RELEVANT LIFE 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, 1 Thistle Street, Edinburgh EH2 1DG

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 may request a new application form.

If you have any questions on filling in this form, please contact us on 0345 6094 500.

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.	

Important information about this application form

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

☐ A new Relevant Life Plan only

Quote number

Please give us the quote number and attach the quote. The quote must be attached as this will help us process the application more quickly

☐ 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

Adviser use only – Please DO NOT complete this section if you're attaching a quote

Amount of cover

£

Term of cover

Fixed term — 1–57 years

Renewable 5/10 years — 5 ☐ 10 ☐

To age

Payment of cover

Level lump sum ☐

Increasing lump sum ☐

Increase rate (2-5%) %

or RPI ☐

Decreasing lump sum ☐

Interest rate (0-15%) %

Total payment

£

About Relevant Life Plans

A Relevant Life Plan allows an employer to provide tax efficient life cover for employees. There are a number of requirements that must be met for a plan to be a valid Relevant Life Plan.

- The plan must be taken out by an employer on the life of an employee, which can include shareholding directors.
- The plan is not available for:
  - a partner in a partnership
  - a member of a limited liability partnership, or
  - a sole trader

as they are taxed as self-employed. They can however take out policies on their employees.

- The employer and the employee must both be permanently resident in the UK.
- The plan must only provide Life Cover and must not go beyond the age of 75.

The plan proceeds must be payable to an individual or charity. For this to be met the plan should be placed into trust using a Relevant Life Plan trust form.

1 About the employer

What is the employer's name?

The employer will always be the plan owner of a Relevant Life Plan.

If the employer is a company, please give the registered name of the company and make sure you complete the company details in section 16.

Addressee name

If the plan owner is a 'company' please give the addressee name within the company.

If the plan owner is a 'company' please tell us what type of business this is.

What is the employer's date of birth? (if applicable)

D D M M Y Y Y Y

In which country is the employer permanently resident?

A Relevant Life Plan can only be taken out by an employer resident or registered in the UK.

☐ UK

In the next six months will the employer be moving from the country in which they're permanently resident?

Yes ☐ No ☐

If Yes, please give full details

What is the employer's address?

House name

House/building number

Street name

Town/city

Country

Postcode

2 About the person covered

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

	Person covered
Title	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other (please give details)
First name(s)	
Surname	
Date of birth	D D M M Y Y Y Y
Gender Your gender doesn't affect the premium.	Male ☐ Female ☐
Marital status	Married ☐ Living together as partners ☐ Divorced ☐ Widowed ☐ Single ☐ Separated ☐ Civil partnership ☐ Surviving civil partner ☐
Your home address	
Postcode	
In which country are you permanently resident? You can only be covered by a Relevant Life Plan if you're permanently resident in the UK.	UK ☐ Other ☐ If Other, please give details
In the next six months, will you be moving from the country in which you're permanently resident? If Yes, please give full details.	Yes ☐ No ☐
Email	
Phone number Please enter at least one phone number.	Daytime Evening Mobile

3 Previous applications and cover

	Person covered
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 go to question 3h).	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 ☐
c) Have any of your Royal London applications or plans been accepted on special terms, deferred or declined? If Yes, please provide full details about the previous special terms you received.	Yes ☐ No ☐
d) Please confirm all the plan numbers you have, or have had, with Royal London.	
e) Do you want us to cancel all your existing Royal London plans when this plan starts? If Yes, we will cancel your existing Royal London plans from the next monthly anniversary of those plans starting. If you intend to use Underwrite Later, we strongly recommend that you DO NOT cancel your existing plan(s) until underwriting is complete as there is a risk you may be left without any cover.	Yes ☐ No ☐
f) If you answered No to question e), are you cancelling any of your existing plans?	Yes ☐ No ☐
g) If you answered Yes to question f), please tell us which plans you are cancelling.	
h) Have you ever had an application on your life deferred or declined? If Yes, please give full details.	Yes ☐ No ☐

