

Application form

Version number 01/19

For financial adviser use only

Your Aegon agency number

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(This is your UAN and comprises of three letters and three numbers)

For the purposes of Financial Conduct Authority reporting:

Did you give the applicant(s) advice about choosing to set up this policy?

Yes No

Your online services user ID

If you don't provide this information, you won't be able to access documents relating to this policy using our protection document service.

Unipass users: If you don't know your user ID, you'll find this by logging into our online services as usual and going to the Settings page of the Protection document service.

Important notes for financial advisers

You can't use this form to apply for Personal Protection using our online service.

You should send the fully completed form to us at:

Aegon
Edinburgh Park
Edinburgh
EH12 9SE

If you want to apply using our online service, please use our **Data capture form**. You can download it at aegon.co.uk/support

If you're not registered for our online new business service, please call our Protection Customer Service Centre on 03456 00 14 02.

Money laundering

Current money laundering guidance allows for identity verification for 'reduced risk' (for example, protection) business to be completed after a business relationship has been established and before pay out when there is a claim. This means that we don't require evidence of identity to be provided with this application but we will require evidence of identity before we pay any claim under this policy.

Important notes for the customer

These notes apply to both the policyholder(s) and the insured person(s), if different.

Please read the following important information carefully before completing this application form for Personal Protection from Aegon. These notes will help you complete this form and give you some important details about the information you're asked to give and how we deal with it.

- You must give the answers personally but, if another person is the insured person, they must answer the medical, personal and health questions. If the answers are completed by anyone else then you and the insured person must read them over and agree them before the declaration is signed. You should make and initial your respective changes.
- The questions asked in this application form cover the facts that we think are important to our assessment of the application.
- When answering a question you're personally responsible for making sure you've given complete and accurate information. You shouldn't make any personal assessment about whether the information is relevant or not, or assume that we'll write to your doctor for medical information. If you're in any doubt about the information required, you should give full details.
- You must tell us in writing if there's any change in your circumstances between completion of this application and the start date of the policy. In particular, you must tell us if there are changes in:
 - your financial interest and reason for applying for this policy, for example if there's been a change in your salary or any loan/mortgage applied for;
 - your health, for example if you suffer symptoms that you've already seen or may need to see a doctor for, or if you're having any form of medical investigation;
 - your lifestyle circumstances, for example if you've started smoking, increased drinking, or you've had an unexplained recent loss of weight;
 - your occupation, employer or employment status, or
 - your recreational activities, for example if you take up a hazardous pursuit such as rock climbing.

The examples included above aren't exhaustive. If there's any change in your circumstances at all, you should tell us.

If you don't give full and accurate information, as detailed above, all the protection provided by the policy could be lost or cancelled in the event of a claim, not just the benefit affected or the benefit that's being claimed under.

- For confidentiality – for example if you'd prefer not to share medical information with another policyholder, insured person or your financial adviser – you can send your answers in a sealed envelope direct to the Chief Medical Officer, Aegon, Edinburgh Park, Edinburgh EH12 9SE. Please tick the box in the declaration at the end of this form if you've done this. If you prefer you can attach the envelope securely to this application form.
- If insurance is being applied for with other companies at the same time, by signing the declaration you're consenting to us sending copies of medical reports to these other companies if they ask for them. However, if they ask us for any highly sensitive information, including HIV or genetic test results, we'll ask for your specific permission before we send it.
- Once we've assessed the application we'll let the policyholder know the terms on which we're prepared to offer protection. Protection will often start later than the date of acceptance, for example if the policy is linked to a house purchase or if we're given instructions for a later start date.
- Please ask if you'd like a copy of the completed application form as submitted to us and/or a copy of the policy conditions which set out our standard terms and conditions for protection.
- To comply with UK Money Laundering Regulations and guidance and protect you and us from financial crime, we'll require evidence of identity before we pay any claim under this policy.

We may get evidence of identity by using reference agencies to carry out a search of sources of information about you (an identity search). This doesn't affect your credit rating. If this identity search fails we may ask you for documents to confirm your identity.

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you're claiming.

Checklist

Please make sure you fill in all sections necessary for the benefits chosen.

Sections to be completed:

- All applications: **1, 2, 3, 4, 5, 6, 7, 10, 11**

When filling in sections 5, 6 and 7, please make sure you answer all the questions accurately and that you supply additional information where necessary. If you're in any doubt about the information required, you should give full details.

Please note that both male and female applicants need to complete question 7.4k within the health questions (section 7). Only female applicants need to complete question 7.4l.

Please make sure that you've signed the following areas of the application form (where necessary):

- Declaration and consent – section 11
- Direct Debit instruction – at the end of this form.

Please send the completed form to: Aegon, Edinburgh Park, Edinburgh EH12 9SE.

