Protectdirectonline.co.uk is an internet trading style of Temple Bar Independent Financial Advice Ltd.

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This questionnaire may be sent to the panel of insurers of Protect Direct (PD) to assess what terms may be available.

Section - A General Details

You may if you wish complete the health/medical questions in private and have them forwarded in confidence. If you wish to do this please print off all of **Section H** and complete it (including your name and date of birth) and submit to RPS in a sealed envelope marked "Private and Confidential – Medical Information" (attached to the application if that is also to be posted).

Genetic Testing

You do not need to give information about any genetic test result you have had if this application, together with any other insurance policies you have, are within the following limits:

- £500,000 or less for life assurance
- £300,000 or less for critical illness, income protection or long term care insurance.

Above these limits you may need to give information about certain test results when applying for insurance. Only genetic test results, which have been approved, by the Government's Genetics and Insurance Committee will be used.

You must however give information if you have a family history or symptoms of a genetic condition. It may be to your benefit to disclose if you have had a negative genetic test for such a condition.

1. Personal Details	First Life Assured	Second Life Assured
Title (Mr, Mrs, Miss, Ms, Dr etc..)		
Surname		
Forenames/Firstnames (in full)		
Marital Status - (married, single, divorced, etc)		
Gender	Male ☐ Female ☐	Male ☐ Female ☐
If joint life applicant, please state relationship of First and Second Life Assured. If **Other**, Please give details of the insurable interest you have:	Married ☐ Other ☐	Married ☐ Other ☐
Current Address: Post Code:		
Contact Telephone Number - Daytime		
Contact Telephone Number - Evening		
Date of Birth:		
E-mail Address:		

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2. Doctor's Details:

	First Life Assured	Second Life Assured
Name and address of your Doctor: Name: Address: Post Code:		
Telephone Number: (please provide whenever possible)		
If you have registered with a new doctor within the last 6/12 months please give the name and address of your previous doctor: Name: Address: Post Code:		
Telephone Number: (please provide whenever possible)		
Should a medical examination be required, please specify the town/area you would prefer to see a doctor in: (give 2 choices if possible)		

Life of Another OR Key Man Application

3. To be completed if proposer is not the life assured.

Company Name (if Key Man):	
Full Name and Title (if LOA):	
Home/Company Address: Post Code:	
Contact Telephone Number:	
Relationship to Life Assured:	

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Section - B Reason for Cover

Personal		Business	
Protection (self/dependants)	Yes ☐ No ☐	Share purchase*	Yes ☐ No ☐
Safeguard (mortgage/loan)	Yes ☐ No ☐	Protect loan*	Yes ☐ No ☐
Lifetime gift/inheritance tax	Yes ☐ No ☐	Partnership protection*	Yes ☐ No ☐
Other reasons (please state)		Keyman coverage*	Yes ☐ No ☐

**** Financial Underwriting required, please complete Form Fin 01***

Section - C Details of Cover and Benefits

1. Type of policy required (please tick the relevant boxes):

Term Assurance	**Whole of Life**
(i) Type a) ☐ Decreasing either ☐ - Mortages Protection or ☐ - Gift Inter Vivos b) ☐ Level Term c) ☐ Family Income Benefit	**(i) Type** a) ☐ Guaranteed b) ☐ Flexible* (Unit-linked reviewable premium & cover) ☐ Minimum ☐ Standard ☐ Maximum c) ☐ Low Cost
(ii) Options (at additional costs, if applicable) ☐ Guaranteed Premium Rates ☐ Reviewable Premium Rates ☐ Indexation ☐ Conversion ☐ Renewable ☐ Waiver of Premium Benefits	**(ii) Options (at additional costs, if applicable)** ☐ Guaranteed (guaranteed premium & cover) ☐ Reviewable Premium Rates ☐ Indexation ☐ Waiver of Premium Benefits

(iii) Benefits Basis: ☐ Single Life ☐ Joint Life 1st Death ☐ Joint Life 2nd Death

(iv) Amount of Cover Required: **** £**

If Term Assurance is Selected, how long is cover required? Years or to age:

**** The fund choice for the investment element can be selected once the Product Provider has been established***

***** If benefit amount is over £500,000 please complete Form Fin 01***

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Section - D Health and Lifestyle Details