3 Previous applications and cover continued

	Person covered
i) 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.	Yes ☐ No ☐
j) If Yes, please tell us how many applications or plans that you have, or have made, for these types of cover?	
k) What is the cover for?	Personal ☐ Business ☐ Relevant life plan ☐
l) What is the cover type?	Life cover only ☐ Life or critical illness cover ☐ Critical illness cover only ☐
m) What is the amount of the cover?	£
n) Will the cover be cancelled when this plan starts? If Yes, please go to section 4 (Lifestyle).	Yes ☐ No ☐
o) Is the cover in force or a current application?	In force ☐ Current application ☐
p) Will the cover be paid as a lump sum or as an income? If income, please answer question 3q).	Lump sum ☐ Income ☐
q) What is the remaining term of the cover?	years

3 Previous applications and cover continued

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

If you need to tell us about more previous applications and cover, please use the additional information section on page 26.

4 Lifestyle

	Person covered
a) What is your height?	☐ 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
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
d) Have you smoked or used any tobacco, nicotine replacement products or e-cigarettes in the last 12 months? If Yes, please go to question 4h). If No, please go to question 4e).	Yes ☐ No ☐
e) Which of the following are you? We may require a simple test to confirm this. If you're an ex-smoker, user of nicotine replacement products or user of e-cigarettes in the last 12 months, please go to question 4f). If you're an occasional smoker, please go to question 4h).	I have never smoked ☐ Ex-smoker ☐ Occasional smoker ☐ User of nicotine replacement products in the last 12 months ☐ User of e-cigarettes in the last 12 months ☐

4 Lifestyle continued

Person covered

f) If you're an ex-smoker, user of nicotine replacement products or user of e-cigarettes in the last 12 months, how much of each of the following products did you use on a daily basis before stopping?

Cigarettes
Cigars
Pipes
Nicotine replacement products
E-cigarettes
Other
If Other, please give details

g) When did you last use any tobacco, nicotine replacement products or e-cigarettes?

M M Y Y Y Y

h) If you're a smoker, occasional smoker, user of nicotine replacement products or user of e-cigarettes, how much of each of the following do you use on a daily basis?

Cigarettes
Cigars
Pipes
Nicotine replacement products
E-cigarettes
Other
If Other, please give 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

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

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 driving in the last five years 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 covered
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 ☐
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. Do not 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 ☐
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 covered
a) What is your current job?	
b) What is your employment status? A Relevant Life Plan can only be taken out on the life of an employee.	Salaried employee ☐ Self-employed ☐
c) How much did you earn over the last 12 months before tax? If you're a shareholder in the business, you can include any regular dividends. Don't include any unearned income, such as investment income.	£
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)
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 ☐
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 ☐
f) Have you lived, worked or travelled outside the UK, European Union, North America, Japan, Australia or New Zealand during the last two years or do you intend to or expect to do so in the next two years? Ignore holidays of up to a month. 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.	Yes ☐ No ☐

6 General medical history

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

	Person covered
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 10) for each condition you've had.	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 10) for each condition you've had.	Yes ☐ No ☐
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 10) for each condition you've had.	Yes ☐ No ☐

6 General medical history continued

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 10) for each condition you've had.

Yes ☐ No ☐

e) Any mental health issue that has required hospital treatment or referral to a specialist, or have you considered or attempted self-harm?

Including:

- Specialist clinic or referral to a psychiatrist. 'Specialist' includes psychiatrist and any hospital or clinic including private clinic, such as the Priory.
- Attempting or contemplating suicide

If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 10) for each condition you've had.

Yes ☐ No ☐

f) 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 10) for each condition you've had.

