Data collection form

Decreasing Mortgage Cover Plan

Level Protection Plan

Adaptable Life Plan

This is not an application form and is for Intermediary use only

Client(s) name(s):

1st life:

2nd life:

☐ Decreasing Mortgage Cover Plan

☐ Level Protection Plan

☐ Adaptable Life Plan

When to use this form

This form is NOT an application form and is only to be used for the interim collection of data from your client to help you with the subsequent completion of an online application on their behalf.

Intermediary guidance

Please fully complete all the relevant questions in this form.

Before completing this form, please ensure your client receives a copy of and reads Zurich's data protection leaflet. 'Your privacy is important to us' available from the Zurich Extranet or you can obtain a copy at www.zurich.co.uk. Please also read the accompanying important notes to your client and ensure that your client is fully aware of their importance.

If your client does not want you to know the answer to one or more of the medical questions they will need to apply in writing rather than electronically. After receiving a copy of Zurich's data protection leaflet, they should submit a fully completed paper application form direct to Zurich's Chief Medical Officer at Zurich Assurance Ltd, Tricentre One, New Bridge Square, Swindon SN1 1HN, marked 'Confidential – Application Questions'.

The forms on pages 25 to 30 are for your use should you need them during your client meeting; they do not form part of the online submission for an underwriting decision. If used you will need to complete and send them to Zurich Assurance Ltd, at the above address.

How to contact us

Call us on 0500 546546 between Monday to Friday 8.30am to 6pm. We may record or monitor calls to improve our service.

These are important notes that you need to read to your client

The form that we are about to complete together is designed to help me gather the necessary information from you so that I can subsequently complete an online application to Zurich Assurance Ltd (Zurich) on your behalf. As you will not be present when I complete and submit the application(s), it is important that I take this opportunity to bring certain important matters to your attention. If there are any answers to the medical questions that you do not wish me to know, I will not be able to apply online for you. Instead you will need to complete a paper application form and send it direct to Zurich. I can help you complete most of that form leaving you to fill in the questions that you want to keep private from me.

Please note

- Your application is subject to acceptance by Zurich.
- Completing and submitting an application does not guarantee that Zurich will accept your application and, if they do, on what terms.
- The collection of any payment by Zurich after receiving your application does not necessarily mean that your application has been accepted. Zurich will let you know whether, or not, they have accepted your application.
- The standard terms and conditions for the plan applied for are available on request from Zurich Assurance Ltd, Tricentre One, New Bridge Square, Swindon SN1 1HN.
- Zurich policies are only suitable for customers who are UK residents.

Answering the questions – your duty to take reasonable care

- As the information you give me will be used to help me answer Zurich's questions on the application form and any subsequent questions they ask, it is essential that you answer all the questions honestly and accurately and to the best of your knowledge.
- Please don't assume Zurich will contact your doctor, to ask for any medical or other information.
- You need to let Zurich know in writing if there is any change to your personal health (whether or not you seek or intend to seek medical advice), family history, occupation, travel, hazardous activities, alcohol consumption, smoking habits or use of recreational drugs, that happens before the plan starts, if that change makes any of your answers to the questions Zurich asked wrong or incomplete. If your application is accepted you do not have to tell Zurich about any changes that happen after your plan has started unless Zurich ask you to if you apply for an increase or extension in cover.
- You need to make sure that your answers are recorded completely and accurately. Zurich's decision to offer cover, and the terms of that cover, will be based upon the recorded answers and won't take into account any verbal information that has not been confirmed in writing.
- Zurich will send you a summary of the questions asked and the answers you have given. You need to make sure the answers are accurate and complete and, if they are not, you must immediately let Zurich know in writing.
- If you don't answer the questions correctly the plan may be cancelled or its terms may be changed, or a claim may be rejected or not fully paid. Cancelling a plan means that no cover or other benefits will be provided.
- As your adviser I am your agent, not Zurich's. I act for you, not Zurich.

Genetic tests

- You must tell Zurich if you have had a genetic test for Huntington's disease if you are applying for more than £500,000 of life cover. This limit includes any existing cover you have with Zurich.
- If you wish to tell Zurich about a negative genetic test result, which shows that you have not inherited a genetic disorder, Zurich will take this into account when assessing your application provided that your clinical geneticist confirms to Zurich, in writing, that the test result indicates you have a reduced risk of developing the inherited disease.
- You must tell Zurich if you have a family history of, are experiencing symptoms of, or are having treatment for, a medical condition including any genetically inherited condition.

Access to medical reports

If Zurich needs a report from your doctor they will explain your rights and obtain your written consent.

Data protection – your information

You must read the data protection leaflet 'Your privacy is important to us' as this explains how your data will be used. If you do not understand any of the information set out in the leaflet, please ask for more information. Any application will contain a declaration that you have read the leaflet.

- Any application will also contain your consent to:
  - personal data (including medical and court proceeding details) being used in the way described in the leaflet;
  - Zurich using a reference agency for identity verification and fraud checking purposes;
  - Zurich obtaining medical information from any doctor you have consulted about your physical or mental health, in order to assess the application;
  - Zurich, its agents, the Zurich Group, and any companies they become associated with, using your information for setting up, processing and administering your plan(s). Where we talk about the Zurich Group in this form, we mean Zurich Financial Services and its subsidiaries;
  - your personal details (excluding medical details) being used, passed to and shared by Zurich, its agents, the Zurich Group and any companies they become associated with, so that they can contact you (by mail, email, telephone or other appropriate means) about carefully selected products, services or offers they believe will be of interest to you.

Do you want to be contacted in this way?
(tick as appropriate) ☐ Yes ☐ No

- You authorise those asked by Zurich for such information to provide it on production of a copy of consent.
- Your doctor or other medical practitioner may choose to fax medical data to Zurich if Zurich needs this information to decide whether to offer you cover and on what terms. They will be given Zurich's underwriting fax machine number, which is located within Zurich's underwriting department and is regularly attended by underwriting staff. It is not used for general faxed communications.
- Zurich's confidentiality policy means that your medical data is held securely and access limited to appropriate individuals with a business need to see it.
- Any relevant information obtained by Zurich during the assessment of your application, in addition to that provided in the application, may be used as part of that assessment and as part of the administration of any claim. Where the application is made on a joint life basis, and where it is reasonable and appropriate to do so, information relating to either party may be considered in relation to the other.
- **If you do not wish me (your adviser) to know the answer to any one or more of the questions on this data collection form, you will need to fully complete a separate paper application form in private and send it direct to Zurich's Chief Medical Officer, at Zurich Assurance Ltd, Tricentre One, New Bridge Square, Swindon SN1 1HN, marked 'Confidential – Application Questions'.**

Declaration

Any application will contain the following declaration:

- I/We have answered the questions in this application, and in any additional forms completed in connection with the application, honestly and accurately and the information I/we have provided in response to the questions is, to the best of my/our knowledge, complete and correct.
- I/We will tell Zurich about any change to my/our personal health, family history of disease, driving convictions, occupation, travel, hazardous activities, alcohol consumption, smoking habits or use of recreational drugs, that happens before the plan starts, if that change makes any of my/our answers to the questions Zurich asked wrong or incomplete. I am/We are aware that if I/we haven't answered the questions correctly the plan may be cancelled, or its terms may be changed, or a claim may be rejected or not fully paid. Cancelling a plan means that no cover or other benefits will be provided.

