

# APPLICATION FORM (SA4).

## Family Protection Mortgage Protection

### Welcome to Legal & General.

This form is designed to mirror OLP Connect. It is made up of three parts:

**Part A** – Quote

**Part B** – Standard Underwriting

**Part C** – Client Declaration and Direct Debit

Please answer all questions in this form to the best of your knowledge and belief, as this will help avoid any delay in processing your application. If you don't answer fully and accurately, it will very likely mean that a claim will be declined and your policy may be cancelled.

See the following pages for some brief notes that will help you with your application. Thank you.

### Adviser Declaration – For adviser use only

Full name of firm

Principal FCA Firm  
Reg. No.

Appointed Representative FCA  
Firm Reg. No. (if applicable)

FCA Individual  
Reg. No.

Legal & General Agency No.

Name of Representative

Signature

Adviser email address

Your reference

Date (DDMMYYYY)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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**Please remind your client of the importance of answering questions fully and accurately.**

We do not require you to provide proof of identification for clients or 3rd party payers, as we will complete our own checks.

All intermediaries should maintain processes to prevent them from being used to further financial crime, and Legal & General's requirements do not prevent them from collecting client verification for their own purposes.

### Basis of Advice Declaration

To meet our reporting requirements, Legal & General must record whether advice was given to your client(s) regarding this sale. Please select the relevant answer below.

Was advice given?

Yes

☐

No

☐

## Tips for completing this application form

- **Blue** parts **must be completed**.
- **Green** parts are additional questionnaires which **only need to be completed if you are instructed to do so** within the form.
- **For joint life plans**, please complete Client 1 and Client 2 sections, each client must fill out their own details.
- **If your financial adviser is going to complete this form on your behalf** using the information you have provided, you must read all of the questions and answers carefully before signing the Client Declaration at the end.  
Your financial adviser is acting on your behalf in this respect.

### To help you complete this application you will need:

- Information relating to existing or previous life insurance.
- Details of medication or treatment that you are currently having.
- Your doctor's name and the practice name and address (including their postcode).
- Your bank account details.

### Please be aware of the following points before proceeding with this application:

## IMPORTANT CUSTOMER INFORMATION

- You must answer the application questions truthfully and accurately. This is to help ensure Legal & General can pay valid claims.
- The questions must only be answered by the person(s) to be insured.
- Around one in ten applications will be checked by obtaining information from your doctor, either before or shortly after your policy has started.
- You must give Legal & General your doctor's details, and consent to contact them for a medical report if we need to.
- You may complete the medical questions in private and return the answers in a sealed envelope directly to the Medical Officer at Legal & General Assurance Society Limited, Brunel House, 2 Fitzalan Road, Cardiff CF24 0EB

### Your medical information

Legal & General follow a strict confidentiality code about all medical information you give them, or which they get from any additional medical report. This is held securely and access is limited to authorised individuals who need to see it.

### Genetic Testing

The only genetic test result which you will need to tell us about is one for Huntington's disease, and you will only need to tell us about this when the total life insurance you have or are buying is over £500,000.

### Complaints Procedure

Legal & General have a formal complaints procedure and details will be given to you when you receive your policy documentation.

# OLP CONNECT – QUOTE.

## Family Protection Mortgage Protection

Part A is designed to mirror the quote section in OLP Connect so that you can capture your client's requirements in advance and complete the quote in OLP Connect.

### BASIC DETAILS

**Full name and title**

Please ensure you give all of your middle names.

**Client one**

Mr/Mrs/Miss/Ms/Dr/Rev/Other

Forename(s) and middle name(s) in full

Surname

**Client two**

Mr/Mrs/Miss/Ms/Dr/Rev/Other

Forename(s) and middle name(s) in full

Surname

**Gender**

We only use your gender for purposes that comply with requirements under the Equality Act.

Male ☐ Female ☐

Male ☐ Female ☐

**Date of birth (DDMMYYYY)**
       
       

**During the last 12 months have you smoked any cigarettes, cigars, a pipe or used nicotine replacements?**

Yes – regularly ☐ Yes – occasionally ☐ None at all ☐

A simple medical test may be required to check your answer.

If you smoke cigarettes, cigars, a pipe or use nicotine replacements weekly or more often you should answer 'Yes – regularly'.

Yes – regularly ☐ Yes – occasionally ☐ None at all ☐

A simple medical test may be required to check your answer.

If you smoke cigarettes, cigars, a pipe or use nicotine replacements weekly or more often you should answer 'Yes – regularly'.

**Employment status**

Full time employee ☐ Part time employee ☐

Contract worker ☐ Self employed ☐

Retired ☐ Student ☐

Unemployed ☐ Houseperson ☐

Full time employee ☐ Part time employee ☐

Contract worker ☐ Self employed ☐

Retired ☐ Student ☐

Unemployed ☐ Houseperson ☐

## OCCUPATION DETAILS



Only applicable for applications which include Income Protection Benefit or Critical Illness Cover.  
You don't need to answer this question if you are a Houseperson, retired, a student or unemployed.

Please indicate your occupation type from the categories listed opposite.

If your occupation doesn't fit into one of these categories, tick 'Another category'.

	Client one	Client two
Working in an office-type environment for at least 75% of your typical working day	<input type="checkbox"/>	<input type="checkbox"/>
Retail – for example, salesperson, retailer, shop worker or manager, <b>(except market traders)</b>	<input type="checkbox"/>	<input type="checkbox"/>
Catering – for example, caterer, chef, cook, waiter, waitress, kitchen staff	<input type="checkbox"/>	<input type="checkbox"/>
Education – for example, teacher, lecturer, head teacher, classroom assistant, nursery worker	<input type="checkbox"/>	<input type="checkbox"/>
Healthcare – for example, nursing, medical, surgical, carer	<input type="checkbox"/>	<input type="checkbox"/>
Another category <b>(including market traders)</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>If 'Healthcare', please select:</b>		
Nurse, staff nurse, charge nurse, sister, matron, auxiliary, paramedic, practice nurse, dental nurse, district nurse, midwife	<input type="checkbox"/>	<input type="checkbox"/>
Surgeon, anaesthetist, obstetrician, gynaecologist, dentist, dental hygienist, carer, care assistant, social worker, physiotherapist	<input type="checkbox"/>	<input type="checkbox"/>
Physician, medical or general practitioner, hospital doctor <b>(other than surgeon, anaesthetist, obstetrician or gynaecologist – see above)</b> , psychiatrist, osteopath	<input type="checkbox"/>	<input type="checkbox"/>

  

Client one	Client two
<b>If 'Another category', please give details:</b> <div style="border: 1px solid black; height: 50px; margin: 5px 0;"></div> Occupation*	<b>If 'Another category', please give details:</b> <div style="border: 1px solid black; height: 50px; margin: 5px 0;"></div> Occupation*
Occupation class 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	Occupation class 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
*Please complete for main occupation only.	

The occupation class is to be completed by your financial adviser.

## PRODUCT SELECTION AND PRODUCT DETAILS – LIFE AND CRITICAL ILLNESS COVER PRODUCTS

### Please note:

- **Term Assurance** is Legal & General's product name for life cover and **CIC** stands for Critical Illness Cover throughout this application.
- Start date. If this plan replaces another, please consider the premium collection date of your existing plan, to reduce the possibility of double cover.

PRODUCT SELECTION		PRODUCT DETAILS						
<b>Reason for Purchase</b>  Family Protection <input type="checkbox"/> Mortgage Protection <input type="checkbox"/>	<b>Select a Product</b>  Term Assurance <input type="checkbox"/> Critical Illness Cover (reviewable) <input type="checkbox"/> Family Protection only <input type="checkbox"/> Family and Personal Income Plan <input type="checkbox"/>	<b>Sum Assured/ Monthly Benefit</b>  £ <input type="text"/>  <b>or Premium</b>  £ <input type="text"/>	<b>Premium Frequency</b>  Monthly <input type="checkbox"/> Annual <input type="checkbox"/>	<b>Policy Term</b>  <input type="text"/> yrs	<b>Level or Decreasing</b>  Level <input type="checkbox"/>  Mortgage Protection only <input type="checkbox"/>  Decreasing <input type="checkbox"/>	<b>Policy Interest Rate</b>  Decreasing only <input type="checkbox"/> <input type="text"/> %	<b>Indexation</b>  Not available if 'Decreasing' or 'Conversion Option' selected  No <input type="checkbox"/> Yes <input type="checkbox"/>	<b>Waiver of Premium Benefit</b>  No <input type="checkbox"/> Client 1 only <input type="checkbox"/> Client 2 only <input type="checkbox"/> Both <input type="checkbox"/>
<b>Select Client</b>  Client 1 only (single life) <input type="checkbox"/> Client 2 only (single life) <input type="checkbox"/> Both (joint life) <input type="checkbox"/>		<b>Conversion Option</b> Not available if 'Decreasing' or 'Indexation' is selected, or on plans including CIC  No <input type="checkbox"/> Yes <input type="checkbox"/>	<b>Critical Illness Cover</b>  No – Life cover only <input type="checkbox"/> Yes – Life with CIC <input type="checkbox"/> (FPIP) CIC only <input type="checkbox"/>	<b>Total and Permanent Disability Cover</b> Plans including CIC  No <input type="checkbox"/> Yes – Own Occupation <input type="checkbox"/> Yes – Specified Work Tasks <input type="checkbox"/>	<b>Guaranteed or Reviewable Premiums</b>  Guaranteed <input type="checkbox"/> Plans including CIC <input type="checkbox"/> Reviewable <input type="checkbox"/>	<b>Start date (DDMMYYYY)</b>  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>  Or not known <input type="checkbox"/>		