Yes ☐ No ☐

7 Recent medical history 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 covered
a) Raised blood pressure, raised cholesterol or chest pain? If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 10) for each condition you've had.	Yes ☐ No ☐
b) Anxiety, depression, stress or mental illness? Including: • Work stress • Insomnia • Eating disorders such as anorexia or bulimia • Persistent tiredness or fatigue including chronic fatigue syndrome and ME • Addiction • Any treatment or medication for mental illness e.g. counselling, tablets (whether taken or not). If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 10) for each condition you've had.	Yes ☐ No ☐
c) 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 10) for each condition you've had.	Yes ☐ No ☐

7 Recent medical history in the last 5 years continued

	Person covered
d) 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 10) for each condition you've had.	Yes ☐ No ☐
e) 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 10) for each condition you've had.	Yes ☐ No ☐
f) 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 10) for each condition you've had.	Yes ☐ No ☐

7 Recent medical history in the last 5 years continued

	Person covered
g) Asthma, bronchitis, or any other disorder affecting your lungs or breathing? Including: • Sleep apnoea • Sarcoidosis • Emphysema • 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 10) for each condition you've had.	Yes ☐ No ☐
h) Any stomach, digestive system, bowel, liver or blood disorder? Including: • Liver, pancreas and gall bladder conditions • 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 10) for each condition you've had.	Yes ☐ No ☐
i) 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 10) for each condition you've had.	Yes ☐ No ☐

8 Recent medical history in the last 3 years

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

	Person covered
a) Been prescribed medication or treatment regularly for a period of four consecutive weeks or more, or have you been under review from your doctor or a medical professional? Including: • Physio • Counselling • Prescriptions from your own doctor even if you did not take them You don't need to tell us about contraception, fertility, dental treatment or reviews purely in relation to pregnancy. If Yes, please tell us the name of the condition **and** complete an additional medical details section (section 10) for each condition you've had.	Yes ☐ No ☐
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 10) for each condition you've had.	Yes ☐ No ☐

8 Recent medical history in the last 3 years continued

Person covered

c) Apart from anything you've already told us about, 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 10) for each condition you've had.

Yes ☐ No ☐

Regardless of anything you have already told us about:

d) Have any of the following applied to you in the last month?

Please select all that apply.

All relevant information must be given to this question even if we've told you we don't need to know about it under a previous question.

- I've tested positive for Coronavirus ☐
- I've been advised to self-isolate ☐
- I've had a new continuous cough and/or a high temperature ☐
- I've had a loss or change to my sense of taste or smell ☐
- None of the above ☐

9 Your family

	Person covered	
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	☐
	Stroke	☐
	Diabetes	☐
	Cancer	☐
	Leukaemia or lymphoma	☐
	Multiple sclerosis	☐
	Huntington's disease	☐
	Cardiomyopathy	☐
	Polycystic kidney disease	☐
	Muscular dystrophy	☐
	Motor neurone disease	☐
	Alzheimer's disease	☐
	Parkinson's disease	☐
	Haemochromatosis	☐
	Familial colon polyps	☐
	Any other disorder which runs in your family for which you've received or been advised to have screening for	☐
	None of the above	☐

For each condition, please answer the following questions:

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

9 Your family continued

g) Where this is cancer, what was the type of cancer?	
h) How many of your parents, brothers or sisters have had this condition?	

i) Which relatives have had this condition?

For each relative, please tell us the age they were diagnosed with this condition.

	Relative(s) affected	Age at diagnosis
Father		
Mother		
Brother		
Sister		

If you need to tell us about any more conditions, please use the additional information section on page 26.

10 Additional medical details 1

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

	Person covered
a) What is the name of the medical condition?	
b) When did symptoms first occur?	
c) Do you have recurrent symptoms?	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 ☐
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 ☐
i) Have you seen a specialist for the condition?	Yes ☐ No ☐
j) If Yes, please give details of the specialist's name and hospital.	
k) What medical investigations have been performed?	

10 Additional medical details 1 continued

	Person covered
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 ☐
n) If Yes, please give full details. Please use the additional information section on page 26 if you need more space.	
o) What treatment have you been prescribed?	
p) Is it continuing?	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 ☐

10 Additional medical details 2

	Person covered
a) What is the name of the medical condition?	
b) When did symptoms first occur?	
c) Do you have recurrent symptoms?	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 ☐

10 Additional medical details 2 continued

	Person covered
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 ☐
i) Have you seen a specialist for the condition?	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 ☐
n) If Yes, please give full details. Please use the additional information section on page 26 if you need more space.	
o) What treatment have you been prescribed?	
p) Is it continuing?	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 ☐

