employer, you must complete section 17.	Business Partner Co-shareholder Employer Other If Other, please give full details
If the other applicant's relationship to the people covered is 'employer', please tell us the nature of the business.	
In which country is the other applicant permanently resident? If the other applicant is a company, in which country is their registered address?	UK Jersey Guernsey Isle of Man Other If Other, please give full details

1 Other applicant details continued

	Person 1	Person 2
In the next six months, will the other applicant be moving from the country in which they're permanently resident?	Yes No If Yes, please give full details	
What is the other applicant's address?		
Postcode		
Email		
Phone number Please enter at least one phone number.	Daytime Mobile	Evening

If you've completed details of another applicant they must sign and date the declaration page under Other applicant on page 42.

Important information before you begin

Our underwriting process

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

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

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

2 About the people covered

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

	Person 1	Person 2
Title	Mr Mrs Miss Ms Other (please give details)	Mr Mrs Miss Ms Other (please give details)
First name(s)		
Surname		
Date of birth	D D M M Y Y Y Y	D D M M Y Y Y Y
Gender Your gender doesn't affect the premium.	Male Female	Male Female
Marital status	Married Living together as partners Divorced Widowed Single Separated Civil partnership Surviving civil partner	Married Living together as partners Divorced Widowed Single Separated Civil partnership Surviving civil partner
What is your relationship to Person 1?		Co-shareholder Business partner Employee Employer Other Other (please give details)
If the relationship to person 1 is 'company' please tell us what type of business this is.		
Your home address		
Postcode		

2 About the people covered continued

	Person 1	Person 2
In which country are you permanently resident?	UK ☐ Jersey ☐ Guernsey ☐ Isle of Man ☐ Other ☐ Other (please give details)	UK ☐ Jersey ☐ Guernsey ☐ Isle of Man ☐ Other ☐ Other (please give details)
In the next six months, will you be moving from the country in which you're permanently resident? If Yes, please give full details.	Yes ☐ No ☐	Yes ☐ No ☐
Email		
Phone number Please enter at least one phone number.	Daytime Evening Mobile	Daytime Evening Mobile

3 Previous applications and cover

	Person 1	Person 2
a) Do you have an existing plan or application with Royal London? Royal London includes Bright Grey, Scottish Provident and Pegasus. Please include in-force plans as well as any previous applications which didn't go in force or are pending. We don't need to know about any pension plans. If No, please continue to question 3h).	Yes ☐ No ☐	Yes ☐ No ☐
b) Does the total amount of your current application and all existing plan(s) with Royal London amount to, or exceed: • £600,000 Life Cover; or • £500,000 Critical Illness Cover?	Yes ☐ No ☐	Yes ☐ No ☐
c) Have any of your Royal London applications or plans been: • **accepted on special terms, or** • **not accepted as we've been unable to offer you cover?** If Yes, please give full details.	Yes ☐ No ☐	Yes ☐ No ☐
d) Please confirm all the plan numbers you have, or have had, with Royal London.		

3 Previous applications and cover continued

	Person 1	Person 2
e) Do you want us to cancel all your existing Royal London plans when this plan starts? If Yes, we will cancel your existing Royal London plans from the next monthly anniversary of those plans starting. If you intend to use Underwrite Later, we strongly recommend that you DO NOT cancel your existing plan(s) until underwriting is complete as there is a risk you may be left without any cover.	Yes No	Yes No
f) If you answered No to question e), are you cancelling any of your existing plans?	Yes No	Yes No
g) If you answered Yes to question f), please tell us which plans you are cancelling.		
h) Does the total amount of insurance cover you're applying for, added to the amount you already have, across all insurance companies, exceed: • £1,000,000 life cover; or • £500,000 critical illness cover? Answer No to this question if you have no existing cover elsewhere and it is only this application that breaches these limits. You need to tell us about: • Any other plans that are already in force if they break these thresholds, even if you intend to cancel them. • Any other applications you're making elsewhere which are additional to this application or any other cover you're intending to apply for. You don't need to include death in service benefits in this total. If No, please continue to question 3q).	Yes No	Yes No
i) If Yes, please tell us how many applications or plans that you have, or have made, for these types of cover.		
j) What is the cover for?	Life cover only Life or critical illness cover Critical illness cover only	Life cover only Life or critical illness cover Critical illness cover only