1. Health and Lifestyle details:	First Life Assured	Second Life Assured
a) What is your height without shoes? b) What is your weight in indoor clothes?	ft ins or cms st lbs or kgs	ft ins or cms st lbs or kgs
c) Have you smoked or used any tobacco or nicotine products in the last 12 months? If ***yes***, what is average daily amount? Please note we may require a test to confirm your non-smoking status	Yes ☐ No ☐ _____ Per day	Yes ☐ No ☐ _____ Per day
d) What is your average weekly consumption of alcohol? (i.e. a unit of alcohol equals half a pint of normal strength beer, lager or cider, one standard glass of wine, or a single measure of spirit)	Units ☐	Units ☐
e) Have you ever been given medical advice to cease or reduce your alcohol consumption? If **yes**,	Yes ☐ No ☐ please give full details below	Yes ☐ No ☐ please give full details below
f) Have you ever used recreational drugs (e.g. cannabis, ecstasy, cocaine, heroin etc) or taken drugs other than on the advice of your doctor? If **yes**, please complete the "Drugs" supplementary questionnaire "**Form Med 07**"	Yes ☐ No ☐	Yes ☐ No ☐
g) Have you ever tested positive for HIV/AIDS or Hepatitis B or C or are you awaiting the result of such a test? If **yes**,	Yes ☐ No ☐ please give full details below	Yes ☐ No ☐ please give full details below
h) Have you (or a sexual partner of yours) ever been in the following categories: Homosexual, Bisexual, Intravenous (I.V.) Drug user or anyone whose normal place of residence is or was outside the UK? If **yes**,	Yes ☐ No ☐ please give full details below	Yes ☐ No ☐ please give full details below
i) Have you ever had, or are you waiting to have, a blood transfusion? If **yes**,	Yes ☐ No ☐ please give full details below	Yes ☐ No ☐ please give full details below

If yes to (e), (g), (h) or (i), please give full details and question number

Please use Section I where additional space is required for your answers to any questions

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Section - E Employment Details

1. Employment details:	First Life Assured	Second Life Assured
a) What is your occupation?* *if your occupation is one of these, please complete form: i) Fishing Industry - **Form Occ 01** ii) HM Armed Forces **- Form Occ 02** iii) North Sea/Offshore **- Form Occ 03**		
b) In what industry do you work? Please give brief details of your duties.		
c) Employment status? (Employed/Self Employed)		
d) Total yearly earnings?	£	£
e) How long have you been in your current occupation?	Years Months	Years Months
f) Does your job involve (answer **yes** or **no**) i) supervision of manual workers or inspection of work? ii) manual/physical duties iii) working with machinery or tools? iv) working at heights or underground? v) carrying or lifting? vi) standing or bending? vii) working offshore?	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
If **yes,** please give details and state percentage of time on activities listed. (Please use Section I, if additional space is required).		
viii) Do you work at heights If yes please state: Maximum height in metres: / Average height in metres:	Yes ☐ No ☐ Max ____ metres Av ____ metres	Yes ☐ No ☐ Max ____ metres Av ____ metres
g) Does your job involve driving (excluding commuting to and from your normal place of work)? If **yes**, what is your annual business mileage	Yes ☐ No ☐ = ____ miles	Yes ☐ No ☐ = ____ miles
h) Does your job involve flying other than as a passenger on commercial airlines? If **yes**, please complete **Form Pst 01**	Yes ☐ No ☐	Yes ☐ No ☐

Please use Section I where additional space is required for your answers to any questions