10 Additional medical details 3

	Person covered
a) What is the name of the medical condition?	
b) When did symptoms first occur?	
c) Do you have recurrent symptoms?	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 ☐
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 ☐
i) Have you seen a specialist for the condition?	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 ☐
n) If Yes, please give full details. Please use the additional information section on page 26 if you need more space.	
o) What treatment have you been prescribed?	
p) Is it continuing?	Yes ☐ No ☐

10 Additional medical details 3 continued

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 ☐

10 Additional medical details 4

	Person covered
a) What is the name of the medical condition?	
b) When did symptoms first occur?	
c) Do you have recurrent symptoms?	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 ☐
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 ☐
i) Have you seen a specialist for the condition?	Yes ☐ No ☐
j) If Yes, please give details of the specialist's name and hospital.	
k) What medical investigations have been performed?	

10 Additional medical details 4 continued

	Person covered
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 ☐
n) If Yes, please give full details. Please use the additional information section on page 26 if you need more space.	
o) What treatment have you been prescribed?	
p) Is it continuing?	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 ☐

If you need to tell us about further conditions, please use the additional information section on page 26.

11 Additional information

12 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 covered
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 26.

13 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.

How would you, or the person paying for this plan, like to pay?

Depending on the start date of your plan, the first payment may not be collected on the day you choose. We'll write to you at least 10 working days before we collect the first payment.

Monthly by direct debit ☐

Please tell us the day of the month between the 1st and 28th you would like us to collect your payment.

Yearly by direct debit ☐

Is more than one signature required to authorise payments?

Yes ☐ No ☐

If Yes, both people must complete and sign the direct debit mandate on page 34. You must then post the signed mandate to us when you submit the application.

Account details for direct debit payments

Name of account holder

Sort code ☐☐☐☐☐☐

Account number ☐☐☐☐☐☐☐☐

14 Trusts

The plan must be held under trust from commencement to meet the legislative requirements of being an effective Relevant Life Plan by the benefit being paid to an individual or a charity. Placing the policy into trust fulfils this requirement.

Has the Relevant Life Plan trust form been completed?

If the trust form hasn't been completed you won't be able to specify a start date on the next page.

Yes ☐ No ☐

15 Start date

Would you like to use Underwrite Later to start this cover before we have 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 don't need to answer the Start Date questions below. If accepted, the plan will start straight away.	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	☐

16 Company or employer additional role details

Please 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 13 that the payer is a company or employer**

Please provide the details of all Beneficial Owner(s) and Person(s) of Significant Control (if not a Beneficial Owner) A Beneficial Owner is an individual who directly or indirectly owns a 25% or more share of the business A Person of Significant Control is an individual who: directly or indirectly holds 25% or more of the voting rights, directly or indirectly holds 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. For more detailed information on the above definitions, please see Companies House.

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

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

16 Company or employer additional role details continued

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

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

17 Client declaration

Declaration for the person covered

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

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

Plan Owner Declaration

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

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

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

I do not want to receive these communications ☐

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

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

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

18 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 19. 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. We'll let you know if we ask for a report. 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've 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 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 or questions relating to the process of getting, assessing or storing medical information, **please write to us at Royal London, 1 Thistle Street, Edinburgh EH2 1DG.**

19 Client declaration

Access to medical reports declaration

The person covered should always complete these boxes.

	Person covered
Name	
Postcode	
	I've read the statement in section 18 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. Enter plan number here if your financial adviser is sending this page to Royal London as an AMRA declaration for an application submitted online.	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.

Client declaration

	Person covered
Signature	
Date	D D M M Y Y Y Y

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

	Employer
Signature	
Date	D D M M Y Y Y Y
Employer print name	
Employer position	

20 Direct Debit details

Please complete and return this form to Royal London, 1 Thistle Street, Edinburgh EH2 1DG

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 covered.

	Person covered
Name	
Postcode	
Date of birth	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.	

20 Direct Debit details continued

The Royal London Mutual Insurance Society Limited

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

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

DIRECT Debit

- 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
1 Thistle Street, Edinburgh EH2 1DG
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.
All of our printed products are produced on stock which is from FSC® certified forests.

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