3 Previous applications and cover continued

	Person 1	Person 2
k) What is the amount of the cover?	£	£
l) Will the cover be cancelled when this plan starts? If Yes, please go to question 3q).	Yes No	Yes No
m) Is the cover in force or a current application?	In force Current application	In force Current application
n) Will the cover be paid as a lump sum or as an income? If income, please answer question 3o).	Lump sum Income	Lump sum Income
o) What is the remaining term of the cover?	years	years
p) What is the reason for the cover?	Key person Key person loan Shareholder/partnership protection Inheritance tax Relevant life plan Personal cover Other Other (please give details)	Key person Key person loan Shareholder/partnership protection Inheritance tax Relevant life plan Personal cover Other Other (please give details)

If you need to tell us about more previous applications and cover, please use the additional information section on page 32.

If you're applying for Income Protection or Key Person Income Protection, please answer the following questions.

q) Do you have, or are you making an application for, any other income protection, mortgage payment protection or accident and sickness cover? This includes plans with any provider. If Yes, then for each of the covers you have in force, or applications you have made, please answer the following questions.	Yes No	Yes No
r) Please tell us how many applications or plans that you have, or applications you have made, for these types of cover?		
s) What is the cover for?	Income protection Mortgage payment protection Accident and sickness	Income protection Mortgage payment protection Accident and sickness
t) What is the amount of cover, per year?	£	£

3 Previous applications and cover continued

	Person 1	Person 2
u) Will the cover be cancelled when this plan starts? If No, please answer the following questions, otherwise please move on to the next section.	Yes No	Yes No
v) What is the deferred period before payment is made?	weeks	weeks
w) Will the cover be paid for the full term?	Yes No	Yes No
x) If No, what is the payment period of the cover?	months	months
y) If you're unable to work because of an illness or accident, will you continue to receive an income or work related sick pay from your employment or self-employment?	Yes No	Yes No
Please tell us the percentage of your monthly income that you'd continue to receive.	%	%
For how many months would you continue to receive this income?	months	months

If you need to tell us about more previous applications and cover, please use the additional information section on page 32.

4 Lifestyle

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

4 Lifestyle continued

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

4 Lifestyle continued

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

5 Occupation and travel

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

5 Occupation and travel continued

If you're applying for Income Protection, Total Permanent Disability or Waiver of Premium (Sickness), please answer the following question, otherwise go to question 5e)

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

Answer questions f) and g) if you're applying for Income Protection or Key Person Income Protection, otherwise go to question h).

f) Do you have another job in addition to the one you've already told us about?	Yes No	Yes No
g) If Yes, please state that job.		

5 Occupation and travel continued

	Person 1	Person 2
h) Have you lived, worked or travelled outside the UK, European Union, North America, Japan, Australia or New Zealand during the last two years or do you intend to or expect to do so in the next two years?	Yes No	Yes No
Ignore holidays of up to a month.		
If Yes, please give us the name of each country together with the reason, frequency and duration of each visit. Please also include the area within each of the countries you list.		

6 Mental health

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

6 Mental health continued

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

7 Physical health

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

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

7 Physical health continued

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

8 Physical health in the last 5 years

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

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

8 Physical health in the last 5 years continued

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

8 Physical health in the last 5 years continued

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

9 Medical history in the last 3 years

Apart from anything you've already told us about, in the last 3 years have you:

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

9 Medical history in the last 3 years continued

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

9 Medical history in the last 3 years continued

If you're applying for Income Protection, please answer questions d) and e).
If you're applying for Total Permanent Disability or Waiver of Premium (Sickness), please answer question d).
Otherwise go to question f).