1. Personal details of insured person(s)

First insured person (1st life)

Surname

Previous surname (if any)

Title

Forename(s)

Gender

Male Female

Date of birth

Address

Postcode

Daytime phone number

Alternative phone number

Second insured person (2nd life)

Surname

Previous surname (if any)

Title

Forename(s)

Gender

Male Female

Date of birth

Address

Postcode

Daytime phone number

Alternative phone number

1. Personal details of insured person(s) – continued

Email

We'll use your email address and phone number to contact you about your policy. We might also use them to keep you informed about our products and services but only where you've consented to this.

Occupation

Industry

Full details of occupation (If you have more than one occupation, please give details on a separate sheet and attach it to your completed application form.) ☒

Employment basis (tick one box only)

- Employed full-time
- Employed part-time over 16 hours a week
- Employed part-time under 16 hours a week
- Self-employed
- Unemployed

Total yearly earnings

To be completed in all cases. (If you're self-employed, please give your net taxable earnings after allowable expenses.)

Email

We'll use your email address and phone number to contact you about your policy. We might also use them to keep you informed about our products and services but only where you've consented to this.

What is your relationship with the first insured person? (for example spouse/civil partner, shared dependent children, joint domestic mortgage, living with partner, joint loan)

Occupation

Industry

Full details of occupation (If you have more than one occupation, please give details on a separate sheet and attach it to your completed application form.) ☒

Employment basis (tick one box only)

- Employed full-time
- Employed part-time over 16 hours a week
- Employed part-time under 16 hours a week
- Self-employed
- Unemployed

Total yearly earnings

To be completed in all cases. (If you're self-employed, please give your net taxable earnings after allowable expenses.)

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you're claiming.

2. Details of policyholder(s) (if different from insured person(s))

First policyholder

Surname

Title

Forename(s)

Current address

Daytime phone number

Alternative phone number

What is the insurable interest between the policyholder and the insured person(s) (for example spouse/civil partner, shared dependent children, joint domestic mortgage, living with partner, joint loan, trustee proposal)?

Second policyholder

Surname

Title

Forename(s)

Current address

Daytime phone number

Alternative phone number

What is the insurable interest between the policyholder and the insured person(s) (for example spouse/civil partner, shared dependent children, joint domestic mortgage, living with partner, joint loan, trustee proposal)?

If trustee proposal is the insurable interest, please give us full details of the trust in the Extra notes section, page 32.

3. Policy details

3.1 Premium details

Premium frequency

- Monthly by Direct Debit
- Yearly by Direct Debit
- Yearly by cheque **(We don't accept cheques for yearly premiums under £5,000. The only exception is the first premium where we'll accept a cheque if it's less than £5,000)**

Premium – only fill in this box if one of the benefits is premium driven

£

Premium from illustration

£

Date of illustration

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

Illustration number

Q												/						
---	--	--	--	--	--	--	--	--	--	--	--	---	--	--	--	--	--	--

Direct Debits should normally be paid from the policyholder's own bank or building society account. If this isn't the case, please tell us the reason and the name and address of the person making the policy payments.

Name(s)

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Address

Postcode

Reason for paying Direct Debit

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3.2 Policy start date

Preferred policy start date

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

- To be advised
- From the date of acceptance on our standard terms

If you're unsure of a start date, please leave this blank and we'll tell you when the policy is ready to start. The earliest start date for your policy will be the date that we decide we can accept your application.

3.3 Trusts

Will you be writing this policy under trust?

- Yes No

If you're intending to write this policy under trust, please submit a fully completed trust document to us.

Business trusts can't be used with this application.

4. Benefit details

Benefit basis

Benefits that pay out on death (life protection, reducing life protection, life with critical illness protection, reducing life with critical illness protection, family income benefit and life with critical illness family income benefit) can be set up to cover both lives (joint life) or 1st life only or 2nd life only. Gift inter vivos is only available on a single-life basis.

Premium type

Premiums are either guaranteed or reviewable, the benefit table will tell you which type of premium is available for your chosen benefit.

Total permanent disability benefit (TPD)

TPD is available with all critical illness benefits. If you'd like to include this benefit, please tick the relevant box in the benefit tables on the next two pages.

TPD benefit will be on a reviewable premium basis, except where it's taken out with critical illness protection, life with critical illness protection or reducing life with critical illness protection on a guaranteed premium basis, in which case it will be on a guaranteed premium basis.

If you apply for a main benefit on a joint-life basis then the attaching TPD must also be on a joint-life basis. This means that if one insured person is declined for TPD then it won't be available for the other insured person.