I am/We are aware that:

- Where applicable, Zurich can decline the Waiver of Payment benefit and/or the Total Permanent Disability (own occupation) on my life/either or both our lives (as appropriate). Zurich does not need to tell me/us that either, or both, of these benefits has/have been declined before issuing the plan(s). The plan schedule will say if a benefit has been included.
- Where the plan provides Waiver of Payment benefit, the benefit will not be paid in respect of any illness or disability which arises from any condition that I/we had before the plan started.
- Zurich can also exclude, where applicable, the guaranteed insurability option or special event benefit from the plan(s). Zurich does not need to tell me/us that this option has been excluded before issuing the plan(s). The plan schedule will say if this option has not been included.

For plans being issued subject to the Relevant Life Policy Trust only

Please note that if the plan continues after your employment with the principal employer ends the terminal illness benefit will stop. The plan's terms and conditions will be changed to say this.

Before you complete this form, you need to make sure your client is fully aware of the information set out in the section headed 'Answering the questions – your duty to take reasonable care' on page 2. Please make sure you record your client's answers accurately.

Personal contact details

First life assured

Mr ☐ Mrs ☐ Miss ☐ Other title ☐

Surname

Full forename(s)

Address

Previous name (if applicable)

Is this life assured also the plan owner? Yes ☐ No ☐

If No, complete the applicants details on the next page

Telephone no. (Evening)

Telephone no. (Daytime)

Email address

Sex Male ☐ Female ☐

Nationality

Date of birth D D M M Y Y Y Y

Second life assured

Mr ☐ Mrs ☐ Miss ☐ Other title ☐

Surname

Full forename(s)

Address

Previous name (if applicable)

Is this life assured also the plan owner? Yes ☐ No ☐

If No, complete the applicants details on the next page

Telephone no. (Evening)

Telephone no. (Daytime)

Email address

Sex Male ☐ Female ☐

Nationality

Date of birth D D M M Y Y Y Y

Before you complete this form, you need to make sure your client is fully aware of the information set out in the section headed ‘Answering the questions – your duty to take reasonable care’ on page 2. Please make sure you record your client’s answers accurately.

Life of another – applicant(s) details

Only complete if the plan owner(s) are different to the life/lives assured. If the plan is to be issued to the trustees of an existing trust, please make sure they are aware that all correspondence and notices will be sent to the first named trustee only, except for cancellation notices which will be sent to each applicant.

Full name

Address

Nationality

Full name

Address

Nationality

Full name

Address

Nationality

Full name

Address

Nationality

Corporate

If your client is applying for a plan that will be issued subject to the Relevant Life Policy Trust you need to make sure they are aware that if the plan continues after the life to be assured’s employment ends, the terminal illness benefit will stop. The plan’s terms and conditions will be changed to say this.

Company name

Location of business (full operating address)

Insurable interest

Please supply details of insurable interest

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Cover details

Decreasing Mortgage Cover Plan

Start date D D M M Y Y Y Y

Term in years

Plan type ☐ Single life ☐ Joint life

Guaranteed rate

Life or earlier Critical Illness cover £ with extra life cover of £

or

Life cover only £

Payment amount £ ☐ Monthly ☐ Yearly

Total Permanent Disability (TPD) own occupation
(Only available if you select life or earlier Critical Illness cover) ☐ 1st life ☐ 2nd life ☐ Both lives ☐ Not required

If Total Permanent Disability own occupation and/or Payment Protection Benefit is required please complete the occupation details on page 19.

Payment Protection Benefit (PPB) ☐ 1st life ☐ 2nd life ☐ Both lives ☐ Not required

	1st life	**2nd life**
Payment Protection Benefit amount	£	£
Current annual earnings	£	£
What percentage of earnings are paid as bonus and/or commission?	%	%
Deferred period 3, 6 or 12 months	months	months

Waiver Of Payment
(do not complete for those lives selecting PPB) ☐ 1st life ☐ 2nd life ☐ Both lives ☐ Not required

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Cover details

Level Protection Plan

Start date D D M M Y Y Y Y

Term in years

Plan type ☐ Single life ☐ Joint life

Guaranteed rate

Term options ☐ Term ☐ Convertible term – life cover only ☐ Renewable term

Life or earlier Critical Illness cover £ with extra life cover of £

or

Life cover only £

Payment amount £ ☐ Monthly ☐ Yearly

Total Permanent Disability (TPD) own occupation ☐ 1st life ☐ 2nd life ☐ Both lives ☐ Not required

Only available if you select life or earlier Critical Illness cover

If Total Permanent Disability own occupation and/or Payment Protection Benefit is required please complete the occupation details on page 19.

Indexation ☐ AWE% ☐ RPI% ☐ 5% ☐ 10% ☐ Not required

Payment protection benefit (PPB) ☐ 1st life ☐ 2nd life ☐ Both lives ☐ Not required

Not available if you select either of the renewable or convertible term options.

	1st life	2nd life
Payment protection benefit amount	£	£
Current annual earnings	£	£
What percentage of earnings are paid as bonus and/or commission?	%	%
Deferred period 3, 6 or 12 months	months	months

Waiver Of Payment
(do not complete for those lives selecting PPB) ☐ 1st life ☐ 2nd life ☐ Both lives ☐ Not required

Cover details

Adaptable Life Plan

Start date D D M M Y Y Y Y

Plan type ☐ Single life ☐ Joint life First Death ☐ Joint life Second Death

Guaranteed rate

Life cover £

Payment amount £ ☐ Monthly ☐ Yearly

Indexation ☐ AWE% ☐ Not required

Waiver Of Payment ☐ 1st life ☐ 2nd life ☐ Both lives ☐ Not required

Before you complete this form, you need to make sure your client is fully aware of the information set out in the section headed 'Answering the questions – your duty to take reasonable care' on page 2. Please make sure you record your client's answers accurately.

Health and medical details

Height and weight

	1st life			2nd life		
What is your height?	ft in	or	cms	ft in	or	cms
What is your weight?	st lbs	or	kgs	st lbs	or	kgs

Tobacco and Smoking

Non-smoker rates apply where the customer confirms they have not used any tobacco products, including nicotine substitutes in the last 12 months.