	Person 1	Person 2
d) Through illness or injury in the last two years, which of the following apply?	Currently off work Altered duties in the last two years Reduced hours in the last two years Required more than four consecutive weeks off work None of the above	Currently off work Altered duties in the last two years Reduced hours in the last two years Required more than four consecutive weeks off work None of the above
e) Have you either: • Been registered with a GP in the UK for the last 2 years; or • A GP in the UK who can provide a minimum of the last 2 years' medical records? Jersey, Guernsey and Isle of Man are also acceptable.	Yes No	Yes No

Regardless of anything you have already told us about:

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

10 Your family

	Person 1	Person 2
a) Have any of your parents, brothers or sisters ever been diagnosed with or died from any of the following conditions before the age of 60? Screening includes any test, investigation or blood test. In line with the ABI's policy on genetics and insurance, you don't need to tell us about any predictive genetic test result you've had unless that test was for Huntington's disease and you're applying for life insurance which, when added to any existing life insurance policies you have, exceeds £500,000 of life cover. If you've had any genetic test and feel that the result may be in your favour, then you may inform us of this, if you wish. You need to tell us if you're having treatment for, or are experiencing symptoms of, a genetic condition.	Heart attack or angina	Heart attack or angina
	Stroke	Stroke
	Diabetes	Diabetes
	Cancer	Cancer
	Leukaemia or lymphoma	Leukaemia or lymphoma
	Multiple sclerosis	Multiple sclerosis
	Huntington's disease	Huntington's disease
	Cardiomyopathy	Cardiomyopathy
	Polycystic kidney disease	Polycystic kidney disease
	Muscular dystrophy	Muscular dystrophy
	Motor neurone disease	Motor neurone disease
	Alzheimer's disease	Alzheimer's disease
	Parkinson's disease	Parkinson's disease
	Haemochromatosis	Haemochromatosis
	Familial colon polyps	Familial colon polyps
	Any other disorder which runs in your family for which you've received or been advised to have screening for	Any other disorder which runs in your family for which you've received or been advised to have screening for
	None of the above	None of the above

For each condition, please answer the following questions:

	Person 1	Person 2
Condition 1 **b) What is the name of the condition that any of your parents, brothers or sisters have had before the age of 60?**		
c) Where this is cancer, what was the type of cancer?		
d) How many of your parents, brothers or sisters have had this condition?		

10 Your family continued

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

If you need to tell us about any more conditions, please use the additional information section on page 32.

11 Additional medical details 1

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

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

11 Additional medical details 1 continued

	Person 1	Person 2
e) How often do you have symptoms?	All the time Daily Weekly Monthly Infrequently No longer have symptoms	All the time Daily Weekly Monthly Infrequently No longer have symptoms
f) If you no longer have symptoms, when did you last have symptoms?		
g) Please describe the nature and severity of the symptoms.		
h) Do these symptoms restrict you in any way?	Yes No	Yes No
i) Have you seen a specialist for the condition?	Yes No	Yes No
j) If Yes, please give details of the specialist's name and hospital.		
k) What medical investigations have been performed?		
l) Are you awaiting any investigations, tests, or referral to a specialist?		
m) Have you had any surgery, investigations or tests for this condition?	Yes No	Yes No
n) If Yes, please give full details. Please use the additional information section on page 32 if you need more space.		
o) What treatment have you been prescribed?		
p) Is it continuing?	Yes No	Yes No
q) How many days have you been off work because of this condition?		

11 Additional medical details 1 continued

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

11 Additional medical details 2

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

11 Additional medical details 2 continued

	Person 1	Person 2
j) If Yes, please give details of the specialist's name and hospital.		
k) What medical investigations have been performed?		
l) Are you awaiting any investigations, tests, or referral to a specialist?		
m) Have you had any surgery, investigations or tests for this condition?	Yes No	Yes No
n) If Yes, please give full details. Please use the additional information section on page 32 if you need more space.		
o) What treatment have you been prescribed?		
p) Is it continuing?	Yes No	Yes No
q) How many days have you been off work because of this condition?		
r) Which of the following best describes the severity of your condition?	Fully recovered with no remaining disability Ongoing condition with no restrictions in daily activities or mobility Mild symptoms with infrequent restriction of daily activities or mobility Moderate symptoms with infrequent restriction of daily activities or mobility Severe symptoms with infrequent restriction of daily activities or mobility Daily activities or tasks significantly or regularly restricted	Fully recovered with no remaining disability Ongoing condition with no restrictions in daily activities or mobility Mild symptoms with infrequent restriction of daily activities or mobility Moderate symptoms with infrequent restriction of daily activities or mobility Severe symptoms with infrequent restriction of daily activities or mobility Daily activities or tasks significantly or regularly restricted