Income protection

The total of all income protection benefits payable is limited to the lower of 55% of your total earnings or £150,000 a year (see the **Key features** for details). For housepersons, four- and eight-week deferred periods aren't available and the 'activities of daily work' definition will apply. Waiver of premium is automatically included and will be on the same deferred period and definition of incapacity as the income protection benefit. If you're applying for income protection, please complete the benefit table below and on pages 8 and 9 and the income protection benefit table on page 9.

Please select the benefits you want from the benefit tables on the next two pages.

Benefit term and maximum age at end of benefit term

Benefit	Guaranteed premiums – benefit term	Reviewable premiums – benefit term	Maximum age at end of term
Life with critical illness protection, Critical illness protection	5-40 years	5-50 years	84 for guaranteed and reviewable
Reducing life with critical illness protection, Reducing critical illness protection	5-40 years	5-50 years	84 for guaranteed and reviewable
Life protection	1-50 years	n/a	89
Reducing life protection	2-50 years	n/a	89
Family income benefit	5-50 years	n/a	84
Critical illness family income benefit, Life with critical illness family income benefit	5-50 years	n/a	84
Gift inter vivos	7 years (This benefit is only available with a 7-year term)	n/a	89
Income protection	5-51 years	5-51 years	69

Extra benefits

If you want more than one of the same benefit, please complete the **Extra benefits** section at the bottom of the benefit table on pages 8 and 9. If you choose more than one benefit that will payout on death, they must all be on the same benefit basis.

Benefit	Benefit basis (please tick one box only)	Benefit amount	Benefit term	Premium type	Total permanent disability required?	Waiver of premium required?	Additional benefits
Level life protection	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/> Joint-life 1st claim <input type="checkbox"/> Joint-life 2nd claim <input type="checkbox"/>	£ <input type="text"/>	Years <input type="text"/> or to age <input type="text"/>	Guaranteed <input checked="" type="checkbox"/>	N/A	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/>	Indexation option <input type="checkbox"/> Renewal option ¹ <input type="checkbox"/>
Level critical illness protection	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/> Joint-life 1st claim <input type="checkbox"/>	£ <input type="text"/>	Years <input type="text"/> or to age <input type="text"/>	Guaranteed <input type="checkbox"/> Reviewable <input type="checkbox"/>	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/>	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/>	Indexation option <input type="checkbox"/> Renewal option ² <input type="checkbox"/>
Level life with critical illness protection	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/> Joint-life 1st claim <input type="checkbox"/>	£ <input type="text"/>	Years <input type="text"/> or to age <input type="text"/>	Guaranteed <input type="checkbox"/> Reviewable <input type="checkbox"/>	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/>	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/>	Indexation option <input type="checkbox"/> Renewal option ² <input type="checkbox"/>
Level family income benefit	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/> Joint-life 1st claim <input type="checkbox"/>	£ <input type="text"/> a year	Years <input type="text"/>	Guaranteed <input checked="" type="checkbox"/>	N/A	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/>	Indexation option <input type="checkbox"/>
Level critical illness family income benefit	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/> Joint-life 1st claim <input type="checkbox"/>	£ <input type="text"/> a year	Years <input type="text"/>	Guaranteed <input checked="" type="checkbox"/>	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/>	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/>	Indexation option <input type="checkbox"/>
Level life with critical illness family income benefit	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/> Joint-life 1st claim <input type="checkbox"/>	£ <input type="text"/> a year	Years <input type="text"/>	Guaranteed <input checked="" type="checkbox"/>	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/>	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/>	Indexation option <input type="checkbox"/>
Gift inter vivos	1st insured person <input type="checkbox"/> or 2nd insured person <input type="checkbox"/>	£ <input type="text"/> £ <input type="text"/>	7 years	Guaranteed <input checked="" type="checkbox"/>	N/A	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/>	Legislation option ³ <input type="checkbox"/>
Extra benefits							

¹ Available if you've chosen a five-year term.

² Available if you've chosen a five-year term and reviewable premiums.

³ You can only choose this option at the start.

Benefit table (continued)

Benefit	Benefit basis (please tick one box only)	Benefit amount	Benefit term	Premium type	Total permanent disability required?	Waiver of premium required?	Additional benefits
Reducing life protection	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/> Joint-life 1st claim <input type="checkbox"/>	£ <input type="text"/>	Years <input type="text"/>	Guaranteed <input checked="" type="checkbox"/>	N/A	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/>	N/A
Reducing critical illness protection	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/> Joint-life 1st claim <input type="checkbox"/>	£ <input type="text"/>	Years <input type="text"/>	Guaranteed <input type="checkbox"/> Reviewable <input type="checkbox"/>	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/>	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/>	N/A
Reducing life with critical illness protection	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/> Joint-life 1st claim <input type="checkbox"/>	£ <input type="text"/>	Years <input type="text"/>	Guaranteed <input type="checkbox"/> Reviewable <input type="checkbox"/>	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/>	1st insured person <input type="checkbox"/> 2nd insured person <input type="checkbox"/>	N/A
Extra benefits							

Income protection benefit table

Please fill in the table below and the section on the next page if you want income protection. If you want a second income protection benefit with a different deferred period, please fill in the 'Extra benefit' section at the bottom of this table.