	1st life	2nd life
Have you smoked or used any form of tobacco or nicotine product in the past 12 months?	☐ **Yes** ☐ **No – please answer the questions in the grey section below**	☐ **Yes** ☐ **No – please answer the questions in the grey section below**
	☐ I have never smoked	☐ I have never smoked
	I used to smoke but I gave up	I used to smoke but I gave up
	☐ between 1 & 3 years ago	☐ between 1 & 3 years ago
	☐ between 3 & 5 years ago	☐ between 3 & 5 years ago
	☐ between 5 & 10 years ago	☐ between 5 & 10 years ago
	☐ over 10 years ago	☐ over 10 years ago
If "Yes", please state amount smoked on average each day	Cigarettes Cigars grams of tobacco	Cigarettes Cigars grams of tobacco
Do you use e-cigarettes containing nicotine or any other tobacco or nicotine product?	☐ Yes ☐ No	☐ Yes ☐ No

Alcohol Consumption

	1st life	2nd life
Do you drink alcohol?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
If "Yes" how often do you have a drink containing alcohol?	☐ once a month or less ☐ 2 to 4 times a month ☐ 2 or 3 times a week ☐ 4 or more times a week	☐ once a month or less ☐ 2 to 4 times a month ☐ 2 or 3 times a week ☐ 4 or more times a week
How many drinks containing alcohol do you have on a typical day when you are drinking?	☐ 1 or 2 drinks ☐ 3 or 4 drinks ☐ 5 or 6 drinks ☐ 7, 8 or 9 drinks ☐ 10 or more drinks	☐ 1 or 2 drinks ☐ 3 or 4 drinks ☐ 5 or 6 drinks ☐ 7, 8 or 9 drinks ☐ 10 or more drinks

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Health and Medical details (continued)

	1st life	2nd life
Alcohol Consumption		
Have you ever been advised or treated for alcohol consumption or abuse, or attended an alcohol support group, or been told you have any liver damage?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
If "Yes" how long ago was this?	☐ up to 6 months ago ☐ 6 months to 12 months ago ☐ over 12 months ago	☐ up to 6 months ago ☐ 6 months to 12 months ago ☐ over 12 months ago
What was the reason for this?		

	1st life	2nd life
Drug use		
In the last 10 years, have you used recreational drugs such as cannabis, ecstasy, cocaine, heroin, amphetamines, or anabolic steroids?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
	☐ cannabis ☐ ecstasy ☐ cocaine ☐ heroin ☐ amphetamines ☐ anabolic steroids ☐ other drugs	☐ cannabis ☐ ecstasy ☐ cocaine ☐ heroin ☐ amphetamines ☐ anabolic steroids ☐ other drugs
	If other drugs please specify	If other drugs please specify
If "Yes" to any drug please confirm for each drug		
Drug 1		
Which drug did you use?		
Do you or did you inject this type of drug?	☐ Yes ☐ No	☐ Yes ☐ No
When was the last time you used this drug?		
Drug 2		
Which drug did you use?		
Do you or did you inject this type of drug?	☐ Yes ☐ No	☐ Yes ☐ No
When was the last time you used this drug?		

If you have used more drugs please use a continuation sheet for this information.

Before you complete this form, you need to make sure your client is fully aware of the information set out in the section headed 'Answering the questions – your duty to take reasonable care' on page 2. Please make sure you record your client's answers accurately.

Medical history – Have you ever had?

Question	1st life	2nd life
Diabetes or sugar in the urine?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
If "Yes" to type 1 or 2 diabetes please answer the Diabetes additional questions on page 22.	☐ type 1 diabetes ☐ type 2 – treated with diet or tablets ☐ type 2 – treated with insulin ☐ gestational diabetes ☐ sugar in the urine	☐ type 1 diabetes ☐ type 2 – treated with diet or tablets ☐ type 2 – treated with insulin ☐ gestational diabetes ☐ sugar in the urine
Raised blood pressure or raised cholesterol?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
If "Yes" please answer the raised blood pressure or raised cholesterol additional questions on page 22.	☐ raised blood pressure ☐ raised cholesterol	☐ raised blood pressure ☐ raised cholesterol
Any heart disease or disorder, such as heart attack, angina, chest pain, cardiomyopathy, heart murmur, narrow or leaky heart valves, or heart surgery?	☐ **Yes** ☐ **No – go to next question** Specify condition(s)	☐ **Yes** ☐ **No – go to next question** Specify condition(s)
A disorder or abnormality of the blood vessels or arteries such as narrowing, blockages, blood clots or deep vein thrombosis (DVT)?	☐ **Yes** ☐ **No – go to next question** Specify condition(s)	☐ **Yes** ☐ **No – go to next question** Specify condition(s)
Any heart rhythm abnormalities such as atrial fibrillation, fast or slow heart rate or palpitations?	☐ **Yes** ☐ **No – go to next question** Specify condition(s)	☐ **Yes** ☐ **No – go to next question** Specify condition(s)
Any brain disease or disorder such as stroke, brain haemorrhage, transient ischaemic attack (TIA) or mini stroke, aneurysm, meningitis, any brain damage, or been in a coma?	☐ **Yes** ☐ **No – go to next question** Specify condition(s)	☐ **Yes** ☐ **No – go to next question** Specify condition(s)
Cancer, leukaemia, Hodgkin's disease, melanoma, lymphoma, brain or spinal tumours or growths?	☐ **Yes** ☐ **No – go to next question** Specify condition(s)	☐ **Yes** ☐ **No – go to next question** Specify condition(s)

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Medical history – Have you ever had?

Question	1st life	2nd life
Schizophrenia, bi-polar disorder, manic depression, attempted suicide, episode of self harm, an eating disorder, or any other mental illness that has required a stay in hospital or referral to a psychiatrist?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
	☐ bi-polar disorder	☐ bi-polar disorder
	☐ clinical depression	☐ clinical depression
	☐ eating disorder – anorexia or bulimia	☐ eating disorder – anorexia or bulimia
	☐ episode of self harm	☐ episode of self harm
	☐ manic depression	☐ manic depression
	☐ paranoia	☐ paranoia
	☐ personality disorder	☐ personality disorder
	☐ post-traumatic stress disorder	☐ post-traumatic stress disorder
	☐ psychosis	☐ psychosis
	☐ schizophrenia	☐ schizophrenia
	☐ suicide attempt/overdose	☐ suicide attempt/overdose
	☐ other mental illness requiring hospitalisation or psychiatric referral	☐ other mental illness requiring hospitalisation or psychiatric referral
If "Yes" to "other mental illness" please provide the name of the condition.		
Any disorder of the nervous system such as multiple sclerosis, Devic's disease, optic neuritis, Parkinson's disease, paralysis, cerebral palsy, motor neurone disease, dementia, memory loss or impairment?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
	Specify condition(s)	Specify condition(s)
Any disease or disorder of the liver or pancreas such as any form of hepatitis, abnormal liver function test, fatty liver, cirrhosis or pancreatitis?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
	Specify condition(s)	Specify condition(s)
A positive test for HIV or are you awaiting the results of an HIV test?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
	☐ HIV positive	☐ HIV positive
	☐ awaiting HIV test results	☐ awaiting HIV test results
If "HIV positive" please give details of when you were diagnosed and what treatment you received or are receiving		
If "awaiting HIV test" when do you expect the test results to be available?		