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**PRODUCT SELECTION AND PRODUCT DETAILS – LIFE AND CRITICAL ILLNESS PRODUCTS** continued

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<b>Reason for Purchase</b>  Family Protection <input type="checkbox"/> Mortgage Protection <input type="checkbox"/>	<b>Select a Product</b>  Term Assurance <input type="checkbox"/> Critical Illness Cover (reviewable) <input type="checkbox"/>  Family Protection only <input type="checkbox"/> Family and Personal Income Plan <input type="checkbox"/>	<b>Sum Assured/ Monthly Benefit</b>  £ <input type="text"/>  <b>or Premium</b>  £ <input type="text"/>	<b>Premium Frequency</b>  Monthly <input type="checkbox"/> Annual <input type="checkbox"/>	<b>Policy Term</b>  <input type="text"/> yrs	<b>Level or Decreasing</b>  Level <input type="checkbox"/>  Mortgage Protection only <input type="checkbox"/>  Decreasing <input type="checkbox"/>	<b>Policy Interest Rate</b>  Decreasing only <input type="checkbox"/> %	<b>Indexation</b>  Not available if 'Decreasing' or 'Conversion Option' selected  No <input type="checkbox"/> Yes <input type="checkbox"/>	<b>Waiver of Premium Benefit</b>  No <input type="checkbox"/> Client 1 only <input type="checkbox"/> Client 2 only <input type="checkbox"/> Both <input type="checkbox"/>
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## INCOME PROTECTION BENEFIT

PRODUCT SELECTION		PRODUCT DETAILS						
<b>Reason for Purchase</b>  Family Protection <input type="checkbox"/> Mortgage Protection <input type="checkbox"/>		<b>Premium Frequency</b>  Monthly <input type="checkbox"/> Annual <input type="checkbox"/>	<b>Annual Earnings</b>  <input type="text" value="£"/>  Earnings are defined as your annual pre tax earnings for PAYE assessment purposes and can include your P11d benefits. Please refer to your Key Features Document for full information.	<b>Do you work more than 16 hours per week?</b>  Yes <input type="checkbox"/> No <input type="checkbox"/> If 'No', your occupation will be classed as a 'Houseperson'	<b>Type of cover</b>  Standard <input type="checkbox"/> Low Cost <input type="checkbox"/>	<b>Monthly Benefit (stage 1)</b>  <input type="text" value="£"/>	<b>Deferred period (stage 1)</b>  4 weeks <input type="checkbox"/> 13 weeks <input type="checkbox"/> 26 weeks <input type="checkbox"/> 52 weeks <input type="checkbox"/>	<b>Age at expiry</b>  <input type="text" value=""/> yrs
<b>Select Client</b>  Client 1 (only) <input type="checkbox"/> Client 2 (only) <input type="checkbox"/>		<b>Stepped Benefit</b>  Yes <input type="checkbox"/> No <input type="checkbox"/> Option not available for low cost		<b>Stage 2 (only if Stepped Benefit selected)</b>  Deferred period 13 weeks <input type="checkbox"/> 26 weeks <input type="checkbox"/> 52 weeks <input type="checkbox"/>  Monthly benefit <input type="text" value="£"/>		<b>Indexation</b>  Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Start date (DDMMYYYY)</b>  <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> Or not known <input type="checkbox"/>	

PRODUCT SELECTION		PRODUCT DETAILS						
<b>Reason for Purchase</b>  Family Protection <input type="checkbox"/> Mortgage Protection <input type="checkbox"/>		<b>Premium Frequency</b>  Monthly <input type="checkbox"/> Annual <input type="checkbox"/>	<b>Annual Earnings</b>  <input type="text" value="£"/>  Earnings are defined as your annual pre tax earnings for PAYE assessment purposes and can include your P11d benefits. Please refer to your Key Features Document for full information.	<b>Do you work more than 16 hours per week?</b>  Yes <input type="checkbox"/> No <input type="checkbox"/> If 'No', your occupation will be classed as a 'Houseperson'	<b>Type of cover</b>  Standard <input type="checkbox"/> Low Cost <input type="checkbox"/>	<b>Monthly Benefit (stage 1)</b>  <input type="text" value="£"/>	<b>Deferred period (stage 1)</b>  4 weeks <input type="checkbox"/> 13 weeks <input type="checkbox"/> 26 weeks <input type="checkbox"/> 52 weeks <input type="checkbox"/>	<b>Age at expiry</b>  <input type="text" value=""/> yrs
<b>Select Client</b>  Client 1 (only) <input type="checkbox"/> Client 2 (only) <input type="checkbox"/>		<b>Stepped Benefit</b>  Yes <input type="checkbox"/> No <input type="checkbox"/> Option not available for low cost		<b>Stage 2 (only if Stepped Benefit selected)</b>  Deferred period 13 weeks <input type="checkbox"/> 26 weeks <input type="checkbox"/> 52 weeks <input type="checkbox"/>  Monthly benefit <input type="text" value="£"/>		<b>Indexation</b>  Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Start date (DDMMYYYY)</b>  <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> Or not known <input type="checkbox"/>	

**PRINT**

[Click here to print Part A – Quote \(only\).](#)



# OLP CONNECT – STANDARD UNDERWRITING (SA4).

## Family Protection Mortgage Protection

Part B is designed to mirror the Standard Underwriting route in OLP Connect so that you can capture your client's answers in advance and complete the application in OLP Connect. This form **cannot** be used with the Interactive Underwriting route.

### CUSTOMER CONTACT DETAILS

**What is your contact address, including postcode?**

Please check that you've filled in your postcode as this is essential for processing the application more quickly.

**What is your home address, including postcode, if different from the contact address provided above?**

Please check that you've filled in your postcode.

**What are your contact details?**

Please ensure that you complete all details.

**It may be necessary for us to contact you to discuss your application, which might include discussing matters of a sensitive nature. Are you happy for us to telephone you in this event?**

Please note, we may record and monitor calls.

Client one	Client two
<p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p>Postcode <input type="text"/></p>	<p>As Client 1 <input type="checkbox"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p>Postcode <input type="text"/></p>
<p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p>Postcode <input type="text"/></p>	<p>As Client 1 <input type="checkbox"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p>Postcode <input type="text"/></p>
<p>Work phone <input type="text"/></p> <p>Home phone <input type="text"/></p> <p>Mobile phone <input type="text"/></p> <p>Email address <input type="text"/></p>	<p>Work phone <input type="text"/></p> <p>Home phone <input type="text"/></p> <p>Mobile phone <input type="text"/></p> <p>Email address <input type="text"/></p>
<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If 'Yes', which phone number <b>and</b> time is most suitable?</p> <p>Work <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/></p> <p>Mon-Fri 9am-11am <input type="checkbox"/> Mon-Fri 11am-2pm <input type="checkbox"/></p> <p>Mon-Fri 2pm-4pm <input type="checkbox"/> Mon-Fri 4pm-6pm <input type="checkbox"/></p> <p>Mon-Fri 6pm-8pm <input type="checkbox"/></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If 'Yes', which phone number <b>and</b> time is most suitable?</p> <p>Work <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/></p> <p>Mon-Fri 9am-11am <input type="checkbox"/> Mon-Fri 11am-2pm <input type="checkbox"/></p> <p>Mon-Fri 2pm-4pm <input type="checkbox"/> Mon-Fri 4pm-6pm <input type="checkbox"/></p> <p>Mon-Fri 6pm-8pm <input type="checkbox"/></p>

## DOCTOR'S DETAILS

Please include your doctor's practice name or clinic, postcode and telephone number as this is essential for processing your application more quickly.



**Please don't assume that we'll contact your doctor for confirmation of medical details.**

<div>Doctor's name</div> <div>Practice/clinic name and address (including postcode)</div> <div>Postcode</div> <div>Telephone number</div>	<div>Doctor's name</div> <div>Practice/clinic name and address (including postcode)</div> <div>As client 1 <input type="checkbox"/></div> <div>Postcode</div> <div>Telephone number</div>
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## PERMISSION TO REQUEST A MEDICAL REPORT FROM YOUR DOCTOR

Legal & General may need to request a medical report from your doctor in order to assess your application.

We will need your consent to be able to do this and a form for this is provided as part of this application form. You don't have to provide consent but it will mean we won't be able to continue with your application if we do need a medical report.

If you have any questions relating to the process of obtaining, assessing or storing medical information, please write to:  
The Claims and Underwriting Director, Legal & General, City Park, The Drove Way, Hove BN3 7PY

We would like to ask you for your consent to request a medical report to help us assess your application. This request is made using the Access to Medical Reports Act 1988, the Access to Personal Files and Medical reports (Northern Ireland) Order 1991, and the Isle of Man Access to Health Records and Reports Act 1993.