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Section - F Pastimes

1. Do you now, or do you intend to take part in:	First Life Assured	Second Life Assured
a) Any form of Flying activity (other than as a fare-paying passenger)? If **yes**, please complete **Form Pst 01**	Yes ☐ No ☐	Yes ☐ No ☐
b) Any form of Diving? If **yes**, please complete **Form Pst 02**	Yes ☐ No ☐	Yes ☐ No ☐
c) Any form of Hand-Gliding or Para-Gliding? If **yes**, please complete **Form Pst 03**	Yes ☐ No ☐	Yes ☐ No ☐
d) Any form of Motor Sport? If **yes**, please complete **Form Pst 04**	Yes ☐ No ☐	Yes ☐ No ☐
e) Any form of Climbing? If **yes**, please complete **Form Pst 05**	Yes ☐ No ☐	Yes ☐ No ☐
f) Any form of Parachuting/Skydiving? If **yes**, please complete **Form Pst 06**	Yes ☐ No ☐	Yes ☐ No ☐
g) Any form of Caving/Potholing? If **yes**, please complete **Form Pst 07**	Yes ☐ No ☐	Yes ☐ No ☐
h) Any form of Power/Sports Boat Racing? If **yes**, please complete **Form Pst 08**	Yes ☐ No ☐	Yes ☐ No ☐
i) Any form of Yachting/Sailing? If **yes**, please complete **Form Pst 10**	Yes ☐ No ☐	Yes ☐ No ☐
j) Have you lived or worked (for more than 4 weeks) outside Western Europe, North America, Australia or New Zealand in the last five years or do you have any future intention of doing so? If **yes**, please complete **Form Pst 09**	Yes ☐ No ☐	Yes ☐ No ☐

Section - G Other Life Office Applications

	First Life Assured	Second Life Assured
a) Has any application you have made for life, health or critical illness cover been declined, postponed or accepted on special terms or have you ever withdrawn an application? If **yes**, please supply dates, the insurance company name and details of the rating etc:	Yes ☐ No ☐	Yes ☐ No ☐

Please use Section I where additional space is required for your answers to any questions.

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Section - H Health and Medical Details

If you answer "yes" to any of these questions, please give full details in Section I or, if there is a "Supplementary Questionnaire" referred to within that question (ie: if yes, please complete Form Med 06), then please also complete and return that Form with this application.

1. Have you ever had symptoms of or been diagnosed with any of the following:	First Life Assured	Second Life Assured
a) high blood pressure, angina, heart attack, stroke, chest pain, raised cholesterol or other disorder of heart or circulation? If **yes**,	Yes ☐ No ☐ please give full details in **Section I**	Yes ☐ No ☐ please give full details in **Section I**
b) lump, growth, tumour or cancer? if **yes**, please complete **Form Med 09**	Yes ☐ No ☐	Yes ☐ No ☐
c) diabetes? if **yes**, please complete **Form Med 06**	Yes ☐ No ☐	Yes ☐ No ☐
d) kidney or bladder disorder? if **yes**, please complete **Form Med 05**	Yes ☐ No ☐	Yes ☐ No ☐
e) gynaecological disorder? if **yes**, please complete **Form Med 10**	Yes ☐ No ☐	Yes ☐ No ☐
f) hepatitis, colitis or other liver, bowel or stomach disorder or hernia? if **yes**, please complete **Form Med 13**	Yes ☐ No ☐	Yes ☐ No ☐
g) anxiety, depression or other mental or nervous disorders (including stress)? if **yes**, please complete **Form Med 01**	Yes ☐ No ☐	Yes ☐ No ☐
h) multiple sclerosis, paralysis (temporary or permanent) or visual disturbance or any form of tingling or numbness? If **yes**,	Yes ☐ No ☐ please give full details in **Section I**	Yes ☐ No ☐ please give full details in **Section I**
i) asthma, bronchitis, shortness of breath or other chest complaint? if **yes**, please complete **Form Med 03**	Yes ☐ No ☐	Yes ☐ No ☐
j) arthritis, rheumatism or gout? if **yes**, please complete **Form Med 02**	Yes ☐ No ☐	Yes ☐ No ☐
k) joint complaints (including Cartilage or ligaments, Tenosynovitis etc)? if **yes**, please complete **Form Med 11**	Yes ☐ No ☐	Yes ☐ No ☐
l) back pain, including whiplash, sciatica and slipped disc? if **yes**, please complete **Form Med 04**	Yes ☐ No ☐	Yes ☐ No ☐
m)other muskuloskeletal disorder or skin disorders? If **yes**,	Yes ☐ No ☐ please give full details in **Section I**	Yes ☐ No ☐ please give full details in **Section I**
n) Epilepsy, fits or blackouts? if **yes**, please complete **Form Med 08**	Yes ☐ No ☐	Yes ☐ No ☐

Please use Section I where additional space is required for your answers to any questions.