Waiver of premium is automatically included with income protection.

Benefit basis	Benefit amount ¹	Benefit term	Premium type	Deferred period in weeks ²	Indexation option?
1st insured person <input type="checkbox"/>	£ <input type="text"/> a month	Years <input type="text"/> or to age <input type="text"/>	Guaranteed <input type="checkbox"/> Reviewable <input type="checkbox"/>	4 <input type="checkbox"/> 8 <input type="checkbox"/> 13 <input type="checkbox"/> 26 <input type="checkbox"/> 52 <input type="checkbox"/>	<input type="checkbox"/>
2nd insured person <input type="checkbox"/>	£ <input type="text"/> a month	Years <input type="text"/> or to age <input type="text"/>	Guaranteed <input type="checkbox"/> Reviewable <input type="checkbox"/>	4 <input type="checkbox"/> 8 <input type="checkbox"/> 13 <input type="checkbox"/> 26 <input type="checkbox"/> 52 <input type="checkbox"/>	<input type="checkbox"/>
Extra benefit 1st insured person <input type="checkbox"/>	£ <input type="text"/> a month	Years <input type="text"/> or to age <input type="text"/>	Guaranteed <input type="checkbox"/> Reviewable <input type="checkbox"/>	4 <input type="checkbox"/> 8 <input type="checkbox"/> 13 <input type="checkbox"/> 26 <input type="checkbox"/> 52 <input type="checkbox"/>	<input type="checkbox"/>
Extra benefit 2nd insured person <input type="checkbox"/>	£ <input type="text"/> a month	Years <input type="text"/> or to age <input type="text"/>	Guaranteed <input type="checkbox"/> Reviewable <input type="checkbox"/>	4 <input type="checkbox"/> 8 <input type="checkbox"/> 13 <input type="checkbox"/> 26 <input type="checkbox"/> 52 <input type="checkbox"/>	<input type="checkbox"/>

¹The total of all income protection benefits payable is limited to the lower of 55% of income or £150,000 a year. At claim, we'll treat the first 12 months of unemployment as if the claimant was in full employment for occupation and benefit purposes, but apart from that, if the insured person isn't in paid employment (for example a houseperson or unemployed), the total maximum benefit entitlement can't be greater than £1,500 a month, and the activities of daily work definition will apply.

²The four- and eight-week deferred periods aren't available if the insured person isn't in paid employment (for example a houseperson or unemployed).

4. Benefit details – continued

Income protection – continued

You only need to complete this section if you're applying for income protection and have completed the benefit table on pages 8 and 9.

	1st insured person	2nd insured person
Do you have existing cover?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'Yes', what's the existing yearly benefit amount?	£ <input type="text"/>	£ <input type="text"/>
If 'Yes', how much of this cover do you intend to cancel?	£ <input type="text"/>	£ <input type="text"/>
In the event of incapacity, would you receive income from work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would this income from work continue after the end of the chosen deferred period?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'Yes', please specify:	<input type="text"/> %	<input type="text"/> %
• percentage of salary received, and	<input type="text"/>	<input type="text"/>
• how long would payment be received	<input type="text"/>	<input type="text"/>
If you're employed, what's your total yearly income?		
(By total income we mean 'income that will be lost in the event of incapacity', so this may include regular income such as salary, commission, bonuses and overtime.)		
Current salary	£ <input type="text"/>	£ <input type="text"/>
Regular bonuses	£ <input type="text"/>	£ <input type="text"/>
Regular overtime	£ <input type="text"/>	£ <input type="text"/>
Any other payments	£ <input type="text"/>	£ <input type="text"/>
Total	£ <input type="text"/>	£ <input type="text"/>
If you're self employed, please give details of your net taxable earnings (after allowable expenses) for the last three years:		
Last year	£ <input type="text"/>	£ <input type="text"/>
Previous year	£ <input type="text"/>	£ <input type="text"/>
Year before	£ <input type="text"/>	£ <input type="text"/>

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you're claiming.

5. Medical details

Please answer the following questions for all types of benefit. You must not assume that we'll write to your doctor. If you need to give further details please use the Extra notes section on page 32. Or, you can write the details on a separate piece of paper, put your name and date of birth on it, then sign and date it and attach it securely to this form. ✉

1st insured person

How tall are you?

m	cms	ft	inches
---	-----	----	--------

How much do you currently weigh?

kgs	st	lbs
-----	----	-----

Have you been registered with a doctor in the UK for the past 12 months?