Please complete the following details to help your doctor's surgery to match your records:

Full Name:	Mr/Mrs/Miss/Ms/Dr/Rev/Other <input type="text"/>	GP Name (if known): <input type="text"/>
Current Address:	<input type="text"/> <input type="text"/> <input type="text"/>	GP Address: <input type="text"/> <input type="text"/> <input type="text"/>
Date of Birth (DDMMYYYY):	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Surgery Name: <input type="text"/>

#### Things you need to know before you give your consent

- If you would like to see a copy of the report before we receive it, please let us know below. You will then have 21 days from the date we request the report to arrange an appointment with your doctor to see it.
- If you read the report and think that anything is incorrect or misleading you may ask your doctor to amend it, or you may attach a personal statement to the report before it's sent to us.
- Your doctor may decide not to show you the report if he or she feels that it would cause physical or mental harm to you or others.
- You can request to see a copy of the report any time within 6 months from the date your doctor sends it to us.
- We will not request a medical report from your doctor without your consent to do so. Though please be aware that we may not be able to offer you the cover requested without seeing a medical report.

The medical report that your doctor sends to us could include details of consultations with any doctor or healthcare professional but we will only ask for information about your current or past health that's relevant to your application.

#### We will not ask your doctor to reveal information about:

- negative tests for HIV, hepatitis B or C;
- any sexually transmitted infections 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.

To see an example of the questions we will ask your GP please visit the following website  
[www.legalandgeneral.com/medicalquestions](http://www.legalandgeneral.com/medicalquestions)

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

Claims and Underwriting Director  
Legal & General Assurance Society  
City Park  
The Droveaway  
HOVE  
BN3 7PY

#### Declaration of Consent

I consent to Legal & General asking any doctor I have consulted about my physical or mental health to provide a medical report so that they may assess my application. I authorise those asked to provide a medical report when they see a copy of this consent form. This consent is valid for six months from today's date.

Signature:

Date (DDMMYYYY):

If Legal & General need to ask for a report from your doctor  
do you want to see the report before it is sent to us?

Yes ☐ No ☐



We would like to ask you for your consent to request a medical report to help us assess your application. This request is made using the Access to Medical Reports Act 1988, the Access to Personal Files and Medical reports (Northern Ireland) Order 1991, and the Isle of Man Access to Health Records and Reports Act 1993.

Please complete the following details to help your doctor's surgery to match your records:

Full Name:	Mr/Mrs/Miss/Ms/Dr/Rev/Other <input type="text"/>	GP Name (if known): <input type="text"/>
Current Address:	<input type="text"/> <input type="text"/> <input type="text"/>	GP Address: <input type="text"/> <input type="text"/> <input type="text"/>
Date of Birth (DDMMYYYY):	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Surgery Name: <input type="text"/>

#### Things you need to know before you give your consent

- If you would like to see a copy of the report before we receive it, please let us know below. You will then have 21 days from the date we request the report to arrange an appointment with your doctor to see it.
- If you read the report and think that anything is incorrect or misleading you may ask your doctor to amend it, or you may attach a personal statement to the report before it's sent to us.
- Your doctor may decide not to show you the report if he or she feels that it would cause physical or mental harm to you or others.
- You can request to see a copy of the report any time within 6 months from the date your doctor sends it to us.
- We will not request a medical report from your doctor without your consent to do so. Though please be aware that we may not be able to offer you the cover requested without seeing a medical report.

The medical report that your doctor sends to us could include details of consultations with any doctor or healthcare professional but we will only ask for information about your current or past health that's relevant to your application.

#### We will not ask your doctor to reveal information about:

- negative tests for HIV, hepatitis B or C;
- any sexually transmitted infections 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.

To see an example of the questions we will ask your GP please visit the following website  
[www.legalandgeneral.com/medicalquestions](http://www.legalandgeneral.com/medicalquestions)

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

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The Droveaway  
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BN3 7PY

#### Declaration of Consent

I consent to Legal & General asking any doctor I have consulted about my physical or mental health to provide a medical report so that they may assess my application. I authorise those asked to provide a medical report when they see a copy of this consent form. This consent is valid for six months from today's date.

Signature:

Date (DDMMYYYY):

If Legal & General need to ask for a report from your doctor  
do you want to see the report before it is sent to us?

Yes ☐ No ☐



## WORK, TOTAL COVER AND TRAVEL

It's very important you answer every question truthfully and accurately to ensure all valid claims are paid to protect you and your dependants. If you don't, it could mean a claim may not be paid and your policy may be cancelled. Legal & General won't always write to your doctor to confirm your answers.

### Client one

Please tick to confirm you've read the above statement.

☐

### Client two

Please tick to confirm you've read the above statement.

☐


Only answer this question if you're applying for Income Protection Benefit with an occupation class 1 or 2.

How many business miles do you drive on average each year?

 miles

 miles

Please ignore travel to and from your usual place of work.



If you're a Houseperson, retired, a student or unemployed, please ignore this question and proceed to the next question.

Do you work in any of the occupations or environments opposite?

If 'Yes', tick all that apply.

If 'No', tick 'None of the above'.

15 metres is the height of a typical 3 storey house.

Outside at heights over 15 metres (50 ft) for more than 5 hours during a typical week

☐
☐

The Armed Forces or as a member of the Army Reserve

☐
☐

The offshore fishing industry

☐
☐

The offshore oil or gas industry

☐
☐

As a full time barman, barmaid or landlord in a public house.

Full time means working an average of 30 or more hours a week.

☐
☐

Underwater

☐
☐

Underground, for example mining, tunnelling

☐
☐

With explosives

☐
☐

None of the above

☐
☐

### Client one

Occupation\*

### Client two

Occupation\*

Please tell us your occupation if you haven't told us already in this form and you've ticked one of the occupations in this question.

\*If you have more than one, please state your main occupation only.

Including this application, will the total amount of cover on your life for family and mortgage purposes exceed £1,500,000 life cover or £750,000 critical illness cover?

Please ignore cover that will be cancelled and applications that are for comparison purposes only.

Yes ☐ No ☐

If 'Yes':

How much family, mortgage and Inheritance Tax protection life cover do you have?

 £

How much family and mortgage critical illness cover do you have?

Enter an amount if you answered yes to this question and this application includes critical illness cover.

 £

Yes ☐ No ☐

If 'Yes':

How much family, mortgage and Inheritance Tax protection life cover do you have?

 £

How much family and mortgage critical illness cover do you have?

Enter an amount if you answered yes to this question and this application includes critical illness cover.

 £


If you've answered 'Yes' to the above question, please complete the Personal Assurance Questionnaire (page 22) BEFORE continuing with the next question.

**During the last 5 years have you spent more than 90 consecutive days in Africa, the Caribbean, Russia, Thailand or Ukraine?**

The Caribbean includes Antigua, Bahamas, Barbados, Bermuda, Cuba, Dominican Republic, Grenada, Haiti, Jamaica, Trinidad and Tobago and its other islands.

**During the next 2 years do you intend to spend more than 30 consecutive days outside the UK?**

Please ignore travel as a member of the Armed Forces.

In this context, UK includes England, Scotland, Wales and Northern Ireland.

#### Client one

Yes ☐ No ☐

If 'Yes', which part of the world was this?  
(tick all that apply)

Africa – Algeria, Egypt, Libya, Morocco, Tunisia ☐

Africa – other ☐ The Caribbean ☐

Russia or Ukraine ☐ Thailand ☐

Yes ☐ No ☐

If 'Yes', please give the following details:

Will you be staying within the European Union, United States of America, Canada, Australia or New Zealand?

Yes ☐ No ☐

Do you plan to leave the UK permanently?

Yes ☐ No ☐

If 'Yes' to leaving permanently, when do you intend to leave?

Within 3 months ☐ Later than 3 months ☐

If 'No' to leaving permanently:

How long do you plan to be outside the UK or Republic of Ireland during the next 2 years?

weeks

days

Which countries or islands outside the European Union, United States of America, Canada, Australia or New Zealand are you going to?

#### Client two

Yes ☐ No ☐

If 'Yes', which part of the world was this?  
(tick all that apply)

Africa – Algeria, Egypt, Libya, Morocco, Tunisia ☐

Africa – other ☐ The Caribbean ☐

Russia or Ukraine ☐ Thailand ☐

Yes ☐ No ☐

If 'Yes', please give the following details:

Will you be staying within the European Union, United States of America, Canada, Australia or New Zealand?

Yes ☐ No ☐

Do you plan to leave the UK permanently?

Yes ☐ No ☐

If 'Yes' to leaving permanently, when do you intend to leave?

Within 3 months ☐ Later than 3 months ☐

If 'No' to leaving permanently:

How long do you plan to be outside the UK or Republic of Ireland during the next 2 years?

weeks

days

Which countries or islands outside the European Union, United States of America, Canada, Australia or New Zealand are you going to?

## HAZARDOUS ACTIVITIES

#### Client one

Caving or Potholing ☐

Flying (other than as a fare-paying passenger or cabin crew) ☐

Hang gliding or Paragliding ☐

Motor car sport ☐

Motorcycle sport ☐

Mountaineering or Rock climbing ☐

Parachuting, Sky diving or BASE jumping ☐

Powerboat racing ☐

Sailing other than inland ☐

Underwater diving ☐

Any Extreme Sport, for example bungee jumping, canyoning, white water rafting ☐

None of the above ☐

#### Client two

Caving or Potholing ☐

Flying (other than as a fare-paying passenger or cabin crew) ☐

Hang gliding or Paragliding ☐

Motor car sport ☐

Motorcycle sport ☐

Mountaineering or Rock climbing ☐

Parachuting, Sky diving or BASE jumping ☐

Powerboat racing ☐

Sailing other than inland ☐

Underwater diving ☐

Any Extreme Sport, for example bungee jumping, canyoning, white water rafting ☐

None of the above ☐

**Do you regularly take part in any of the activities listed opposite or do you intend to do so within the next 6 months?**

Please ignore one off bungee and parachute jumps.