11 Additional medical details 3

	Person 1	Person 2
a) What is the name of the medical condition?		
b) When did symptoms first occur?		
c) Do you have recurrent symptoms?	Yes No	Yes No
d) If Yes, please state how many episodes or attacks of symptoms you've had since the onset of the condition.		
e) How often do you have symptoms?	All the time Daily Weekly Monthly Infrequently No longer have symptoms	All the time Daily Weekly Monthly Infrequently No longer have symptoms
f) If you no longer have symptoms, when did you last have symptoms?		
g) Please describe the nature and severity of the symptoms.		
h) Do these symptoms restrict you in any way?	Yes No	Yes No
i) Have you seen a specialist for the condition?	Yes No	Yes No
j) If Yes, please give details of the specialist's name and hospital.		
k) What medical investigations have been performed?		
l) Are you awaiting any investigations, tests, or referral to a specialist?		
m) Have you had any surgery, investigations or tests for this condition?	Yes No	Yes No
n) If Yes, please give full details. Please use the additional information section on page 32 if you need more space.		
o) What treatment have you been prescribed?		
p) Is it continuing?	Yes No	Yes No

11 Additional medical details 3 continued

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

11 Additional medical details 4

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

11 Additional medical details 4 continued

	Person 1	Person 2
j) If Yes, please give details of the specialist's name and hospital.		
k) What medical investigations have been performed?		
l) Are you awaiting any investigations, tests, or referral to a specialist?		
m) Have you had any surgery, investigations or tests for this condition?	Yes No	Yes No
n) If Yes, please give full details. Please use the additional information section on page 32 if you need more space.		
o) What treatment have you been prescribed?		
p) Is it continuing?	Yes No	Yes No
q) How many days have you been off work because of this condition?		
r) Which of the following best describes the severity of your condition?	Fully recovered with no remaining disability Ongoing condition with no restrictions in daily activities or mobility Mild symptoms with infrequent restriction of daily activities or mobility Moderate symptoms with infrequent restriction of daily activities or mobility Severe symptoms with infrequent restriction of daily activities or mobility Daily activities or tasks significantly or regularly restricted	Fully recovered with no remaining disability Ongoing condition with no restrictions in daily activities or mobility Mild symptoms with infrequent restriction of daily activities or mobility Moderate symptoms with infrequent restriction of daily activities or mobility Severe symptoms with infrequent restriction of daily activities or mobility Daily activities or tasks significantly or regularly restricted

If you need to tell us about further conditions, please use the additional information section on page 32.

12 Plan options

Has a trust form been completed by the following people?
A trust must be set up for each plan owner with a self-owned plan, before the plan starts. If the plan is placed under trust after it has started, any pay out may be subject to Capital Gains Tax.

If Yes, please send us a copy of the completed trust form as soon as possible.

If No, you should choose To be advised for the start date.

Person 1 Yes No

Person 2 Yes No

Please tell us who will own each cover and when that cover is to start. You can choose a different plan owner and start date for each cover meaning we'll split the application into more than one plan. We'll also split the application if there are two people covered and the application includes covers that could pay out on the death of each of them at different times.

If we are able to offer you an immediate decision on some of the covers, we'll give you the option of starting these covers now, or at a time that suits your client.

If we split the application for any reason the total premium for all the covers under your application will remain the same.

Please use the cover number shown on the quote to identify each cover that's part of this application.

Cover 1

Insert the name of the cover you're applying for.

Who will own this cover?*

(Please tick one only)

Person 1 Person 2 Person 1 & 2 Other applicant

*If the plan will be used for company share purchase or life of another key person cover, you must only tick the Other applicant box.

Would you like to use Underwrite Later to start this cover before we've completed our underwriting assessment?