Yes No

Name of current doctor

Surgery name

Address

Postcode

Phone number

Have you been registered with your current doctor for more than 12 months?

Yes No

If 'No', please give your previous doctor's details below.

Name of previous doctor

Surgery name

Address

Postcode

Phone number

2nd insured person

How tall are you?

m	cms	ft	inches
---	-----	----	--------

How much do you currently weigh?

kgs	st	lbs
-----	----	-----

Have you been registered with a doctor in the UK for the past 12 months?

Yes No

Name of current doctor

Surgery name

Address

Postcode

Phone number

Have you been registered with your current doctor for more than 12 months?

Yes No

If 'No', please give your previous doctor's details below.

Name of previous doctor

Surgery name

Address

Postcode

Phone number

5. Medical details – continued

5.1 Tobacco and/or nicotine use

Are you a smoker?

You're classed as a smoker if you've smoked or used any type of tobacco or nicotine products in the last 12 months. This includes, but isn't limited to cigarettes, cigars, nicotine gum/patches, e-cigarettes or pipe/rolled tobacco.

If 'No', we may ask for a simple medical test to confirm this.

Please answer the relevant questions below based on whether you told us that you were a smoker or non-smoker.

Non-smoker

Tell us which one of these options best describes you.

If you've ever smoked, when did you last smoke tobacco or use any nicotine-based products?

Smoker

Tell us the average amount of the following that you've smoked or used a day over the last year. If you've only used nicotine replacement products such as gum, patches or e-cigarettes in the last year, please enter 0.

1st insured person

Yes No

Life-long non smoker
 Ex-smoker
 Very occasional smoker
 Current user of products containing nicotine

Cigarettes, including roll ups

Cigars

Other tobacco (in grammes)

1 ounce = 28 grammes

2nd insured person

Yes No

Life-long non smoker
 Ex-smoker
 Very occasional smoker
 Current user of products containing nicotine

Cigarettes, including roll ups

Cigars

Other tobacco (in grammes)

1 ounce = 28 grammes

5.2 Alcohol consumption

Please answer both the questions below about alcohol consumption even if you don't drink/have never drunk alcohol.

a. How many of the following do you drink a week?

Think back over the last three months and consider what you'd normally drink in a week.

If you don't drink alcohol please enter 0 in each box.

Pints of beer, lager or cider

Glasses of wine (125ml)

Measures of spirits (25ml) or bottles of alcopops (275ml)

Other alcoholic drinks

Pints of beer, lager or cider

Glasses of wine (125ml)

Measures of spirits (25ml) or bottles of alcopops (275ml)

Other alcoholic drinks

5. Medical details – continued

	1st insured person	2nd insured person
<p>b. Have you been advised to reduce or stop your alcohol consumption by a doctor, nurse or other medical professional? This includes a referral for specialist support such as an alcohol dependence unit or Alcoholics Anonymous.</p> <p>If 'Yes', give full details including any treatment, relevant dates, the number of units you were drinking each week at the time and details of any medical tests, driving convictions or hospital visits related to your alcohol consumption.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div>

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you're claiming.

6. Personal questions

Please answer the following questions for all types of benefit.

	1st insured person	2nd insured person
<p>6.1 Travel</p> <p>In the next 12 months do you intend to live, work or travel abroad, or have you done so in the past five years?</p> <p>You don't have to tell us about holidays if they total less than 30 days in any 12 month period.</p> <p>Future travel/residence (next 12 months)</p> <p>Tell us which countries (including regions) you expect to visit, and how many months you expect to spend in each country/region in the next year.</p> <p>Past travel/residence (last five years)</p> <p>Tell us which countries you've visited or lived in, and how many months you spent in each country in the last five years.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, complete the relevant sections below:</p> <div style="border: 1px solid black; height: 80px; margin-bottom: 10px;"></div> <div style="border: 1px solid black; height: 80px;"></div>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, complete the relevant sections below:</p> <div style="border: 1px solid black; height: 80px; margin-bottom: 10px;"></div> <div style="border: 1px solid black; height: 80px;"></div>
<p>6.2 Leisure</p> <p>Do you intend to take part in any hazardous activity?</p> <p>You don't need to tell us about:</p> <ul style="list-style-type: none"> • flying only as fare-paying passenger or cabin crew on scheduled or charter aircraft; • 'track' or 'experience' days; • a one-off parachute jump, or • a one-off scuba-dive. <p>If 'Yes', tick all that apply.</p> <p>Questionnaires for each of these pursuits are available at www.aegon.co.uk/support. Completing these will help speed up the underwriting process. If you won't have access to these questionnaires, please give full details of your activities in the 'Details' section below.</p> <p>If you need to give further details please write the details on a separate piece of paper, put your name and date of birth on it, sign and date it and send it to us at our head office. ✉</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Aviation</p> <p><input type="checkbox"/> Aviation-related activities (for example, ballooning, gliding, parachuting, parasailing)</p> <p><input type="checkbox"/> Caving/potholing</p> <p><input type="checkbox"/> Motor sports</p> <p><input type="checkbox"/> Mountaineering</p> <p><input type="checkbox"/> Sailing</p> <p><input type="checkbox"/> Sports diving</p> <p><input type="checkbox"/> Other – give details below</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Aviation</p> <p><input type="checkbox"/> Aviation-related activities (for example, ballooning, gliding, parachuting, parasailing)</p> <p><input type="checkbox"/> Caving/potholing</p> <p><input type="checkbox"/> Motor sports</p> <p><input type="checkbox"/> Mountaineering</p> <p><input type="checkbox"/> Sailing</p> <p><input type="checkbox"/> Sports diving</p> <p><input type="checkbox"/> Other – give details below</p>
<p>Details:</p> <p>Give full details including the activity you take part in, how often you take part in this activity, details of any related qualifications/experience and any equipment you use.</p>	<div style="border: 1px solid black; height: 100px;"></div>	<div style="border: 1px solid black; height: 100px;"></div>