If 'Yes', tick all that apply.

If 'No', tick 'None of the above'.



If you've ticked any of the activities listed in the question above, please complete the Hazardous Activities Questionnaire (page 25) BEFORE continuing with the next question.



**i** Please don't assume that we'll contact your doctor for confirmation of medical details.

**Genetic Testing.**

The Association of British Insurers (ABI) have a policy on genetics and insurance. Currently, you only need to tell us about any genetic test results concerning Huntington's disease, for life insurance over £500,000 in total. This is because the Government has approved this test for insurers to use. The total is for any life insurance application being made now together with any life insurance you have already. You don't need to tell us about any other genetic test result. However, you must tell us if you are experiencing symptoms of, or are having treatment for, a medical condition including any genetically inherited condition. You must also tell us of any family history of a medical condition as asked for in the relevant question in this application. If you want to tell us about a negative genetic test result, we'll be willing to consider this when setting your premium. A copy of the Concordat and Moratorium on Genetics and Insurance is available from us on request or from the ABI website [www.abi.org.uk](http://www.abi.org.uk)

	Client one	Client two
<b>What is your height (without shoes)?</b>	<input type="text"/> m OR <input type="text"/> ft <input type="text"/> in	<input type="text"/> m OR <input type="text"/> ft <input type="text"/> in
<b>What is your weight (in indoor clothes)?</b>	<input type="text"/> kg OR <input type="text"/> st <input type="text"/> lb	<input type="text"/> kg OR <input type="text"/> st <input type="text"/> lb
If you're pregnant, please give your weight immediately prior to this pregnancy.		
<b>What is your trouser size, your UK dress or skirt size?</b> Complete only one answer.	<input type="text"/> cm OR <input type="text"/> in OR <input type="text"/> UK dress, skirt or trouser size	<input type="text"/> cm OR <input type="text"/> in OR <input type="text"/> UK dress, skirt or trouser size
Please use the size from the most recent clothing purchase you made for yourself. If you're pregnant, please advise your size immediately prior to this pregnancy.		
<b>How many cigarettes do you smoke on average each day?</b>	<input type="text"/> cigarettes per day	<input type="text"/> cigarettes per day
If you don't smoke cigarettes daily, please enter '0'.		
<b>During the last 5 years have you used any of the drugs listed opposite?</b> We'll only use the answer to this question to assess your application and at claim stage. Therefore there are no 'legal implications' in answering yes to this question.	<ul style="list-style-type: none"> <li>Recreational drugs other than cannabis, for example cocaine, ecstasy, heroin</li> <li>Methadone</li> <li>Anabolic steroids not prescribed by a doctor</li> </ul> Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Recreational drugs other than cannabis, for example cocaine, ecstasy, heroin</li> <li>Methadone</li> <li>Anabolic steroids not prescribed by a doctor</li> </ul> Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Have you ever tested positive for HIV, or are you waiting for the result of an HIV test?</b> A negative HIV test result won't, by itself, have any effect on your acceptance terms for insurance.	Tested positive for HIV <input type="checkbox"/> Awaiting results of HIV test <input type="checkbox"/> No <input type="checkbox"/>	Tested positive for HIV <input type="checkbox"/> Awaiting results of HIV test <input type="checkbox"/> No <input type="checkbox"/>
<b>How often do you drink alcohol?</b> Tick only one answer.	Never <input type="checkbox"/> On special occasions only <input type="checkbox"/> Monthly or less frequently <input type="checkbox"/> Two or three times a month <input type="checkbox"/> Weekly <input type="checkbox"/>	Never <input type="checkbox"/> On special occasions only <input type="checkbox"/> Monthly or less frequently <input type="checkbox"/> Two or three times a month <input type="checkbox"/> Weekly <input type="checkbox"/>
For example, a drink is a glass of wine or a glass or bottle of beer.	If 'Two or three times a month', on a typical day when you have alcohol, how many alcoholic drinks do you have? <input type="text"/> If 'Weekly', during a typical week, how many alcoholic drinks do you have? <input type="text"/>	If 'Two or three times a month', on a typical day when you have alcohol, how many alcoholic drinks do you have? <input type="text"/> If 'Weekly', during a typical week, how many alcoholic drinks do you have? <input type="text"/>
<b>Have you ever been seen by an alcohol specialist or attended an alcohol support group or been told that you have any liver damage?</b> Tick all that apply.	Seen by an alcohol specialist or attended a support group <input type="checkbox"/> Told about liver damage <input type="checkbox"/> Neither <input type="checkbox"/>	Seen by an alcohol specialist or attended a support group <input type="checkbox"/> Told about liver damage <input type="checkbox"/> Neither <input type="checkbox"/>
<b>Have you ever been told by a health professional that you should reduce the amount of alcohol you have because you were drinking too much?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/> If 'Yes', when was this? <input type="text"/> Please tell us what you were drinking and the amount <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> If 'Yes', when was this? <input type="text"/> Please tell us what you were drinking and the amount <input type="text"/>

## HEALTH – EVER



When answering the following questions, if you're unsure whether to tell us about a medical condition, please tell us anyway. There's no need to tell us about the same condition more than once in this application.

Have you ever:

	Client one		Client two	
a) had diabetes or a heart condition, for example angina, heart attack, heart valve problem, heart surgery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b) had a stroke, mini stroke, transient ischaemic attack (TIA), brain haemorrhage or surgery to your blood vessels? <i>Please ignore varicose veins unless there's ulceration present.</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c) had cancer, Hodgkin lymphoma, Non-Hodgkin lymphoma, leukaemia or a melanoma?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d) had a cyst, growth or tumour in either your brain or spine?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
e) had any neurological condition or visual disturbance, for example epilepsy, multiple sclerosis, muscular dystrophy, cerebral palsy, motor neurone disease, Parkinson's disease, optic neuritis? <i>Please ignore long and short sightedness that's been corrected.</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
f) been admitted overnight to hospital or referred to a psychiatrist for mental illness, anorexia or bulimia?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>



If you've answered 'Yes' to ANY part of the above question, please complete one of the Medical Questionnaires (page 26) BEFORE continuing with the next question.

## HEALTH – LAST 5 YEARS

Apart from anything you've already told us about in this application, during the last 5 years have you seen a doctor, nurse or other health professional for:

a) raised blood pressure, raised cholesterol or condition affecting blood or blood vessels, for example anaemia, excess sugar in the blood, blood clot, deep vein thrombosis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b) any condition affecting your kidneys, bladder or prostate, for example blood or protein in the urine, kidney or bladder stones?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c) any condition affecting your stomach, oesophagus or bowel, for example Crohn's disease, ulcerative colitis? <i>Please ignore diarrhoea, food poisoning, sickness or vomiting, stomach bug or upset, provided no hospital investigation was advised or completed.</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d) any condition affecting your gall bladder, liver or pancreas, for example hepatitis, fatty liver?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
e) any condition affecting your lungs or breathing, for example asthma, emphysema, sleep apnoea, sarcoidosis? <i>Please ignore hay fever and one off chest infections from which you've fully recovered.</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
f) lupus, fibromyalgia, gout or any type of arthritis, neck, back, spine or joint trouble, for example rheumatoid arthritis, sciatica?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
g) anxiety, depression or any mental illness that's required treatment or counselling, or chronic fatigue syndrome?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
h) a growth, lump, polyp or tumour of any kind?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
i) chest pain, palpitations or irregular heartbeat, paralysis, numbness, persistent tingling or pins and needles, tremor or facial pain other than dental pain, memory loss, dizziness or balance problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>



If you've answered 'Yes' to ANY part of the above question, please complete one of the Medical Questionnaires (page 26) BEFORE continuing with the next question.

## HEALTH – LAST 5 YEARS continued



When answering the following questions, if you're unsure whether to tell us about a medical condition, please tell us anyway. There's no need to tell us about the same condition more than once in this application.



Only answer this question if you're applying for Critical Illness Cover or Income Protection Benefit.

Apart from anything you've already told us about in this application, during the last 5 years have you seen a doctor, nurse or other health professional for:

	Client one	Client two
a) a mole or freckle? <i>Please ignore birthmarks where no treatment or specialist referral has been advised.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) any condition affecting your thyroid?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c) any condition affecting your ears or hearing, for example Meniere's disease, deafness? <i>Please ignore simple earache and ear infections that have resolved leaving no continuing hearing loss.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
d) any condition affecting your eyes or vision, not wholly corrected by spectacles, lenses or laser treatment, for example cataract, blindness?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>This question is applicable for females only:</b>		
e) any gynaecological condition for which you've not yet been discharged from follow up, or a cervical smear requiring further investigations? <i>Please ignore routine cervical smears if the results have been normal.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Only answer this question if you're applying for Income Protection Benefit:</b>		
f) any other illness, injury or disability that's kept you off work for a continuous period of 2 weeks or more, for example stress, headaches, trapped nerve? <i>Please ignore colds and flu from which you've fully recovered and pregnancy where no complications were present.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>



If you've answered 'Yes' to ANY part of the above question, please complete one of the Medical Questionnaires (page 26) BEFORE continuing with the next question.