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Recent health – In the last 5 years, have you had:

Question	1st life	2nd life
Anxiety, stress, depression, chronic fatigue, obsessive compulsive disorder, or other mental illness? **If "Yes" please answer mental illness additional questions on page 23.**	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
	☐ anxiety ☐ stress ☐ depression ☐ post natal depression ☐ chronic fatigue ☐ OCD – obsessive compulsive disorder ☐ other mental illness	☐ anxiety ☐ stress ☐ depression ☐ post natal depression ☐ chronic fatigue ☐ OCD – obsessive compulsive disorder ☐ other mental illness
If "Yes" to "other mental illness" please provide the name of the condition.	______________	______________
Any respiratory or lung disease or disorder such as asthma, bronchitis, COPD or sarcoidosis? **If "Yes" to asthma, please complete the additional asthma questions on page 24.**	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
	☐ asthma ☐ bronchitis ☐ bronchiectasis ☐ COPD – chronic obstructive pulomonary disease ☐ emphysema ☐ hayfever ☐ pleurisy ☐ pneumonia ☐ pneumothorax (collapsed lung) ☐ pulmonary embolism ☐ sarcoidosis ☐ sleep apnoea ☐ other respiratory disease/disorder	☐ asthma ☐ bronchitis ☐ bronchiectasis ☐ COPD – chronic obstructive pulomonary disease ☐ emphysema ☐ hayfever ☐ pleurisy ☐ pneumonia ☐ pneumothorax (collapsed lung) ☐ pulmonary embolism ☐ sarcoidosis ☐ sleep apnoea ☐ other respiratory disease/disorder
If "Yes" to "other respiratory disease/disorder", please provide the name of the condition.	______________	______________
Any kidney disease or disorder such as any form of nephritis, cysts or recurrent kidney stones?	☐ **Yes** ☐ **No – go to next question** Specify condition(s)	☐ **Yes** ☐ **No – go to next question** Specify condition(s)
Any disease or disorder of the bladder or urinary tract such as recurrent infections or protein or blood in urine?	☐ **Yes** ☐ **No – go to next question** Specify condition(s)	☐ **Yes** ☐ **No – go to next question** Specify condition(s)

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Recent health – In the last 5 years, have you had:

Question	1st life	2nd life
Epilepsy or seizure, a fit, fainting blackout or loss of consciousness?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
	☐ epilepsy ☐ seizure ☐ fit ☐ fainting ☐ blackout ☐ loss of consciousness ☐ syncope ☐ other neurological disease/ disorder	☐ epilepsy ☐ seizure ☐ fit ☐ fainting ☐ blackout ☐ loss of consciousness ☐ syncope ☐ other neurological disease/ disorder
If "Yes" to "other neurological disease/disorder", please provide the name of the condition.	______	______
Any thyroid disorder?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
	☐ overactive thyroid ☐ underactive thyroid ☐ thyroiditis ☐ goitre ☐ other thyroid problem	☐ overactive thyroid ☐ underactive thyroid ☐ thyroiditis ☐ goitre ☐ other thyroid problem
If "Yes" to "other thyroid problem" please provide the name of the condition.	______	______
Any disease or disorder of the stomach, bowel or digestive system such as ulcers, ulcerative colitis, or Crohn's disease?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
	Specify condition(s)	Specify condition(s)
Any tremor, numbness, loss of feeling or tingling in the limbs or face, loss of balance or co-ordination or loss of muscle power?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
	Specify condition(s)	Specify condition(s)
Any weight loss treatment such as medication, gastric banding or bypass?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
	☐ weight loss medication ☐ gastric banding ☐ gastric bypass ☐ other weight loss treatment	☐ weight loss medication ☐ gastric banding ☐ gastric bypass ☐ other weight loss treatment
If "Yes" to "other weight loss treatment", please provide the name of the treatment.	______	______

Before you complete this form, you need to make sure your client is fully aware of the information set out in the section headed 'Answering the questions – your duty to take reasonable care' on page 2. Please make sure you record your client's answers accurately.

Recent health – In the last 5 years, have you had:

Question	1st life	2nd life
Any disease or disorder of the skin such as psoriasis or a mole or freckle that has bled or changed in appearance?	☐ **Yes** ☐ **No – go to next question** Specify condition(s)	☐ **Yes** ☐ **No – go to next question** Specify condition(s)
Anaemia or other blood disorders such as haemochromatosis or haemophilia?	☐ **Yes** ☐ **No – go to next question** Specify condition(s)	☐ **Yes** ☐ **No – go to next question** Specify condition(s)
Any disease or disorder of the back, bones or joints, such as arthritis, whiplash, sciatica, slipped disc or gout?	☐ **Yes** ☐ **No – go to next question** Specify condition(s)	☐ **Yes** ☐ **No – go to next question** Specify condition(s)
For males only **Any disease or disorder of the prostate or testicle, such as raised prostate specific antigen (PSA) or undescended testicle?**	☐ **Yes** ☐ **No – go to next question** Specify condition(s)	☐ **Yes** ☐ **No – go to next question** Specify condition(s)
For females only **Any biopsy or ultrasound of the breast, cervix, ovary or uterus, or an abnormal mammogram or an abnormal cervical smear? (You don't need to tell us about any tests in connection with routine pregnancy.)**	☐ **Yes** ☐ **No – go to next question** ☐ breast biopsy ☐ breast ultrasound ☐ cervix biopsy ☐ cervix ultrasound ☐ ovary biopsy ☐ ovary ultrasound ☐ uterus biopsy ☐ uterus ultrasound ☐ abnormal cervical smear ☐ abnormal mammogram	☐ **Yes** ☐ **No – go to next question** ☐ breast biopsy ☐ breast ultrasound ☐ cervix biopsy ☐ cervix ultrasound ☐ ovary biopsy ☐ ovary ultrasound ☐ uterus biopsy ☐ uterus ultrasound ☐ abnormal cervical smear ☐ abnormal mammogram

Before you complete this form, you need to make sure your client is fully aware of the information set out in the section headed 'Answering the questions – your duty to take reasonable care' on page 2. Please make sure you record your client's answers accurately.

Recent health – In the last 5 years, have you had:

Please complete these two additional questions if you are applying for Critical Illness cover, Total Permanent Disability (Own Occupation) benefit, Payment Protection benefit or Waiver of Payment benefit.

	1st life	2nd life
Any sight impairment or loss, blurred or double vision or other problems in one or both eyes? (You don't need to tell us about sight problems corrected by glasses or contact lenses.)	☐ **Yes** ☐ **No – go to next question** Specify condition(s)	☐ **Yes** ☐ **No – go to next question** Specify condition(s)
Any hearing impairment or loss, dizziness, ringing or other disorder in one or both ears such as tinnitus, labyrinthitis or Meniere's disease?	☐ **Yes** ☐ **No – go to next question** Specify condition(s)	☐ **Yes** ☐ **No – go to next question** Specify condition(s)

Please complete the questions below for ALL benefits

Other than for the conditions you have already told us about earlier in this application:

	1st life	2nd life
Are you aware of any symptoms that you intend to seek medical advice or treatment for, or are you waiting for any test results, appointments or investigations with your doctor or other medical professional?	☐ **Yes** ☐ **No – go to next question** ☐ intend to seek medical advice or treatment ☐ waiting for a test result, appointment or investigation	☐ **Yes** ☐ **No – go to next question** ☐ intend to seek medical advice or treatment ☐ waiting for a test result, appointment or investigation
If you intend to seek medical advice or treatment, please give full details why.		
When do you intend to do this?		
If you have been referred to a specialist, why was this?		
When do you expect to be seen?		
If you have undergone investigations or tests, what have you had?		
When were these done?		
Do you know the results yet?	☐ Yes ☐ No	☐ Yes ☐ No
If "Yes", what were the results?		
If "No", when do you expect to know the results?		
Are you currently taking drugs, medicines or tablets or receiving any other treatment? **(You don't need to tell us about oral contraceptive treatment, Hormone Replacement Therapy (HRT), iron supplements during pregnancy, hay fever treatments or cold/flu remedies.)**	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
Do these treatments relate only to medical conditions you have already told us about?	☐ Yes ☐ No	☐ Yes ☐ No
If "No", please give full details of the type of drugs, medicines, tablets or other treatment and the condition or symptoms being treated.		