If you would like to use this option, please read and sign the terms and conditions for Underwrite Later. You can get this from our website: **adviser.royallondon.com/underwritelater**

If you answer yes for Underwrite Later, you may choose a specific start date up to 30 days from submission. Any dates chosen after 30 days cannot be accommodated for this option. Further info can be found at **adviser.royallondon.com/underwritelater**

Yes No

Start date:

a) The plan is to start on the date shown D D M M Y Y Y Y

b) The plan is to start as soon as we accept it

c) To be advised

12 Plan options continued

Cover 2

Insert the name of the cover you're applying for.

Who will own this cover?*

(Please tick one only)

Would you like to use Underwrite Later to start this cover before we've completed our underwriting assessment?

If you would like to use this option, please read and sign the terms and conditions for Underwrite Later. You can get this from our website: **adviser.royallondon.com/underwritelater**

If you answer yes for Underwrite Later, you may choose a specific start date up to 30 days from submission. Any dates chosen after 30 days cannot be accommodated for this option. Further info can be found at **adviser.royallondon.com/underwritelater**

Start date:

Person 1 Person 2 Person 1 & 2 Other applicant

*If the plan will be used for company share purchase or life of another key person cover, you must only tick the Other applicant box.

Yes No

a) The plan is to start on the date shown D D M M Y Y Y Y

b) The plan is to start as soon as we accept it

c) To be advised

Cover 3

Insert the name of the cover you're applying for.

Who will own this cover?*

(Please tick one only)

Would you like to use Underwrite Later to start this cover before we've completed our underwriting assessment?

If you would like to use this option, please read and sign the terms and conditions for Underwrite Later. You can get this from our website: **adviser.royallondon.com/underwritelater**

If you answer yes for Underwrite Later, you may choose a specific start date up to 30 days from submission. Any dates chosen after 30 days cannot be accommodated for this option. Further info can be found at **adviser.royallondon.com/underwritelater**

Start date:

Person 1 Person 2 Person 1 & 2 Other applicant

*If the plan will be used for company share purchase or life of another key person cover, you must only tick the Other applicant box.

Yes No

a) The plan is to start on the date shown D D M M Y Y Y Y

b) The plan is to start as soon as we accept it

c) To be advised

12 Plan options continued

Cover 4

Insert the name of the cover you're applying for.

Who will own this cover?*

(Please tick one only)

Person 1 Person 2 Person 1 & 2 Other applicant

*If the plan will be used for company share purchase or life of another key person cover, you must only tick the Other applicant box.

Would you like to use Underwrite Later to start this cover before we've completed our underwriting assessment?

If you would like to use this option, please read and sign the terms and conditions for Underwrite Later. You can get this from our website: **adviser.royallondon.com/underwritelater**

If you answer yes for Underwrite Later, you may choose a specific start date up to 30 days from submission. Any dates chosen after 30 days cannot be accommodated for this option. Further info can be found at **adviser.royallondon.com/underwritelater**

Yes No

Start date:

a) The plan is to start on the date shown D D M M Y Y Y Y

b) The plan is to start as soon as we accept it

c) To be advised

If the quote includes more covers, please use the additional information section on page 32.

If someone other than a person covered will own any of the covers, please complete their details on page 3 and ask them to sign in the Other applicant signature box on page 42.

13 Additional information

14 Financial information

Please complete this section if the application is:

- To protect a loan.
- To cover Income Protection.
- To cover Key Person Income Protection.

Please answer questions a) to d) if the cover you're applying for is in connection with a loan.

	Plan owner
a) What is the name of the lender?	
b) What is the amount of the loan?	
c) What is the term of the loan?	
d) If the term and amount of cover of the plan are different to the term and amount of the loan, please provide full details of why this plan is required.	

Please complete either question e) or f) if you're applying for Income Protection.
Don't answer questions e) or f) if you're applying for Key Person Income Protection.
Please answer question e) if you're employed.

	Person 1			Person 2		
e) What were your earnings for the last three years?	**Current year £**	**Last year £**	**Previous year £**	**Current year £**	**Last year £**	**Previous year £**
Salary						
Dividends						
Regular commission						
P11D benefits						
Profit share						
Total						

Please answer question f) if you're self-employed.