## HEALTH – LAST 12 MONTHS

Apart from anything you've already told us about in this application, during the last 12 months have you:

a) had any medical condition, illness or injury that you've received treatment for over a continuous period of 4 weeks or more? <i>Please ignore oral contraception pill, pregnancy and minor accidents and injuries, for example pulled or strained muscle, torn ligament or tendon, sprained joint, provided they've not kept you off work for 2 weeks or more.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) been referred to or had any investigations in hospital, for example biopsy, scan, ECG? <i>Please ignore investigations related to pregnancy or infertility where the results have been confirmed as normal.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>



If you've answered 'Yes' to ANY part of the above question, please complete one of the Medical Questionnaires (page 26) BEFORE continuing with the next question.

## HEALTH – CONTINUED

Apart from anything you've already told us about in this application, do you have any medical condition or symptom that:

a) your doctor or nurse told you to see them about during the next 3 weeks? <i>Please ignore consultations for repeat prescriptions and pregnancy.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) unexplained bleeding, weight loss, lump or growth – mole or freckle that's bled or changed in appearance – a cough that's lasted for 3 weeks or more – any other symptom that you may see a health professional about for the first time during the next 4 weeks	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>



If you've answered 'Yes' to EITHER of the above questions, please complete one of the Medical Questionnaires (page 26) BEFORE continuing with the next question.

## FAMILY HISTORY



If you're aged over 50, only answer this question if your application includes Critical Illness Cover or Income Protection Benefit. If you're aged 50 or under, please answer this question.

Have any of your natural parents, brothers or sisters, before the age of 60, had any of the conditions opposite?

If 'Yes', tick all that apply.

If 'No', tick 'None of the above'.

Please answer in relation to the family members above that you know about. If you don't know about any of these relatives, answer 'Don't know'.

For each condition selected, please give:

- the total number of relatives who had the condition
- their age(s) at the time the condition first occurred (except where indicated) – but only the youngest (lowest) age(s).

Client one	✓	No. of relatives affected	Youngest age affected	Second youngest age affected	Client two	✓	No. of relatives affected	Youngest age affected	Second youngest age affected
Heart attack, Angina, Stroke or Type 2 Diabetes					Heart attack, Angina, Stroke or Type 2 Diabetes				
Cancer of the Breast					Cancer of the Breast				
Cancer of the Ovary					Cancer of the Ovary				
Cancer of the Bowel (Colon)					Cancer of the Bowel (Colon)				
Cancer of another site					Cancer of another site				
<p>If 'Cancer of another site', for each relative please tell us the part of the body affected by the 'primary' cancer, that is, where it first occurred in the body.</p> <div></div>					<p>If 'Cancer of another site', for each relative please tell us the part of the body affected by the 'primary' cancer, that is, where it first occurred in the body.</p> <div></div>				
Cardiomyopathy (primary disorder of the heart muscle)					Cardiomyopathy (primary disorder of the heart muscle)				
Multiple Sclerosis			N/A	N/A	Multiple Sclerosis			N/A	N/A
<p>If 'Multiple Sclerosis', please tell us the family member(s) affected:</p> <p>Mother <input type="checkbox"/> Father <input type="checkbox"/></p> <p>Brother(s) <input type="checkbox"/> Sister(s) <input type="checkbox"/></p>					<p>If 'Multiple Sclerosis', please tell us the family member(s) affected:</p> <p>Mother <input type="checkbox"/> Father <input type="checkbox"/></p> <p>Brother(s) <input type="checkbox"/> Sister(s) <input type="checkbox"/></p>				
Myotonic Dystrophy					Myotonic Dystrophy				
Polyposis coli (Familial adenomatous)					Polyposis coli (Familial adenomatous)				
Polycystic Kidney Disease					Polycystic Kidney Disease				
Motor Neurone Disease					Motor Neurone Disease				
Huntington's Disease					Huntington's Disease				
Parkinson's Disease					Parkinson's Disease				
Alzheimer's Disease					Alzheimer's Disease				

continues

Client one	✓	No. of relatives affected	Youngest age affected	Second youngest age affected	Client two	✓	No. of relatives affected	Youngest age affected	Second youngest age affected
Any other condition that runs in your family and that you're receiving regular follow up or screening for					Any other condition that runs in your family and that you're receiving regular follow up or screening for				
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				
If 'Any other condition', please give details of the condition(s) and the results of any investigations.					If 'Any other condition', please give details of the condition(s) and the results of any investigations.				
<input type="text"/>					<input type="text"/>				
None of the above <input type="checkbox"/>					None of the above <input type="checkbox"/>				
Don't know <input type="checkbox"/>					Don't know <input type="checkbox"/>				

## TRUST AND OWNERSHIP

Are any of the policies on this application replacing an existing policy or policies held with Legal & General?

We may need to get authority to cancel the policy if it is in trust or owned by someone else.

Is it your intention to put any of the policies on this application under Trust?

Client one	Client two
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If 'Yes', please enter the policy number(s) to be replaced.	If 'Yes', please enter the policy number(s) to be replaced.
<input type="text"/>	<input type="text"/>
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If 'Yes', which policy(ies)?	If 'Yes', which policy(ies)?
<input type="text"/>	<input type="text"/>

**i** If you've answered 'Yes' to the above question, please contact your financial adviser about the type of trust most appropriate to you and your circumstances.

Are any of the policies on this application to be owned by another individual or business?

Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If 'Yes', which policy(ies)?	If 'Yes', which policy(ies)?
<input type="text"/>	<input type="text"/>

**▶** If you've answered 'Yes' to the above question, please complete a Policy Owner Questionnaire for each policy (page 28) BEFORE continuing with the next question.

**▶** This now completes the mandatory question and answer part of your application. The following five green sections are all additional questionnaires which you only need to complete if we've asked you to in one of the previous questions, or if you need to provide us with additional information.

**▶** Please now ensure you read and sign the Client Declaration and complete the Direct Debit instruction in Part C.

## QUESTIONNAIRE 1 – PERSONAL ASSURANCE QUESTIONNAIRE



This questionnaire only applies if you have answered 'Yes' to the Total Cover question on page 15.

1. Do you have, or are you applying for, any other Life cover with Legal & General or with another insurance company?

This includes any Life cover provided by your employer.

If 'Yes' and you need more space, please use the Additional Information section on page 30.

### Client one

Yes ☐ No ☐

If 'Yes', please give details:

Company	
Start date	
Policy type	
Term	years
Amount of cover	£
Reason for cover	

Will this policy remain in force/be going ahead? Yes ☐ No ☐

Do you have any other policies to tell us about? Yes ☐ No ☐



If 'Yes', please give the same details as above for the other policy(ies), on page 30 (Additional Information) before continuing with this section.

### Client two

Yes ☐ No ☐

If 'Yes', please give details:

Company	
Start date	
Policy type	
Term	years
Amount of cover	£
Reason for cover	

Will this policy remain in force/be going ahead? Yes ☐ No ☐

Do you have any other policies to tell us about? Yes ☐ No ☐

If 'Yes', please give the same details as above for the other policy(ies), on page 30 (Additional Information) before continuing with this section.

2. Do you have, or are you applying for, any other Critical Illness cover with Legal & General or with another insurance company?

If 'Yes' and you need more space, please use the Additional Information section on page 30.

Yes ☐ No ☐

If 'Yes', please give details:

Company	
Start date	
Policy type	
Term	years
Amount of cover	£
Reason for cover	

Will this policy remain in force/be going ahead? Yes ☐ No ☐

Do you have any other policies to tell us about? Yes ☐ No ☐



If 'Yes', please give the same details as above for the other policy(ies), on page 30 (Additional Information) before continuing with this section.

Yes ☐ No ☐

If 'Yes', please give details:

Company	
Start date	
Policy type	
Term	years
Amount of cover	£
Reason for cover	

Will this policy remain in force/be going ahead? Yes ☐ No ☐

Do you have any other policies to tell us about? Yes ☐ No ☐

If 'Yes', please give the same details as above for the other policy(ies), on page 30 (Additional Information) before continuing with this section.

3. Please give details of your gross annual earned income for the last three years.

Do not include any unearned income, such as investment income.

Current year	Earned Income	£
Last year	Earned Income	£
Previous year	Earned Income	£

Current year	Earned Income	£
Last year	Earned Income	£
Previous year	Earned Income	£

If you are self employed – please give net taxable earnings after deduction of allowable business expenses.



If your earned income for the current year is less than £10,000, please continue with question 4. Otherwise, please skip question 4 and continue with question 5.

4. Please give details of all other household gross annual earned income for the last three years.

Client one		Client two	
Current year	Earned Income £	Current year	Earned Income £
Last year	Earned Income £	Last year	Earned Income £
Previous year	Earned Income £	Previous year	Earned Income £
£		£	

5. What is the total value of your net assets?

'Net assets' are your total assets (for example house, car, shares), less your total liabilities (for example mortgage, outstanding debt). Where examples are shown, they are not intended to be a complete list.

6. Have you been investigated, arrested, charged, convicted or do you have a prosecution pending for any of the following? Bribery, Corruption, Counterfeiting, Embezzlement, Fraud, Money laundering, Tax evasion.