6. Personal questions – continued

6.3 Other protection policies

1st insured person

Does the total amount of protection under all your existing policies, together with this application and any pending or concurrent applications, exceed £1,500,000 life cover or £750,000 critical illness cover or total permanent disability (TPD)?

Yes – give details of protection already in force, including any existing cover with us

No

	Policy benefit(s) ¹	Amount	Reason for protection	Name of insurer
1				
2				
3				
4				
5				

¹ For example, life cover/life or earlier critical illness cover (no TPD)/life or earlier critical illness cover (with TPD)/critical illness cover (no TPD)/critical illness cover (with TPD)/TPD.

Is any of your existing protection being cancelled?

Yes – give details of which protection is to be cancelled, including the name of insurer and policy number

No

Protection to be cancelled	Name of insurer	Policy number

Give details of protection being applied for, including any other applications to us.

	Policy benefit(s) ¹	Amount	Reason for protection	Name of insurer
1				
2				
3				
4				
5				

¹ For example, life cover/life or earlier critical illness cover (no TPD)/life or earlier critical illness cover (with TPD)/critical illness cover (no TPD)/critical illness cover (with TPD)/TPD.

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you're claiming.

6. Personal questions – continued

1st insured person – continued

Is the intention that all of these applications will go in force if accepted?

Yes

No – give full details

Tell us the reason for this protection (select all that apply)

Inheritance tax liability

Family/Personal protection

Other - give full details

6.4 2nd insured person

Does the total amount of protection under all your existing policies, together with this application and any pending or concurrent applications, exceed £1,500,000 life cover or £750,000 critical illness or total permanent disability (TPD)?

Yes – give details of protection already in force, including any existing cover with us

No

	Policy benefit(s) ¹	Amount	Reason for protection	Name of insurer
1				
2				
3				
4				
5				

¹ For example, life cover/life or earlier critical illness cover (no TPD)/life or earlier critical illness cover (with TPD)/critical illness cover (no TPD)/critical illness cover (with TPD)/TPD.

6. Personal questions – continued

2nd insured person – continued

Is any of your existing protection being cancelled?

- Yes – give details of which protection is to be cancelled, including the name of insurer and policy number
- No

Protection to be cancelled	Name of insurer	Policy number

Give details of protection being applied for, including any other applications to us.

	Policy benefit(s) ¹	Amount	Reason for protection	Name of insurer
1				
2				
3				
4				
5				

¹ For example, life cover/life or earlier critical illness cover (no TPD)/life or earlier critical illness cover (with TPD)/critical illness cover (no TPD)/critical illness cover (with TPD)/TPD.

Is the intention that all of these applications will go in force if accepted?

- Yes
- No – give full details

Tell us the reason for this protection (select all that apply)

- Inheritance tax liability
- Family/Personal protection
- Other - give full details

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you're claiming.

6. Personal questions – continued

6.5 Occupation

You only need to answer questions a-c below if you're applying for either or both of the following benefits – income protection and/or total permanent disability benefit.

Please indicate whether your occupation involves the following duties and give details where applicable:

	1st insured person	2nd insured person
a. Manual work, for example lifting, carrying, working with machinery or tools. If 'Yes', please give full details.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> % Average daily % of duties <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> % Average daily % of duties <input type="text"/>
b. Driving	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> Average yearly business mileage	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> Average yearly business mileage
c. Work at heights	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> % Average % of time spent at heights <input type="text"/> m Average height in metres	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> % Average % of time spent at heights <input type="text"/> m Average height in metres

7. Health questions

Please make sure that you answer all of the questions honestly and accurately. If you're in any doubt about the information we require, you should give full details.