	Person 1			Person 2		
f) What were your net taxable earnings (after allowable deductions/ expenses) for the last three years?	**Current year £**	**Last year £**	**Previous year £**	**Current year £**	**Last year £**	**Previous year £**
How long has the business been established?						

14 Financial information continued

Please complete questions g) to t) if you're applying for Key Person Income Protection.

For us to fully consider an application for Key Person Income Protection, it's important that you provide as much financial information as possible when completing the following questions. The information should be obtained from the person covered or the company accountant or company secretary, and this section must be signed by the company accountant or company secretary.

If you need more space, please use the additional information section on page 32.

	Plan owner
g) What is the name of the business?	
h) What is the nature of this business?	
i) Please tell us how long this business has been operating.	years / months
j) What proportion of the business does the person covered own?	%
k) How many people does the business employ?	
l) Please tell us how long the person covered has been in service with the business.	years / months
m) Is the business applying for Key Person Income Protection on any other key people, or is there another Key Person Income Protection plan in place on any other key people?	Yes No
If Yes, please give full details below.	
Name	
Position	
Amount of benefit (£)	
Who plan is held with	
If No, please give full details why not.	
n) Please provide trading figures for the business over the last three years.	
Year	
Turnover	
Gross profit*	
Net profit*	
* if a gross or net loss is shown, please enclose copies of the last two years' reports and accounts.	

14 Financial information continued

	Person 1	Person 2
o) Please tell us what the person covered's salary or emoluments have been in the last three years.	Current year Last year Previous year	Current year Last year Previous year
p) Please give us full details of the person covered's occupation. This should include full details of their skills, duties and responsibilities.		
q) Please tell us why the person covered is deemed to be key to the business, and how the level of cover has been calculated.		
r) How much of the gross profit of the business is fairly attributed to the person covered?	%	%
s) Please tell us how the payment period has been determined.		
t) Please tell us how the deferred period has been determined.		

Declaration

Only sign here if you've completed Section 14.

I/We declare that:	• The answers above are true to the best of my knowledge. • I haven't witheld any information that may influence the assessment or acceptance of this application. • This questionnaire will form part of the application to Royal London. • If any information in this application is missing or inaccurate, I'll inform Royal London in writing. Royal London will then have the right to change or withdraw terms if appropriate.
Full name of company accountant or company secretary	
Signature	
Title/Position	

The plan owner and person covered must always sign the declaration on page 42.

15 GP details

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

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

If you've changed GP in the last six months, please give the details of your previous GP in the additional information section on page 32.

16 Premium payment details

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

Is the person paying for the plan the plan owner? If Yes, please go to payment frequency question.	Yes No
Account Name If the payer is an employer we'll need you to send us a bank statement dated within the last 3 months.	
What is the plan payer's relationship to the plan owner(s)? If you tell us the relationship is employer, you must complete section 16.	Co-shareholder Business partner Employer Other
If the payer is an employer, please tell us the nature of the business.	
First name(s)	
Surname	

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

Address	
Postcode	
Date of birth	D D M M Y Y Y Y

16 Premium payment details continued

Payment frequency	Monthly Yearly
Payment day Which day would you prefer us to collect your premiums? Please choose between 1st - 28th of each month.	
Sort Code	
Account number	

17 Company or employer additional role details

You must complete this section if:

- **you've told us in section 1 that the plan owner is a company or employer, or**
- **you've told us in section 16 that the payer is a company or employer**

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

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

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

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

A Person of Significant Control is an individual who:

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

A key decision maker is an individual who

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

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

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

17 Company or employer additional role details continued

Additional Role 1

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

Additional Role 2

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

Additional Role 3

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

17 Company or employer additional role details continued

	Additional Role 4
Title	Mr Mrs Miss Ms Other (please give details)
First name(s)	
Surname	
Date of birth	D D M M Y Y Y Y
Address	

18 Client declaration

Declaration for the person covered

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

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

Plan Owner Declaration

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

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

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

I do not want to receive these communications

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

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

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

19 Access to medical reports

We may need to obtain a medical report from your current GP or specialist, or from a doctor you've seen in the past. You have specific rights in relation to medical reports, which are covered in the Access to Medical Reports Act 1988 (also the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991, and the Access to Health Records and Reports Act 1993 (Isle of Man)). Before we ask for such a report, we need your consent, which you can give by signing the declaration in section 20. You can choose not to give your consent, but then we may not be able to continue with your application. This doesn't prevent you from applying to other insurance companies for insurance. Under the above Acts, you can choose to see your medical report before it is sent to us. You'll then have 21 days to make arrangements with your doctor to see it.