Please ignore any conviction that is spent under the Rehabilitation of Offenders Act.

Please tick only one answer.

Investigated	<input type="checkbox"/>	Convicted	<input type="checkbox"/>
Arrested	<input type="checkbox"/>	Prosecution pending	<input type="checkbox"/>
Charged	<input type="checkbox"/>	No	<input type="checkbox"/>
If you have been investigated, arrested or charged, please give details:			



If you require this policy for Mortgage Protection purposes, please go straight to question 11. Otherwise, please continue with the next question.

7. What is the total value of your liabilities?

£	£
---	---

8. Please give details of the number of dependants you have and their relationship to you.

If you need space for more dependants, please use the Additional Information section on page 30.

--	--

9. If this application is required to cover a liability for Inheritance Tax or Capital Gains Tax, please tick whichever applies.

If neither of these apply, tick 'Neither'.

Inheritance Tax	<input type="checkbox"/>	Inheritance Tax	<input type="checkbox"/>
Capital Gains Tax	<input type="checkbox"/>	Capital Gains Tax	<input type="checkbox"/>
Neither	<input type="checkbox"/>	Neither	<input type="checkbox"/>



If you ticked 'Inheritance Tax' in question 9 above, please continue with the next question.

If you require this policy for Mortgage Protection purposes, please go straight to question 11. Otherwise you have completed this questionnaire and you should return to your application at page 16.

**10. Please give details of the Inheritance Tax liability and reliefs.**

Client one	Client two
Estimated Inheritance Tax liability £	Estimated Inheritance Tax liability £
How was your liability calculated?	How was your liability calculated?
Please state all reliefs, if any, that will be available for mitigation of Inheritance Tax. For example business property relief or agricultural property relief.	Please state all reliefs, if any, that will be available for mitigation of Inheritance Tax. For example business property relief or agricultural property relief.
Is this policy required to cover the Inheritance Tax in respect of a gift? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is this policy required to cover the Inheritance Tax in respect of a gift? Yes <input type="checkbox"/> No <input type="checkbox"/>
If 'Yes', please give the date and value of the gift	If 'Yes', please give the date and value of the gift



If you require this policy for Mortgage Protection purposes, please continue with the next question. Otherwise, you have completed this questionnaire and you should return to your application at page 16.

**11. Please give details of the mortgage(s) or loan(s) to which the protection applies.**

What is this mortgage or loan being used to purchase? If 'Other', please give details	What is this mortgage or loan being used to purchase? If 'Other', please give details
Main private residence <input type="checkbox"/> Home improvement <input type="checkbox"/>	Main private residence <input type="checkbox"/> Home improvement <input type="checkbox"/>
Buy to Let property <input type="checkbox"/>	Buy to Let property <input type="checkbox"/>
Other	Other
Name(s) of lender(s)	Name(s) of lender(s)
Name(s) of borrower(s)	Name(s) of borrower(s)
Mortgage or loan amount £	Mortgage or loan amount £
Mortgage or loan term years	Mortgage or loan term years
Interest rate %	Interest rate %
Type of mortgage or loan:	Type of mortgage or loan:
New or remortgage <input type="checkbox"/> Existing arrangement <input type="checkbox"/>	New or remortgage <input type="checkbox"/> Existing arrangement <input type="checkbox"/>
Repayment basis	Repayment basis
If 'Other', please give details	If 'Other', please give details
Interest only <input type="checkbox"/> Capital and interest <input type="checkbox"/>	Interest only <input type="checkbox"/> Capital and interest <input type="checkbox"/>
Other	Other
Are any other policies being taken out to cover this mortgage or loan? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are any other policies being taken out to cover this mortgage or loan? Yes <input type="checkbox"/> No <input type="checkbox"/>
If 'Yes', please give details	If 'Yes', please give details



Please now return to your application at page 16.



## QUESTIONNAIRE 2 – HAZARDOUS ACTIVITIES QUESTIONNAIRE



This questionnaire only applies if you have ticked any of the hazardous activities listed on page 16.

1. What is the name of the activity that you have ticked in the Hazardous Activities question on page 16?

If 'Any Extreme Sport', please tell us which one

Client one

Client two



If you have ticked more than one activity in the Hazardous Activities question on page 16, **you will need to complete a separate Hazardous Activities Questionnaire for each one.** Use this page to give details of the first activity and then use the Additional Information section (page 30), or photocopy this page, to give the same details for the other activity(ies).

2. Do you take part in this as a professional?

Yes ☐ No ☐

Yes ☐ No ☐

3. Are you a member of a recognised club, association or professional body?

Yes ☐ No ☐

Yes ☐ No ☐

4. Where is this activity carried out?  
If 'Other', please tell us where

UK only ☐ Europe only ☐

UK only ☐ Europe only ☐

Other

Other

5. Do you ever take part in this activity alone?

Yes ☐ No ☐

Yes ☐ No ☐

6. Do you, or are you likely to, take part in Aerobatics, Expeditions, Record attempts, Testing of any equipment or Underwater internal wreck exploration in connection with this hobby or pursuit?

Yes ☐ No ☐

Yes ☐ No ☐

7. On average, how many times a year do you do this activity?

times a year

times a year

8. On average, how many hours a year do you spend on this activity?

hours a year

hours a year

9. If this activity is listed opposite, please answer these additional questions, as applicable.

**Motor car and Motorcycle sport**

Type of motor sport

Maximum engine size used cc

**Mountaineering or Rock climbing**

Maximum height you climb to metres

Severity level you climb to

**Parachuting, Sky diving or BASE jumping**

Do you take part in free-fall parachuting, competitions, sky diving or sky surfing?

Yes ☐ No ☐

**Sailing**

Type of sailing – For example, offshore category 1 or 2

**Powerboat racing and Extreme Sports**

Full details

**Underwater diving**

Maximum depth you dive to metres

**Motor car and Motorcycle sport**

Type of motor sport

Maximum engine size used cc

**Mountaineering or Rock climbing**

Maximum height you climb to metres

Severity level you climb to

**Parachuting, Sky diving or BASE jumping**

Do you take part in free-fall parachuting, competitions, sky diving or sky surfing?

Yes ☐ No ☐

**Sailing**

Type of sailing – For example, offshore category 1 or 2

**Powerboat racing and Extreme Sports**

Full details

**Underwater diving**

Maximum depth you dive to metres

10. Did you tick any other activity(ies) in the Hazardous Activities question on page 16?

Yes ☐ No ☐

Yes ☐ No ☐



If 'Yes', please give the same details as above, for the other activity(ies), on page 30 (Additional Information).

If 'Yes', please give the same details as above, for the other activity(ies), on page 30 (Additional Information).



You have completed this additional questionnaire. Please return to your application on page 17.

## QUESTIONNAIRE 3 – MEDICAL QUESTIONNAIRE



Please only complete this questionnaire if you have answered 'Yes' to any health questions on pages 18 or 19. If you have more than one condition to tell us about, use this page to give details of the first condition, use the next questionnaire for the second, and then either use the Additional Information section on page 30 or photocopy this page to give us the same details for any further conditions.

### MEDICAL QUESTIONNAIRE 1

	Client one	Client two
1. Which health question (for example Health – Last 5 Years, part f) does this information relate to?	<input type="text"/>	<input type="text"/>
2. Name of actual medical condition, illness or injury If growth or lump, also state the part of body affected.	<input type="text"/>	<input type="text"/>
3. How long ago did the condition first occur?	<input type="text"/> years <input type="text"/> months	<input type="text"/> years <input type="text"/> months
4. How often do you have symptoms? Please tick appropriate box – do not enter anything else in the box.	No symptoms now <input type="checkbox"/> Yearly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily <input type="checkbox"/>	No symptoms now <input type="checkbox"/> Yearly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily <input type="checkbox"/>
5. How long ago was your last major attack? This means a sudden increase in the severity of symptoms, or need for treatment other than your usual medicine or tablets.	Never had a major attack <input type="checkbox"/> Currently or at present <input type="checkbox"/> Other <input type="text"/> years <input type="text"/> months	Never had a major attack <input type="checkbox"/> Currently or at present <input type="checkbox"/> Other <input type="text"/> years <input type="text"/> months
6. In the last 5 years, have you had surgery or an operation, or any other hospital admission (including an overnight stay) for this condition? Please answer both parts of this question.	Surgery or operation Yes <input type="checkbox"/> No <input type="checkbox"/> If 'Yes', how long ago? <input type="text"/> years <input type="text"/> months Other hospital admission (including overnight stay) Yes <input type="checkbox"/> No <input type="checkbox"/> If 'Yes', how long ago? <input type="text"/> years <input type="text"/> months	Surgery or operation Yes <input type="checkbox"/> No <input type="checkbox"/> If 'Yes', how long ago? <input type="text"/> years <input type="text"/> months Other hospital admission (including overnight stay) Yes <input type="checkbox"/> No <input type="checkbox"/> If 'Yes', how long ago? <input type="text"/> years <input type="text"/> months
7. In the last 5 years, in total, how much time off your normal work or daily activities have you had for this condition?	<input type="text"/> weeks <input type="text"/> days If you haven't taken time off, please enter '0'.	<input type="text"/> weeks <input type="text"/> days If you haven't taken time off, please enter '0'.
8. If you have had time off, how long ago was the most recent occasion? Not applicable if you have answered '0' to the question above.	<input type="text"/> years <input type="text"/> months If you are currently off work, please enter '0'.	<input type="text"/> years <input type="text"/> months If you are currently off work, please enter '0'.
9. Do you expect to have, or are you currently waiting for, surgery or an operation, any other hospital admission (including an overnight stay) or referral to a specialist for this condition? Please answer all three parts of this question.	Surgery or operation Yes <input type="checkbox"/> No <input type="checkbox"/> If 'Yes', when? <input type="text"/> Other hospital admission (including overnight stay) Yes <input type="checkbox"/> No <input type="checkbox"/> If 'Yes', when? <input type="text"/> Referral to a specialist Yes <input type="checkbox"/> No <input type="checkbox"/> If 'Yes', when? <input type="text"/>	Surgery or operation Yes <input type="checkbox"/> No <input type="checkbox"/> If 'Yes', when? <input type="text"/> Other hospital admission (including overnight stay) Yes <input type="checkbox"/> No <input type="checkbox"/> If 'Yes', when? <input type="text"/> Referral to a specialist Yes <input type="checkbox"/> No <input type="checkbox"/> If 'Yes', when? <input type="text"/>
10. Are you currently receiving treatment for this condition?	Yes <input type="checkbox"/> No <input type="checkbox"/> If 'Yes', please give the name of medicine or tablet, or details of other treatment, for example physiotherapy. If more than one treatment, please state them all. <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> If 'Yes', please give the name of medicine or tablet, or details of other treatment, for example physiotherapy. If more than one treatment, please state them all. <input type="text"/>
11. Do you have any more medical conditions to disclose as a result of answering 'Yes' to a health question on pages 18 or 19?	Yes <input type="checkbox"/> No <input type="checkbox"/> If 'Yes', please complete the second Medical Questionnaire overleaf before returning to your application.	Yes <input type="checkbox"/> No <input type="checkbox"/> If 'Yes', please complete the second Medical Questionnaire overleaf before returning to your application.