If you've had a predictive genetic test for Huntington's disease, you only have to tell us the results, if this application, when added together with any cover you have of the same type, is for more than £500,000 life cover.

However if you've had any genetic test and the results are in your favour, you can choose whether to tell us the results or not. You must tell us however, if you think you're having treatment for, or are experiencing symptoms of, a genetic condition.

You must not partially disclose information when answering any questions or assume that we'll write to your doctor.

When answering the following health questions you don't need to tell us about common colds, influenza, hay fever, sinus trouble, wisdom teeth, vasectomy or shingles.

7.1 HIV/AIDS

- a. **Have you ever tested positive for HIV, hepatitis B or C, or are you waiting for the results of such a test?**

If the result is negative, the fact of having an HIV test will not, of itself, have any effect on your acceptance terms for insurance.

If you've answered 'Yes', please tick all that apply.

1st insured person

Yes No

- I've tested positive for HIV
- I'm waiting for a HIV test result
- I've tested positive for hepatitis B or C
- I'm waiting for a hepatitis B or C test result

2nd insured person

Yes No

- I've tested positive for HIV
- I'm waiting for a HIV test result
- I've tested positive for hepatitis B or C
- I'm waiting for a hepatitis B or C test result
-

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you're claiming.

7. Health questions – continued

	1st insured person	2nd insured person
<p>b. Within the last five years have you been exposed to the risk of HIV infection?</p> <p>HIV infection can be caught through unsafe sex, intravenous drug abuse, or blood transfusions or surgery undertaken outside the European Union.</p> <p>If 'Yes', please give full details, including the duration of illness, investigations, date of diagnosis and treatment received.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <input type="text"/>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <input type="text"/>
<p>c. Within the last five years have you tested positive or been treated for any disease which was transmitted sexually?</p> <p>If 'Yes', please give full details, including dates.</p> <p>Are you fully recovered? This means no treatment, discharged from any further review and not under any follow up.</p> <p>How many attacks of this condition have you had needing consultation with a GP or clinic?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <input type="text"/> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <input type="text"/>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <input type="text"/> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <input type="text"/>

7. Health questions – continued

	1st insured person	2nd insured person
7.2 Have you ever taken or injected any recreational drugs, anabolic steroids or prescription drugs not prescribed to you by a doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes , tell us which drug(s) you have taken.	<input type="text"/>	<input type="text"/>
Have you ever injected this drug?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes , when did you last inject this drug?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
When did you last use this drug?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
How many times a month do you use/ did you use this drug?	<input type="text"/>	<input type="text"/>
Give details if you've ever suffered any physical problems, excessive tiredness or any mental problems (for example anxiety or depression) related to the use of these drugs.	<input type="text"/>	<input type="text"/>
If you've ever had problems at work/ taken time off due to use of drugs, or received a caution for driving under the influence of drugs, give full details.	<input type="text"/>	<input type="text"/>

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you're claiming.

7. Health questions – continued

If you answer 'Yes' to any of the following health questions, please give full details in section 8 (Supplementary medical history).

7.3 Do you now have, or have you ever had, any of the following:

	1st insured person	2nd insured person
a. Angina, heart attack, stroke, transient ischaemic attack (TIA), brain haemorrhage or brain injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Chest pain, palpitations, heart murmur or any disease or abnormality of your heart, pulse, veins or arteries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Cancer, tumour, Hodgkin's disease, lymphoma or leukaemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Diabetes or sugar in the urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Any condition of the nervous system such as epilepsy, fits or blackouts, multiple sclerosis, Parkinson's disease, Alzheimer's disease, dementia, cerebral palsy or paralysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Mental illness that has required referral to a hospital, community mental health team or psychiatrist or have you ever attempted self-harm, suicide or had suicidal thoughts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Any disorder of the eyes (including blurred or double vision) or the ears (including impaired hearing)? You can ignore sight problems corrected by glasses or contact lenses.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. Health questions – continued

7.4 Other than previously stated, in the last five years have you had, been treated for or been advised to have follow-up for any of the following, whether or not you've consulted a medical practitioner:

	1st insured person	2nd insured person
a. Raised blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Raised cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. A lump, growth or cyst of any kind, or any mole or freckle that has bled, become painful, changed colour or increased in size?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Numbness, tingling, tremor, temporary loss of muscle power, or loss of balance or co-ordination?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Asthma, bronchitis, or any other condition affecting your lungs or breathing? You don't need to tell us about: • common colds or flu, or • one-off chest infections that you've fully recovered from.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Anxiety, depression, stress, fatigue or any form of nervous or mental disorder, including eating disorders or work-related stress? If you've already told us about your anxiety, depression or mental illness in response to a previous question, there's no need to tell us about this again here.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Anaemia or any blood or thyroid disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Any disorder of the digestive system, liver, stomach, pancreas or bowel, including gastric or duodenal ulcer, hepatitis, colitis or Crohn's disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Any disorder of the kidney, bladder, prostate or genito-urinary system, including blood or protein in the urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Any arthritis, gout, joint or muscle problems, including the knee(s), shoulder(s), neck, back or spine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you're claiming.