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

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

either you've seen the report

or

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

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

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

- Your current health
  - any care, medication or treatment you're currently receiving
  - the results of referrals or tests you're waiting for.
- Any time off work in the last three years
- Your past health
  - details of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultation with your GP or any other medical adviser, therapist or counsellor, in particular whether you have a history of:
    - malignancy (cancer), cardiovascular (heart) disease, diabetes, and degenerative (gradually worsening) diseases
    - musculoskeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles
    - anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue
    - suicidal thoughts or attempts at suicide; or
    - conditions related to drug or alcohol misuse or smoking or chewing tobacco.
- Details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations
- Any blood pressure readings in the last three years
- Any history of disease among your parents or brothers or sisters that you've told your doctor about
- We have asked your doctor not to reveal information about: negative tests for Human Immunodeficiency Virus (HIV), Hepatitis B or C
- Any sexually-transmitted diseases unless there could be long-term effects on your health, **or**
- Predictive genetic test results unless there is a favourable test result which shows that you haven't inherited a condition your family suffers from.

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

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

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

20 Client declaration

Access to medical reports declaration

Person 1 and Person 2 should always complete these boxes.

	Person 1	Person 2
Name		
Postcode		
	I've read the statement in section 19 notifying me of my rights under the Access to Medical Reports (AMRA) legislation, and consent to my doctor providing medical reports to Royal London so that they can deal with my application for a protection plan.	I've read the statement in section 19 notifying me of my rights under the Access to Medical Reports (AMRA) legislation, and consent to my doctor providing medical reports to Royal London so that they can deal with my application for a protection plan.
Please only tick this box if you DO want to see your medical report before it is sent to Royal London.	Yes I **DO** want to see my medical report. I understand that it won't be sent to Royal London until I've seen it, and that they won't be able to make a decision on my application until then.	Yes I **DO** want to see my medical report. I understand that it won't be sent to Royal London until I've seen it, and that they won't be able to make a decision on my application until then.
Enter plan number here if your financial adviser is sending this page to Royal London as an AMRA declaration for an application submitted online.		

Client declaration

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

The other applicant should sign and date here, even if the person or people covered can sign on behalf of the other applicant. If signing on behalf of a company or other corporate entity, please state your name and position.

	Other applicant
Signature	
Date	D D M M Y Y Y Y
Other applicant name	
Other applicant position	

21 Direct Debit details

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

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

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

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

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

Wife

Husband

Civil partner

Partner/co-habitant

Common law spouse

Business partner

Company

Other

If the payer's relationship to the plan owner is 'company' please tell us what type of business this is.

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

The Royal London Mutual Insurance Society Limited

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

Please complete all of this form.

Service user number

6	7	1	7	5	2

Reference (internal use only)

Name and full postal address of your bank or building society

To: The Manager — Bank/building society

Address

Postcode

Name(s) of account holder(s)

Bank/building society account number

Branch sort code

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

Signature(s)

Date

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

This Guarantee should be detached and retained by the payer.

The Direct Debit Guarantee

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits
- If there are any changes to the amount, date or frequency of your Direct Debit The Royal London Mutual Insurance Society Limited will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request The Royal London Mutual Insurance Society Limited to collect a payment, confirmation of the amount and date will be given to you at the time of the request
- If an error is made in the payment of your Direct Debit, by The Royal London Mutual Insurance Society Limited or your bank or building society, you are entitled to a full and immediate refund of the amount paid from your bank or building society
  - If you receive a refund you are not entitled to, you must pay it back when The Royal London Mutual Insurance Society Limited asks you to
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.

Verifying your identity and preventing fraud

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

Royal London
royallondon.com

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

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