## MEDICAL QUESTIONNAIRE 2

1. Which health question (for example Health – Last 5 Years, part f) does this information relate to?

Client one

Client two



Use this page to give details of a second condition and then use the Additional Information section (page 30), or photocopy this page, to give the same details for any further medical condition(s).

2. Name of actual medical condition, illness or injury  
If growth or lump, also state the part of body affected.



3. How long ago did the condition first occur?

 years  months

 years  months

4. How often do you have symptoms?  
Please tick appropriate box – do not enter anything else in the box.

No symptoms now ☐ Yearly ☐  
Monthly ☐ Weekly ☐ Daily ☐

No symptoms now ☐ Yearly ☐  
Monthly ☐ Weekly ☐ Daily ☐

5. How long ago was your last major attack? This means a sudden increase in the severity of symptoms, or need for treatment other than your usual medicine or tablets.

Never had a major attack ☐ Currently or at present ☐  
Other  years  months

Never had a major attack ☐ Currently or at present ☐  
Other  years  months

6. In the last 5 years, have you had surgery or an operation, or any other hospital admission (including an overnight stay) for this condition?  
Please answer both parts of this question.

Surgery or operation Yes ☐ No ☐  
If 'Yes', how long ago?  years  months  
Other hospital admission (including overnight stay) Yes ☐ No ☐  
If 'Yes', how long ago?  years  months

Surgery or operation Yes ☐ No ☐  
If 'Yes', how long ago?  years  months  
Other hospital admission (including overnight stay) Yes ☐ No ☐  
If 'Yes', how long ago?  years  months

7. In the last 5 years, in total, how much time off your normal work or daily activities have you had for this condition?

 weeks  days

If you haven't taken time off, please enter '0'.

 weeks  days

If you haven't taken time off, please enter '0'.

8. If you have had time off, how long ago was the most recent occasion?  
Not applicable if you have answered '0' to the question above.

 years  months

If you are currently off work, please enter '0'.

 years  months

If you are currently off work, please enter '0'.

9. Do you expect to have, or are you currently waiting for, surgery or an operation, any other hospital admission (including an overnight stay) or referral to a specialist for this condition?  
Please answer all three parts of this question.

Surgery or operation Yes ☐ No ☐  
If 'Yes', when?   
Other hospital admission (including overnight stay) Yes ☐ No ☐  
If 'Yes', when?   
Referral to a specialist Yes ☐ No ☐  
If 'Yes', when?

Surgery or operation Yes ☐ No ☐  
If 'Yes', when?   
Other hospital admission (including overnight stay) Yes ☐ No ☐  
If 'Yes', when?   
Referral to a specialist Yes ☐ No ☐  
If 'Yes', when?

10. Are you currently receiving treatment for this condition?

Yes ☐ No ☐

If 'Yes', please give the name of medicine or tablet, or details of other treatment, for example physiotherapy. If more than one treatment, please state them all.

Yes ☐ No ☐

If 'Yes', please give the name of medicine or tablet, or details of other treatment, for example physiotherapy. If more than one treatment, please state them all.

11. Do you have any more medical conditions to disclose as a result of answering 'Yes' to a health question on pages 18 or 19?

Yes ☐ No ☐

If 'Yes', please give the same details as above, for the other medical condition(s), on page 30 (Additional Information).

Yes ☐ No ☐

If 'Yes', please give the same details as above, for the other medical condition(s), on page 30 (Additional Information).



You have completed this questionnaire and you may return to your application.

## QUESTIONNAIRE 4 – POLICY OWNER QUESTIONNAIRE



This questionnaire only applies if any of the policies on this application are to be owned by another individual or business.

If more than one policy is to be owned by someone else you must complete a separate Policy Owner Questionnaire for each – please ask your financial adviser for another questionnaire, as required.

- Please note, if the Policy Owner is not the Applicant(s) **they must be over 18 and have an insurable interest** in the Applicant(s).
- Please consult your financial adviser if you wish to assign your policy to someone else once the policy has been accepted and issued.
- Your financial adviser can help you to complete this section.

1. Is the Policy Owner an individual or a business?

### Policy Owner

An individual ☐

A business ☐

2. What is the name of the Policy Owner?

Give the full name or business name as applicable.

Mr/Mrs/Miss/Ms/Dr/Rev/Other

Forename(s) and middle name(s) in full

Surname

or

Business name

### Second Policy Owner (if applicable)

An individual ☐

A business ☐

Mr/Mrs/Miss/Ms/Dr/Rev/Other

Forename(s) and middle name(s) in full

Surname

or

Business name

3. Contact name within the organisation?

4. What is the Policy Owner's relationship to the Applicant(s)?

Spouse ☐

Employer ☐

Business Partner ☐

Ex-spouse ☐

Co-habiting Partner ☐

Ex-partner ☐

Civil Partner ☐

Trustee ☐

Creditor ☐

Other ☐

Co-shareholder ☐

Spouse ☐

Employer ☐

Business Partner ☐

Ex-spouse ☐

Co-habiting Partner ☐

Ex-partner ☐

Civil Partner ☐

Trustee ☐

Creditor ☐

Other ☐

Co-shareholder ☐

5. What is the Policy Owner's current address?

Please give the full address (including postcode) of the person or business who is to own the policy(ies).

Postcode

Postcode

6. What are the Policy Owner's contact details?

If the policy is to be owned by a business, please give the contact details of the business's representative.

Phone

Phone

7. Declaration of the Policy Owner(s) (who is not the Client(s))

**i** This Declaration should be read, confirmed, signed and dated by the Policy Owner, not by the Client(s).

I declare that the answers given are, to the best of my knowledge and belief, true and complete.

**Use of personal information:** Legal & General takes client privacy very seriously. I understand that Legal & General will use the personal information collected via this application and any other information that I provide to Legal & General ("my information") for the purposes of:

1. Providing me with Legal & General products and services and dealing with my enquiries and requests;
2. Underwriting and administering my policy including processing claims; and
3. Carrying out market research, statistical analysis and client profiling.

I understand that given the global nature of Legal & General's business, it may be necessary to transfer my information to countries outside the European Economic Area in order to provide Legal & General's services to me.

**Disclosures:** I understand that Legal & General will disclose my information to other companies within the Legal & General group of companies, regulatory bodies, law enforcement agencies, future owners of Legal & General's business, suppliers engaged by Legal & General to process data on its behalf and when necessary, to a reinsurer.

If I have been dealing with a financial adviser, Legal & General will give them information about the product and, where appropriate, provide them with other information about my dealings with Legal & General to enable them to give me informed advice.

Where I have been introduced to Legal & General by another company (e.g. a bank, insurer or building society) Legal & General may share my information with them to enable them to:

- (a) carry out market research, statistical analysis and client profiling; and
- (b) send me marketing information about their products and services and products and services of companies in the Legal & General group and of third parties whose products and services Legal & General offers to its clients.

By signing this Declaration I agree to receive the information as described in (b) above by post or telephone, unless I indicate otherwise by writing with my full contact details to Legal & General P10290, 5 Gemini Business Park, Europa Boulevard, Warrington, Cheshire WA5 7YF

**Access:** I understand that I have the right to ask for a copy of my information in return for payment of a small fee. To obtain a copy of your information please write to Legal & General at Legal & General Group Information Protection, Legal & General House, Kingswood, Tadworth, Surrey KT20 6EU

**Approaching fraud prevention agencies:** Legal & General will check my details with fraud prevention agencies. If false or inaccurate information is provided and fraud is identified details will be passed to fraud prevention agencies. Law enforcement agencies may access and use this information.