Before you complete this form, you need to make sure your client is fully aware of the information set out in the section headed 'Answering the questions – your duty to take reasonable care' on page 2. Please make sure you record your client's answers accurately.

Recent health – In the last 5 years, have you had:

	1st life	2nd life
In the last 3 months have you had any symptoms of ill health such as unexplained bleeding, weight loss, change of bowel habit, unexplained lump or growth, breathing problems or shortness of breath, or a cough that's lasted for 4 weeks or more?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
	☐ unexplained bleeding	☐ unexplained bleeding
	☐ unexplained weight loss	☐ unexplained weight loss
	☐ change of bowel habit	☐ change of bowel habit
	☐ unexplained lump or growth	☐ unexplained lump or growth
	☐ breathing problems or shortness of breath	☐ breathing problems or shortness of breath
	☐ a cough that's lasted 4 weeks or more	☐ a cough that's lasted 4 weeks or more
	☐ other symptoms of ill health	☐ other symptoms of ill health
If "Yes" to "other symptoms of ill health" then please provide details of the symptoms.		
When did this start?		
Have you seen a doctor for this?	☐ Yes ☐ No	☐ Yes ☐ No
If "Yes", are you awaiting any further tests, investigations or referral to a specialist?	☐ Yes ☐ No	☐ Yes ☐ No
If "Yes", when is the next appointment due?		
If "No" (to have you seen a doctor for this), are you intending to see a doctor?	☐ Yes ☐ No	☐ Yes ☐ No
If "Yes", when do you expect to be seen?		
Have you had more than 10 days' sick leave in the last year?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
If "Yes", in total, how many days was this?		
Please provide reasons for the absence		

Family History

Have any of your natural parents, brothers or sisters been diagnosed with any of the following before their 65th birthday:

	1st life	2nd life
Breast, bowel/colon, ovarian* or other cancer?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
	Condition 1	Condition 1
	Number of relatives	Number of relatives
	Age at onset of disease:	Age at onset of disease:
	Youngest	Youngest
	2nd youngest	2nd youngest

Before you complete this form, you need to make sure your client is fully aware of the information set out in the section headed 'Answering the questions – your duty to take reasonable care' on page 2. Please make sure you record your client's answers accurately.

Family history (continued)

	1st life	2nd life
	Condition 2	Condition 2
	Number of relatives	Number of relatives
	Age at onset of disease: Youngest	Age at onset of disease: Youngest
	2nd youngest	2nd youngest

***For female applicants with a family history of ovarian cancer please answer the following questions:**

	1st life	2nd life
As a result of your family history of ovarian cancer, have you needed any tests, investigations or treatment, including the removal of both ovaries (a bilateral oophorectomy)? *Please note, if you wish to tell us about a negative genetic test result, which shows that you have not inherited a genetic disorder, we will take this into account.*	☐ **Yes** ☐ **No – go to next question** If "Yes", please give the following details: Date(s)/Type/Results/Outcome	☐ **Yes** ☐ **No – go to next question** If "Yes", please give the following details: Date(s)/Type/Results/Outcome
	Details of any planned review or follow up	Details of any planned review or follow up

	1st life	2nd life
Diabetes, heart attack, angina, stroke or heart disease?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
	Condition 1	Condition 1
	Number of relatives	Number of relatives
	Age at onset of disease: Youngest	Age at onset of disease: Youngest
	2nd youngest	2nd youngest
	Condition 2	Condition 2
	Number of relatives	Number of relatives
	Age at onset of disease: Youngest	Age at onset of disease: Youngest
	2nd youngest	2nd youngest

Before you complete this form, you need to make sure your client is fully aware of the information set out in the section headed 'Answering the questions – your duty to take reasonable care' on page 2. Please make sure you record your client's answers accurately.

Family history (continued)

	1st life	2nd life
Multiple sclerosis, Alzheimer's disease, Parkinson's disease, cardiomyopathy*, motor neurone disease, polycystic kidney disease, Huntington's disease, muscular dystrophy, retinitis pigmentosa, polyposis coli or any other hereditary disorder?**	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
	Condition 1	Condition 1
	Number of relatives	Number of relatives
	Age at onset of disease: Youngest	Age at onset of disease: Youngest
	2nd youngest	2nd youngest
	Condition 2	Condition 2
	Number of relatives	Number of relatives
	Age at onset of disease: Youngest	Age at onset of disease: Youngest
	2nd youngest	2nd youngest

***If you have a family history of cardiomyopathy, please answer the following questions:**

	1st life	2nd life
As a result of your family history of cardiomyopathy, have you had any investigations? *Please note, if you wish to tell us about a negative genetic test result, which shows that you have not inherited a genetic disorder, we will take this into account.*	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
	If "Yes", please give the following details: Date(s)/Type/Results/Outcome	If "Yes", please give the following details: Date(s)/Type/Results/Outcome
	Details of any planned review or follow up	Details of any planned review or follow up

****If you have a family history of polycystic kidney disease, please answer the following questions:**

	1st life	2nd life
As a result of your family history of polycystic kidney disease, have you had a CT scan or ultrasound scan? *Please note, if you wish to tell us about a negative genetic test result, which shows that you have not inherited a genetic disorder, we will take this into account.*	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
	If "Yes", how old were you when these investigations were last carried out?	If "Yes", how old were you when these investigations were last carried out?
	Were the results of the investigations normal or negative? ☐ Yes ☐ No ☐ Don't know	Were the results of the investigations normal or negative? ☐ Yes ☐ No ☐ Don't know

Before you complete this form, you need to make sure your client is fully aware of the information set out in the section headed 'Answering the questions – your duty to take reasonable care' on page 2. Please make sure you record your client's answers accurately.

Occupation

	1st life	2nd life
What is your occupation?	______	______
Does your occupation involve: working externally at heights over 50ft (15m)*, offshore in oil, gas or fishing industries*, underground*, handling explosives*, flying, diving*, or are you in the armed forces, including reserve or territorial forces?	☐ **Yes** ☐ **No – go to next question** ☐ working externally at heights over 50 feet/15 metres ☐ working offshore in the oil or gas industry ☐ working offshore in the fishing industry ☐ working underground ☐ handling explosives ☐ diving ☐ flying (please complete an aviation questionnaire) ☐ member of the armed forces or armed forces reserves (please complete an armed forces questionnaire)	☐ **Yes** ☐ **No – go to next question** ☐ working externally at heights over 50 feet/15 metres ☐ working offshore in the oil or gas industry ☐ working offshore in the fishing industry ☐ working underground ☐ handling explosives ☐ diving ☐ flying (please complete an aviation questionnaire) ☐ member of the armed forces or armed forces reserves (please complete an armed forces questionnaire)

If you have answered "Yes" to the items marked with a * we will require additional information so please also complete an Occupation Questionnaire. If you do this before you complete the online application you will have an opportunity to provide the information electronically.

Please answer the four questions below if you are applying for Total Permanent Disability own occupation or Payment Protection Benefit.