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	First Life Assured	Second Life Assured
o) Migraines or headaches? if **yes**, please complete **Form Med 12**	Yes ☐ No ☐	Yes ☐ No ☐
p) Thyroid disorder or glandular abnormality if yes, please complete **Form Med 14**	Yes ☐ No ☐	Yes ☐ No ☐
q) disorder of the ear (or balance and co-ordination problems) or eye (which is not corrected by a lens)? If **yes**,	Yes ☐ No ☐ please give full details in **Section I**	Yes ☐ No ☐ please give full details in **Section I**
r) Have any of your natural parents, brothers or sisters been diagnosed with or died from any of the following before age 60: Heart attack, stroke, cancer, diabetes, kidney disease, multiple sclerosis, paralysis, brain or nervous disorder or any form of hereditary disorder. If **yes**, please give full details of relative, condition and age.	Father Yes ☐ No ☐ Mother Yes ☐ No ☐ Brothers Yes ☐ No ☐ Sisters Yes ☐ No ☐ Disease: Age at diagnosis: ☐ If deceased, age at time of death: ☐	Father Yes ☐ No ☐ Mother Yes ☐ No ☐ Brothers Yes ☐ No ☐ Sisters Yes ☐ No ☐ Disease: Age at diagnosis: ☐ If deceased, age at time of death: ☐

2. Health/Medical Details:

	First Life Assured	Second Life Assured
a) Have you consulted any doctor or been advised to have an operation, x-ray, check up or investigation in the past 5 years? (You do not have to give details of colds, flu, uncomplicated pregnancies or contraception.) If **yes**,	Yes ☐ No ☐ please give full details in **Section I**	Yes ☐ No ☐ please give full details in **Section I**

3. Are you currently:

	First Life Assured	Second Life Assured
b) experiencing any symptom or disability not mentioned before? If **yes**,	Yes ☐ No ☐ please give full details in **Section I**	Yes ☐ No ☐ please give full details in **Section I**
c) waiting to have any consultation investigation, test or follow up? If **yes**,	Yes ☐ No ☐ please give full details in **Section I**	Yes ☐ No ☐ please give full details in **Section I**
d) taking any medicines or any other form of medical treatment? If **yes**,	Yes ☐ No ☐ please give full details in **Section I**	Yes ☐ No ☐ please give full details in **Section I**

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Section - I Answers to Section H plus any Additional Notes

Please include any further details here that you feel would help us when considering your application. Please state the section and question number alongside any further details.

First Life Assured
Please advise the diagnosis or nature of complaint, dates, any treatment received and full details of medication and follow-up required:

Section/Question No.	

Second Life Assured
Please advise the diagnosis or nature of complaint, dates, any treatment received and full details of medication and follow-up required:

Section/Question No.	

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Notes

The questions seek to obtain the material facts relevant to assessment of the insurance risk. You must answer all questions truthfully and if you are in any doubt about whether to disclose a fact you should still provide details on the questionnaire. Failure to disclose all material facts could mean the insurer will amend/withdraw any terms offered.

If there is any change to your circumstances between completion of the questionnaire and the start date of the policy, you must advise us of the change.

If any questions are completed on your behalf you must read the answers given and check that they record correctly what you have said.

Where the selected insurer from the PD panel does not require completion of their own full Application Form, this questionnaire will become the basis of the contract with that insurer. Otherwise, where the selected insurer does require their own full Application Form to be completed (plus any supplementary questionnaires, if applicable), then this questionnaire will form part of the supporting evidence to the overall application. A copy of the standard terms and conditions of the insurers Plan can be provided on request.

This questionnaire serves to appoint PD as your Financial Adviser for the product proposed and authorises us to receive a proportionate amount of commission agreed with your IFA.

Protect Direct will need to send your completed questionnaire electronically to the Underwriting Unit and to the Panel, using secure links, you have agreed that this method of communication is acceptable by signing the Declaration contained in this questionnaire.