Legal & General and other organisations may also access and use this information to prevent fraud and money laundering, for example, when:

- checking details on applications for credit and credit related or other facilities;
- managing credit and credit related accounts or facilities;
- recovering debt;
- checking details on proposals and claims for all types of insurance;
- checking details of job applicants and employees.

Legal & General and other organisations may access and use from other countries the information recorded by fraud prevention agencies.

#### 8. Declaration of the Policy Owner(s) (who is not the Client(s))

**i** This Declaration should be read, confirmed, signed and dated by the Policy Owner, not by the Client(s).

I understand that I can contact Legal & General at Group Financial Crime, Legal & General House, Kingswood, Tadworth, Surrey KT20 6EU if I want to receive details of the relevant fraud prevention agencies.

**I request that Legal & General Assurance Society Limited issue the proposed policy in my name or the business's name and I understand that this request and Declaration, and any other statement signed by the Client(s) in connection with this application, will be used to determine whether to offer a policy and to assess how much premium should be paid. Alongside the Policy Schedule and Policy Terms and Conditions this information will form part of the legal relationship between us and if any of it is incorrect it may mean that a claim will be declined and the policy cancelled. I understand that if more than one Policy Owner has been requested, then each Policy Owner will be required to complete a version of this document.**

Policy Owner	Second Policy owner (if applicable)
<b>Policy Owner signature</b>   Date (DDMMYYYY) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>Policy Owner signature</b>   Date (DDMMYYYY) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date of birth (DDMMYYYY) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Date of birth (DDMMYYYY) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



If you want another policy(ies) to be owned by someone else, please complete another Policy Owner Questionnaire(s) for each. Otherwise, please return to your application on page 21.

ADDITIONAL INFORMATION



This section only applies if you need more space to answer any questions. If you don't need more space, please now go straight to Part C.

Client one

Section Name  
and Question No.

Additional Information

Client two

Section Name  
and Question No.

Additional Information

continues

ADDITIONAL INFORMATION



This section only applies if you need more space to answer any questions. If you don't need more space, please now go straight to Part C.

Client one

Section Name  
and Question No.

Additional Information

Client two

Section Name  
and Question No.

Additional Information

# OLP CONNECT – CLIENT DECLARATION AND DIRECT DEBIT.

## Family Protection Mortgage Protection

### DATA PROTECTION POLICY

Use of personal information: We, Legal & General, take your privacy very seriously. We use the personal information collected via this form and any other information you provide us for the purposes of:

1. Providing you with our products and services and dealing with your enquiries and requests;
2. Underwriting and administering your policy, including processing claims;
3. Carrying out market research, statistical analysis and customer profiling; and
4. Sending you marketing information (by post, telephone, email and SMS) about products and services of companies in the Legal & General group and of third parties, whose products and services we offer to our customers. We do not share information with third parties for marketing purposes.

By signing below, you agree to receive the information as described in 4 above, unless you tell us otherwise by ticking this box:

Client one ☐ Client two ☐

**Disclosures:** We'll disclose your information to other companies within the Legal & General group of companies, regulatory bodies, law enforcement agencies, future owners of our business, suppliers we engage to process data on our behalf and when necessary, to a reinsurer. If you make a claim, we will share your information (where necessary) with other insurance companies to prevent fraudulent claims.

**Sensitive Data:** We'll use the medical and health information provided in your application and any other medical information provided in the course of your application solely for the purposes of allowing us to underwrite and administer your policy. Your medical information (and other information collected via this application) may be disclosed to Legal & General's reinsurer and to any other insurance company to whom you apply for products or services.

**Access:** You have the right to ask for a copy of your information in return for payment of a small fee. To obtain a copy of your information please write to Legal & General Assurance Society, Technical Support (Protection), Knox Court, 10 Fitzalan Place, Cardiff CF24 0TL

**Financial Crime:** To protect against financial crime, Legal & General may need to confirm your identity. To do this we may use reference agencies to search sources of information about you (an Identity Search) and it won't affect your credit rating. If the identity search fails, we may ask you for documents to confirm your identity.

**Fraud Prevention:** We'll check your details with fraud prevention agencies. If false or inaccurate information is provided and fraud is identified, details will be passed to fraud prevention agencies. Law enforcement agencies may access and use this information.

Legal & General and other organisations may also access and use this information to prevent fraud and money laundering, for example, when:

- Checking details on applications for credit and credit related or other facilities,
- Managing credit and credit related accounts or facilities,
- Recovering debt,
- Checking details on proposals and claims for all types of insurance, and;
- Checking details of job applicants and employees.

We and other organisations may access and use from other countries the information recorded by fraud prevention agencies.

Please contact us at: Group Financial Crime, Legal & General House, Kingswood, Tadworth, Surrey KT20 6EU if you want to receive details of the relevant fraud prevention agencies.

### CLIENT DECLARATION

**All Clients** – it is important that you read and accept all of the following paragraphs. If you are unsure of anything or have any queries please speak to your financial adviser.

**This Declaration must be read by the client(s) before proceeding with this application.**

- The information given in this application has been provided truthfully and accurately.
- I agree to immediately inform Legal & General in writing if there are any changes to any answers given on the application before the policy starts.
- I am aware that the information provided will form part of the legal relationship between us and if any of it is found to be incorrect it may mean that a claim is not paid or the policy(ies) is amended or cancelled.
- I agree to Legal & General processing my information in line with their data protection policy.
- I am a UK resident.
- This contract will be governed by the law of England and Wales.

For all applicants

**Please sign and date this declaration in the box below. Please provide your full name, date of birth, signature and date of signing.**

Client one	Client two
<p>Name <input type="text"/></p> <p>Date of birth (DDMMYYYY) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>Name <input type="text"/></p> <p>Date of birth (DDMMYYYY) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>
<p>Signature <input type="text"/></p> <p>Date (DDMMYYYY) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>Signature <input type="text"/></p> <p>Date (DDMMYYYY) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>



## DIRECT DEBIT INSTRUCTION



If you want to pay for different products by Direct Debit from different bank accounts, you must complete a separate Direct Debit instruction for each bank account – please ask your Adviser for another direct debit instruction(s), as required.

This Direct Debit instruction must be **fully completed, signed and dated** before your application can be processed.

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

Legal & General Assurance Society Limited, Kingswood, Tadworth, Surrey KT20 6EU



#### Originator's Identification Numbers

8	0	6	1	6	2	9	1	3	1	4	8	5	1	1	1	4	8	9	9	6	8	4	1
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

1. Name and full postal address of your bank or building society branch

To:

Bank or Building Society

Address

Postcode

2. Bank account name

3. Bank or building society account number

--	--	--	--	--	--	--	--

4. Branch sort code

		-			-		
--	--	---	--	--	---	--	--

5. Reference number  
(Legal & General use only)

6. Preferred collection date each month

--

7. Instruction to your bank or building society

Please pay Legal & General Assurance 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 Legal & General Assurance Society Limited and, if so, details will be passed electronically to my bank or building society.

Signature

Signature

Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

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



If the person (or business) paying the premiums is neither the policy owner nor the life assured, please supply their name and address in the fields below.

Please now cut off the Direct Debit Guarantee below and keep it somewhere safe.

Use the checklist opposite to make sure that you have completed everything that you need to.

Name of person (or business) paying premium (if not the policy owner or life assured):

Address

Postcode

Cut off here and keep the Direct Debit Guarantee somewhere safe



### The Direct Debit Guarantee – this guarantee should be detached and retained by the payer



- 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 Legal & General Assurance Society Limited will notify you 5 working days in advance of your account being debited or as otherwise agreed. If you request Legal & General Assurance 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 Legal & General Assurance 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 Legal & General Assurance 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.



## Once you've completed your application...

Check that you've completed everything.

It is unlikely that you will need to complete every section of this form in detail, but please make sure that the following parts have been completed (as applicable):

### Part A Quote.

Part A

☐

### Part B Standard Underwriting (SA4).

#### All Clients (blue parts)

Part B

☐

- Please make sure that you have fully completed, signed and dated the **Access to Medical Reports Act consent form(s)**.

☐

#### Additional questionnaires, as applicable (green parts)

- **Personal Assurance Questionnaire:** if you have ticked 'Yes' to the Personal Assurance question and require Family or Mortgage Protection.

Questionnaire 1

☐

- **Hazardous Activities Questionnaire:** if you have ticked any of the activities in the Hazardous Activities question.

Questionnaire 2

☐

- **Medical Questionnaire(s):** if you have been asked to do so.

Questionnaire 3

☐

- **Policy Owner Questionnaire(s):** if any policy(ies) will be owned by someone other than the Client(s).

Questionnaire 4

☐

- **Additional Information:** if you require extra space to complete any question.

☐

### Part C Client Declaration and Direct Debit.

Part C

☐

#### All Clients, as applicable (blue parts)

Please make sure that you have also:

- signed, dated and ticked the relevant boxes in the **Declaration**.

☐

- fully completed, signed and dated the **Direct Debit instruction(s)**.

☐



[legalandgeneral.com](https://legalandgeneral.com)

**Legal & General Assurance Society Limited**

Registered in England and Wales No. 00166055

**Registered office:** One Coleman Street, London EC2R 5AA

We are authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.

W11904 03/16