	1st life	2nd life
Do you work less than 16 hours per week?	☐ **Yes** ☐ **No – go to next question** ______	☐ **Yes** ☐ **No – go to next question** ______
Do you drive more than 20,000 miles a year as part of your work, excluding driving to and from your usual place of work?	☐ **Yes** ☐ **No – go to next question** ______	☐ **Yes** ☐ **No – go to next question** ______
Do you work with machinery or tools or does your work involve bending, lifting or carrying heavy items?	☐ **Yes** ☐ **No – go to next question** ______	☐ **Yes** ☐ **No – go to next question** ______
If "Yes", how much of your time do you spend using machinery or tools, bending, lifting or carrying heavy items?	☐ 1–10% ☐ 11–20% ☐ 21–50% ☐ over 50%	☐ 1–10% ☐ 11–20% ☐ 21–50% ☐ over 50%
Are any of your earnings based on commission?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
If "Yes", how much of your earnings are based on commission?	☐ 1–10% ☐ 11–20% ☐ 21–30% ☐ 31–50% ☐ 51% or more	☐ 1–10% ☐ 11–20% ☐ 21–30% ☐ 31–50% ☐ 51% or more

Before you complete this form, you need to make sure your client is fully aware of the information set out in the section headed 'Answering the questions – your duty to take reasonable care' on page 2. Please make sure you record your client's answers accurately.

Other information

	1st life	2nd life
Will the amount of cover you are now applying for, added to the amount you already hold with any insurance company, exceed £1million life cover or £500,000 Critical Illness cover? (You don't need to include any other cover that you don't intend to proceed with.)	☐ **Yes** ☐ **No** – go to next question	☐ **Yes** ☐ **No** – go to next question

Travel

	1st life	2nd life
In the last 5 years, have you spent more than 30 consecutive days in Africa, Thailand, The Caribbean, Russia, Ukraine, Afghanistan, Iraq, Syria or area of civil unrest?	☐ **Yes** ☐ **No** – go to next question	☐ **Yes** ☐ **No** – go to next question
If "Yes", where did you travel to?		
When did you travel there?		
How long did you travel there for?		
What was the reason for the travel?		
In the next 2 years, do you expect to travel, live or work outside the United Kingdom, European Union, North America, Australia or New Zealand. (You don't need to tell us about a total of 30 days holiday each year or the reason for your travel.)	☐ **Yes** ☐ **No** – go to next question	☐ **Yes** ☐ **No** – go to next question
If "Yes" please provide the country and how long you intend to spend in this country each year (in weeks)		

Activities

	1st life	2nd life
Do you take part, or intend to take part in diving, caving or potholing, climbing or mountaineering outside the UK, flying or other aviation based activity (other than as aircrew or as a fare paying passenger), motor sport, or other hazardous pursuit? (You don't need to tell us about gift experiences, track days, charity parachute jumps or try dives.)	☐ **Yes** ☐ **No** – go to next question ☐ diving ☐ caving or potholing ☐ climbing or mountaineering ☐ flying or other aviation based activity ☐ motor sport ☐ other hazardous pursuit	☐ **Yes** ☐ **No** – go to next question ☐ diving ☐ caving or potholing ☐ climbing or mountaineering ☐ flying or other aviation based activity ☐ motor sport ☐ other hazardous pursuit
If "Yes" to "other hazardous pursuits" please give details of the pursuit.		

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Activities (continued)

	1st life	2nd life
In the last 5 years, have you been banned from driving?	☐ **Yes** ☐ **No – go to next question**	☐ **Yes** ☐ **No – go to next question**
If "Yes", when were you banned from driving?		
Please tell us why you were banned from driving	☐ drink-driving ☐ drug-driving ☐ speeding ☐ accumulation of penalty points (endorsements) ☐ other reasons	☐ drink-driving ☐ drug-driving ☐ speeding ☐ accumulation of penalty points (endorsements) ☐ other reasons
If "Yes" to "other reasons" please give the reason		
If the reason was other than "speeding" or "accumulation of penalty points" please also answer the following questions.		
Has the DVLA given you your licence back?	☐ Yes ☐ No	☐ Yes ☐ No
If "No", when do you expect to get your licence back?		

Doctors details

Asking for this doesn't mean we'll automatically request a medical report.

We need the name and address of the doctor who holds your medical records. If you don't currently have a doctor please provide details of a previous doctor. If you have never been registered with a doctor, please state 'no doctor'.	Dr Initials Surname Address Telephone	Dr Initials Surname Address Telephone

Before you complete this form, you need to make sure your client is fully aware of the information set out in the section headed 'Answering the questions – your duty to take reasonable care' on page 2. Please make sure you record your client's answers accurately.

If you have answered Yes to any of the additional questions, please complete the below, otherwise please go to the Instruction to your bank or building society to pay by direct debit

Additional questions

	1st life	2nd life
Diabetes additional questions		
How long ago was your diabetes diagnosed?		
Since you were told you had diabetes, have you been admitted to hospital for one night or more due to your diabetes?	☐ Yes ☐ No	☐ Yes ☐ No
Have you ever had, been advised to have or are or are waiting to have laser treatment to your eyes due to diabetes?	☐ Yes ☐ No	☐ Yes ☐ No
Have you ever been told by your GP or any medical professional that you have protein in your urine due to diabetes?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have, or ever had, tingling, numbness or loss of sensation in your fingers, toes or feet due to diabetes?	☐ Yes ☐ No	☐ Yes ☐ No
What was your latest HbA1c and when was this?		
Date		

	1st life	2nd life
Raised blood pressure additional questions		
How long ago was your blood pressure first found to be raised?		
Are you currently receiving any treatment or medication for your blood pressure?	☐ Yes ☐ No	☐ Yes ☐ No
How long ago was your blood pressure last checked by a doctor or nurse?		
Have you been told by a doctor that your blood pressure is normal?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Have you had or are you waiting for any hospital tests or investigations related to your raised blood pressure, such as heart investigations, kidney tests or eye screening?	☐ Yes ☐ No	☐ Yes ☐ No

	1st life	2nd life
Raised cholesterol additional questions		
Have you been told that your raised cholesterol is linked to a family history of raised cholesterol?	☐ Yes ☐ No	☐ Yes ☐ No
How long ago was your cholesterol first found to be raised?		
Are you currently receiving any treatment or medication for your cholesterol?	☐ Yes ☐ No	☐ Yes ☐ No
How long ago was your cholesterol last checked by a doctor or nurse?		
Have you been told by a doctor that your cholesterol is normal?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Have you had or are you waiting for any hospital tests or investigations related to your raised cholesterol, such as heart investigations or kidney tests?	☐ Yes ☐ No	☐ Yes ☐ No

Before you complete this form, you need to make sure your client is fully aware of the information set out in the section headed 'Answering the questions – your duty to take reasonable care' on page 2. Please make sure you record your client's answers accurately.