Data Protection Notice

The information provided in the questionnaire will be passed to the Underwriters appointed by PD to carry out an initial assessment. They will decide on the medical or other evidence requirements which may be needed prior to quoting the terms for your application. A copy of the questionnaire and any evidence obtained will then be passed to the Panel to indicate what terms may be available. All Personal Information provided may be used, by the selected provider, to prepare and administer the policy.

A copy of the questionnaire, and any supporting evidence, may be shared with the Reinsurer of the selected insurer, should the risk be reinsured.

We may write to your GP should a condition be noted on a medical examination, which your doctor may not be aware of.

All the information supplied will be kept confidential and not disclosed to any other party without your consent, unless it is lawful to do so.

Any medical information, which is provided in connection with your application, will be used only for underwriting purposes. This information is defined as “sensitive” by the Data Protection Act 1998 and your consent is required before any insurer or agent of the Risk Placement Services can hold, use or retain it. We regret without your consent we will be unable to process your application.

Your personal data may be passed to other companies in the selected insurers group of companies you may then be contacted with details of other products.

If you do not wish your personal details to be used in this way then please tick this box ☐

If you would like to request a copy of the information held about you, please write to the Data Protection co-ordinator of the selected insurer. A fee may be charged for providing this information

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Access to Medical Reports Act

To consider your application we may have to obtain a medical report from a doctor who has cared for you. The Access to Medical Reports Act 1988 or Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 gives you certain legal rights over these reports. Briefly your rights are as follows:

1. Before we can apply for a medical report from a doctor who has cared for you, we need your agreement. You can refuse but in this case we will not be able to make any offer of cover to you.
2. You can ask to see a report before your doctor sends it to our Chief Medical Officer or you can ask your doctor to see a copy of the report for up to six months after it has been sent to us.
3. If you think part of the report is incorrect or misleading when you see it, you can ask to have it changed. If your doctor will not agree to this, you may attach a statement of your own.

Your doctor does not have to let you see the report if he or she believes it is not in the interests of your health, or if the interests of other people have to be considered.

Once you have seen the report your doctor cannot return it to us unless you agree.
If we need a report and you have said you want to see it before it is returned to us, we will write to let you know. You will then have 21 days to contact the doctor to arrange to see the report. After this period the doctor will be free to return the report.

Declaration and Consent

I declare that to the best of my knowledge and belief the answers I have given (whether in my handwriting or not) are true and complete. This declaration also applies to any supplementary questionnaires that are submitted by me or on my behalf. I confirm I have read and understand the Notes in this form.

I am aware of my legal rights under the Access to Medical Reports Act 1988/Access to Personal Files and Medical Reports (Northern Ireland) Order (as amended). I agree that Protect Direct may ask for medical information from any doctor who at any time has attended me about anything that affects my physical or mental health or ask for information, including medical reports, from any insurance office to which a proposal has been made on my life and I authorise the giving of such information. I authorise RPS to give copies of all information obtained to the panel of insurers. I also agree that when the selected insurer will treat this questionnaire as the basis of the contract, then this consent allows the insurer to obtain a medical report at any time during the lifetime of the plan and after my death to support any claim on the plan.

I agree to complete a full Application Form for the selected Provider, where required. I also understand that the Provider retains the right to seek any further medical evidence or alter the terms offered should that Application Form contain any information not previously disclosed or if my/our health or circumstances have changed since completion of this form and the date of the policy going on risk.

I have read and understood the Data Protection Notice. I agree that my personal information (including sensitive data) may be used for the purposes described.

I agree that a copy of this questionnaire can be treated as the original for all purposes.

I understand that if I have failed to provide correct answers to the questions stated then the terms offered by the selected Insurer may be amended or withdrawn.

Your Declaration:

I do not* wish to see this report on me before it is sent to RPS

* Only delete the word **not** if you wish to see the report.

Signature X

Date

Your name in BLOCK CAPITALS

Your Date of Birth

Your Partner's Declaration:

I do not* wish to see this report on me before it is sent to RPS

* Only delete the word **not** if you wish to see the report.

Signature X

Date

Your name in BLOCK CAPITALS

Your Date of Birth

Our preference is for a scanned or faxed copy. If you use "snail-mail" see address below. **PDQ IFA**

Return to:Temple Bar Independent Financial Advice,
FREEPOST SWC2591, Worcester WR37ZA