Additional questions (continued)

	1st life	2nd life
Mental illness additional questions		
Are you currently taking any treatment or receiving counselling, or have you done so in the last 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
How many days, in total, have you had off work or from your normal activities due to this condition in the last 12 months?	☐ No time off work required or normal duties ☐ 1 to 5 days ☐ 6 to 10 days ☐ 11 to 20 days ☐ more than 20 days ☐ no longer able to work	☐ No time off work required or normal duties ☐ 1 to 5 days ☐ 6 to 10 days ☐ 11 to 20 days ☐ more than 20 days ☐ no longer able to work
Do you have ongoing symptoms or have you had any symptoms in the last 6 months?	☐ ongoing symptoms ☐ symptoms in the last 6 months ☐ no symptoms in the last 6 months	☐ ongoing symptoms ☐ symptoms in the last 6 months ☐ no symptoms in the last 6 months
Have you ever been treated as a hospital in-patient or by a psychiatrist?	☐ Yes ☐ No ☐ treated as a hospital in-patient ☐ treated by a psychiatrist but not as an in-patient	☐ Yes ☐ No ☐ treated as a hospital in-patient ☐ treated by a psychiatrist but not as an in-patient
Have you ever planned or attempted suicide or self harmed?	☐ Yes ☐ No ☐ planned suicide but not attempted ☐ attempted suicide ☐ self harmed	☐ Yes ☐ No ☐ planned suicide but not attempted ☐ attempted suicide ☐ self harmed
If yes, when was the last time		
Please give as much information as you can about your condition including the treatment given, cause of the condition, date of last symptoms and frequency of episodes.		
If 'Yes' to post natal depression please answer the following questions in addition to the above		
Are you currently pregnant	☐ Yes ☐ No	☐ Yes ☐ No
If 'Yes' when is your baby due?		

Before you complete this form, you need to make sure your client is fully aware of the information set out in the section headed 'Answering the questions – your duty to take reasonable care' on page 2. Please make sure you record your client's answers accurately.

Additional questions (continued)

Asthma additional questions

	1st life	2nd life
Have you been admitted to hospital for your asthma within the last 5 years?	☐ Yes ☐ No	☐ Yes ☐ No
If 'yes' when were you admitted?	☐ Within the last 6 months ☐ 6 to 12 months ago ☐ 1 to 2 years ago ☐ 2 to 3 years ago ☐ 3 to 5 years ago	☐ Within the last 6 months ☐ 6 to 12 months ago ☐ 1 to 2 years ago ☐ 2 to 3 years ago ☐ 3 to 5 years ago
If you were admitted within the last year please confirm which month	______	______
How often do you have symptoms, such as wheezing, breathlessness, a cough or a tight chest?	☐ none in the last year ☐ a few days a year ☐ 1 or 2 days a week ☐ 3 to 6 days a week ☐ every day in the daytime only ☐ every day, in the daytime and at night	☐ none in the last year ☐ a few days a year ☐ 1 or 2 days a week ☐ 3 to 6 days a week ☐ every day in the daytime only ☐ every day, in the daytime and at night
How often has your asthma affected your daily activities in the last 2 years?	☐ less than once a week ☐ 1 to 2 times a week ☐ more than 2 times a week	☐ less than once a week ☐ 1 to 2 times a week ☐ more than 2 times a week
How many days have you lost from work or been unable to carry out your normal daily activities in the last 2 years?	______	______

Instruction to your bank or building society to pay by direct debit

Please fill in the whole form and send it to:

Zurich Assurance Ltd
UK Life Centre
Swindon
SN1 1HN

Name(s) of account holder(s)

Bank/building society account number

Branch sort code

Name and full postal address of your bank or building society

To: The Manager Bank/building society

Address

Service user number

9	9	6	4	4	4

Instruction to your bank or building society
Please pay Zurich Assurance Ltd 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 Zurich Assurance Ltd and, if so, details will be passed electronically to my bank/building society.

Signature(s)

Date D D M M Y Y Y Y

Banks and building societies may not accept direct debit instructions for some types of account.

This is not part of the instruction to your bank or building society and must be detached by Zurich Assurance Ltd before submission to the paying bank.

Bank account holder declaration
Please complete if the person paying is not the life assured on this plan. I understand Zurich may use a reference agency for identification verification and fraud checking purposes.

Signature(s)

Date D D M M Y Y Y Y

Bank/building society account holder
The full name and address of the bank/building society account holder should be completed if the person, organisation or company making the payments is not a life assured on this plan.

Mr ☐ Mrs ☐ Miss ☐ Other title

Surname

Full forenames

Date of birth D D M M Y Y Y Y

Nationality

Address

If a company makes the payments on this plan, please confirm the registration number:

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, Zurich Assurance Ltd will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request Zurich Assurance Ltd 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 Zurich Assurance Ltd 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 Zurich Assurance Ltd 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.

Please complete the certificate and complete separate certificates for all parties to the contract (e.g. joint applicants, trustees, settlors and attorneys acting under Power of Attorney and third parties where you have been required to undertake identification).

Confirmation of verification of identity certificate

(to be completed by an FCA Regulated or EU Regulated Introducer)

Name of applicant*/trustee*/third party*/Attorney* (delete as applicable)

Mr/Mrs/Miss Other title

Surname

Full forename(s)

Address

Telephone number

Date of birth D D M M Y Y Y Y

Nationality

Plan number

Previous address if moved in last three months

I/We certify that:

a) the information above was obtained by me/us in relation to the customer;

b) the evidence I/we have obtained to verify the identity of the customer: (tick one only)

☐ **meets the standard evidence set out within the guidance for the UK Financial Sector issued by JMLSG; or**

☐ **exceeds the standard evidence (written details of the further verification evidence taken are attached to this confirmation).**

This certificate cannot be used to verify the identity of any customer that falls into one of the following categories:

- Those who are exempt from verification as being an existing client of the introducing firm prior to the introduction of the requirement for such verification;
- Those whose identity has not been verified by virtue of the application of a permitted exemption under the Money Laundering Regulations; or
- Those whose identity has been verified using the 'Source of funds' as evidence.

If you have not verified the identity of the applicant, please give reasons below:

Adviser name

Address

Telephone number

Adviser code

Financial services register number

Name of person completing this certificate

Job title

Signature

Date D D M M Y Y Y Y

Note this certificate must be signed by an officer of the introducer firm who is authorised to confirm the accuracy and effectiveness of the firm's customer identification verification records to which this certificate relates.

We cannot accept photocopies of completed certificates.

Please complete the certificate and complete separate certificates for all parties to the contract (e.g. joint applicants, trustees, settlors and attorneys acting under Power of Attorney and third parties where you have been required to undertake identification).

Confirmation of verification of identity certificate

(to be completed by an FCA Regulated or EU Regulated Introducer)

Name of applicant*/trustee*/third party*/Attorney* (delete as applicable)

Mr/Mrs/Miss Other title

Surname

Full forename(s)

Address

Telephone number

Date of birth D D M M Y Y Y Y

Nationality

Plan number

Previous address if moved in last three months

I/We certify that:

a) the information above was obtained by me/us in relation to the customer;

b) the evidence I/we have obtained to verify the identity of the customer: (tick one only)

☐ **meets the standard evidence set out within the guidance for the UK Financial Sector issued by JMLSG; or**

☐ **exceeds the standard evidence (written details of the further verification evidence taken are attached to this confirmation).**

This certificate cannot be used to verify the identity of any customer that falls into one of the following categories:

- Those who are exempt from verification as being an existing client of the introducing firm prior to the introduction of the requirement for such verification;
- Those whose identity has not been verified by virtue of the application of a permitted exemption under the Money Laundering Regulations; or
- Those whose identity has been verified using the 'Source of funds' as evidence.

If you have not verified the identity of the applicant, please give reasons below:

Adviser name

Address

Telephone number

Adviser code

Financial services register number

Name of person completing this certificate

Job title

Signature

Date D D M M Y Y Y Y

Note this certificate must be signed by an officer of the introducer firm who is authorised to confirm the accuracy and effectiveness of the firm's customer identification verification records to which this certificate relates.

We cannot accept photocopies of completed certificates.

Please complete the certificate and complete separate certificates for all parties to the contract (e.g. joint applicants, trustees, settlors and attorneys acting under Power of Attorney and third parties where you have been required to undertake identification).

Confirmation of verification of identity certificate
Corporate and other non-personal entity

Introduction by a FCA regulated firm

1. Details of customer

Full name of customer

Type of entity (corporate, trust, club, etc.)

Registered number, if any (or appropriate)

Relevant company registry or regulated market listing authority

Location of business (Address)

Names of directors or equivalent

Registered office (in country of incorporation)

Names of principal beneficial owners (Over 25%)

Relevant company registry includes Companies House, other registers, such as those maintained by charity commissions (or equivalent) or chambers of commerce.

2. Confirmation

I/We certify that:

a) the information in section 1 above was obtained by me/us in relation to the customer;

b) the evidence I/we have obtained to verify the identity of the customer: (tick one only)

- ☐ **meets the standard evidence set out within the guidance for the UK Financial Sector issued by JMLSG; or**
- ☐ **exceeds the standard evidence (written details of the further verification evidence taken are attached to this confirmation).**

This certificate cannot be used to verify the identity of any customer that falls into one of the following categories:

- Those who are exempt from verification as being an existing client of the introducing firm prior to the introduction of the requirement for such verification;
- Those whose identity has not been verified by virtue of the application of a permitted exemption under the Money Laundering Regulations; or
- Those whose identity has been verified using the 'Source of funds' as evidence.

If you have not verified the identity of the applicant, please give reasons below:

Signature

Name

Position

Date D D M M Y Y Y Y

3. Details of introducing firm (or sole trader)

Full name of regulated firm (or sole trader)

Financial services Register number

Note this certificate must be signed by an officer of the introducer firm who is authorised to confirm the accuracy and effectiveness of the firm's customer identification verification records to which this certificate relates.

We cannot accept photocopies of completed certificates.

Access to Medical Reports

This leaflet tells you why we ask you about your medical history, why we might ask your doctor for medical reports and what we do with the information given to us. It also explains your rights under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991.

What information will be in the doctor's report?

We use the details about your health, such as the information you give us on your application form and the reports from your doctor, to decide whether to offer you insurance and on what terms. In this way, we ensure the cost of insurance for everyone is fair. Our underwriters must work out what the risk of a person dying, or suffering a serious illness, might be when calculating how much to charge for insurance. We use statistics provided by various health organisations that give us information about 'the average person'. We also look at an individual's history of medical conditions and lifestyle factors that could affect the likelihood of a person dying prematurely or suffering a serious illness in the future. The underwriter will be particularly interested in whether or not it's possible for a person to suffer from a number of critical illnesses that may be covered by the plan applied for. Depending on the type of plan you've applied for, the underwriter will also look at the possibility of the applicant not being able to work because of ill health.

What information will be in the general practitioner's report?

The medical report your doctor fills in asks about:

Your current health:

- Care, medication or treatment you are receiving.
- Results of referrals or tests you are awaiting.
- Time off work in the last three years.

Your past health:

- Details of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your GP or any other medical adviser, therapist or counsellor, in particular whether you have a history of:
  - malignancy, cardiovascular disease, diabetes, or degenerative diseases;
  - musculoskeletal disease or injury, for example, arthritis, rheumatism, back problem or any other disorder of the joints or muscles;
  - anxiety state, depression, neurosis, psychosis, stress or fatigue;
  - suicidal tendencies or attempts;
  - conditions related to drug or alcohol misuse and/or tobacco consumption.
- Details of biopsies, blood tests, electrocardiograms, height, weight if measured in the last two years, urinalyses, x-rays or other investigations.
- Blood pressure readings in the last three years.

Any history of disease in your parents or siblings you've told your doctor about.

Your medical report will not ask for any information about:

- negative tests for HIV, hepatitis B or C;
- isolated or multiple incidences of sexually transmitted diseases unless there are long-term health implications; or
- genetic test results, unless there is a favourable test result that shows you've not inherited a condition.

The information you and your doctor give us about your health may result in insurance being declined, payments being increased above standard rates or payments being set at standard rates.

What are my access to medical reports rights?

We may need to apply to your doctor for a medical report and, if we do, we'll need your permission under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. Your legal rights are:

- You don't have to give your consent, but if you don't we may not be able to proceed. This doesn't stop you applying elsewhere.
- You can ask to see the report before your doctor returns it to us. If you do, we'll ask your doctor to retain it for 21 days so that you can arrange to see the report. This may cause a delay in processing your application.
- You can ask your doctor for a copy of the report at any time during the six months after it has been sent to us.
- You can ask your doctor to amend the report if you consider any aspect of the report to be incorrect or misleading. If your doctor refuses to make the amendments, you may add your comments to the report.
- Your doctor can refuse you access to the report if he feels this would cause physical or mental harm to you or others.
- Your medical report will contain details of relevant illness, trauma, referrals for specialist advice or treatment, hospital admissions, operations, consultations, investigations and test results that you have undergone at any surgery, hospital or clinic. It will also include details of any family history of disease that you have told your doctor about.
- Your consent will enable us to obtain information about your physical or mental health from any doctor and will give us access to copies of any letters, reports and test results.
- Your medical report won't ask for details of any negative tests for HIV, hepatitis B or C. It won't ask about any isolated or multiple incidences of sexually transmitted diseases unless there are long term health implications.

We may need to send your application and any medical report to our reassurers or underwriting company for their opinion or to obtain their agreement to the terms offered. We may also need to send them at a later date in connection with the management of the plan. You can get details of general reassurance principles and details of any company we use to assess your application, from us at the address shown below.

A doctor may choose to fax a medical report to us. The report may also be faxed to our reinsurers. If a medical report indicates abnormal findings or test results, we'll inform your doctor. If you have any questions about your rights under the Act or any questions about the process of obtaining, assessing or storing medical information, please write to us at:

Customer Services,
Tricentre One, New Bridge Square,
Swindon SN1 1HN.

Or call us on 01793 514514.

We are open from Monday to Friday 8.30am to 6pm

Declaration

I/We have read the section headed 'What are my access to medical reports rights?'. I/We consent to Zurich Assurance Ltd (Zurich) obtaining medical information from any doctor about anything affecting my/our physical or mental health and to Zurich obtaining information from other insurers about previous applications I/we have made for any life, sickness, accident or private medical insurance. I/We authorise those asked for such information to provide it on the production of a copy of this consent.

I/We do/do not* want access to any medical report prepared as a result. (*delete as appropriate).

Plan number

Name of 1st life

Signature of 1st life

Date of signature

D D M M Y Y Y Y

Name of 2nd life

Signature of 2nd life

Date of signature

D D M M Y Y Y Y

Zurich Assurance Ltd
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