7. Health questions – continued

	1st insured person	2nd insured person
k. (This question is for both males and females) Any breast disorders, for example lumps, cysts, nipple discharge or inverted nipple, or an abnormal mammogram?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. (This question is for females only) An abnormal cervical smear or other gynaecological disorder from which you haven't fully recovered and/or been discharged from follow-up?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. To the best of your knowledge, have any of your parents, brothers or sisters, died from or been diagnosed with any of the following diseases/ disorders indicated in the table on the next page before the age of 65? Select all that apply.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If 'Yes', please complete the table on the next page:

7. Health questions – continued

7.5

a. 1st insured person

Disease/Disorder	If selected, give full details including their relationship(s) to you and age(s) at diagnosis. Please also give full details if you've had any investigations relating to the condition.
Heart attack, angina or stroke	
Diabetes	
Cancer of the breast, ovaries or bowel or familial bowel polyps	
Alzheimer's disease	
Parkinson's disease	
Polycystic kidney disease	
Polyposis of the colon	
Motor neurone disease	
Multiple sclerosis	
Huntington's disease	
Muscular dystrophy	
Cardiomyopathy	
Any other hereditary disorder – give name of disorder	
None of these	

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you're claiming.

7. Health questions – continued

7.5

b. 2nd insured person

Disease/Disorder	If selected, give full details including their relationship(s) to you and age(s) at diagnosis. Please also give full details if you've had any investigations relating to the condition.
Heart attack, angina or stroke	
Diabetes	
Cancer of the breast, ovaries or bowel or familial bowel polyps	
Alzheimer's disease	
Parkinson's disease	
Polycystic kidney disease	
Polyposis of the colon	
Motor neurone disease	
Multiple sclerosis	
Huntington's disease	
Muscular dystrophy	
Cardiomyopathy	
Any other hereditary disorder – give name of disorder	
None of these	

7. Health questions – continued

If you answer 'Yes' to any of the following health questions, please give full details in section 8 (Supplementary medical history).

	1st insured person	2nd insured person
<p>7.6 Are you awaiting the results of any investigations or are you aware of any symptoms or complaints that you haven't consulted a doctor about or received treatment for?</p> <p>If you've already told us about your investigations, symptoms or complaint in response to a previous question, there's no need to tell us about this again here.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>7.7 Do you have any other information to give us about any medical investigation, test or consultation, advice, counselling, operation, medication or treatment that you've had or been advised to have or are currently having, but haven't already told us about?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>7.8 During the last five years have you been off work or unable to carry out your normal duties due to sickness, accident or injury for more than five days at any one time, other than previously disclosed?</p> <p>You only need to answer this question if you're applying for critical illness, total permanent disability or income protection benefits – you don't have to give details relating to anything you've already told us about.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you're claiming.

8. Supplementary medical history

These questions should only be answered if you've answered 'Yes' to a health question in section 7.

You should complete a separate page for each medical condition and be as specific as possible.

If you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you're claiming.

Medical condition 1	1st insured person	2nd insured person
Which question do the following answers relate to?	<input type="text"/>	<input type="text"/>
What condition has been diagnosed?	<input type="text"/>	<input type="text"/>
When did this condition first occur?	<input type="text" value="M M Y Y Y Y"/>	<input type="text" value="M M Y Y Y Y"/>
When did you last have symptoms?	<input type="text" value="M M Y Y Y Y"/>	<input type="text" value="M M Y Y Y Y"/>
Have symptoms been continuous? If No , how many episodes have you suffered?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
Tell us what symptoms you're suffering or have suffered from, and the severity.	<input type="text"/>	<input type="text"/>
Have you been told that this condition is due to another medical condition? If Yes , give full details.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
Are you currently having treatment, for example any medication or specialist appointments? If Yes , tell us the type of treatment being received and the frequency.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
If you've received treatment in the past, tell us the type, frequency and when this stopped.	<input type="text"/>	<input type="text"/>
Are you waiting for any investigations, operation or the results of any tests/ investigations? If Yes , give full details including date(s) and the results.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
Have you had any tests or investigations? If Yes , give full details including date(s) and the results.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>

8. Supplementary medical history – continued

<p>Have you been admitted to hospital with this condition? If Yes, give full details including the number of admissions and dates.</p>	<p>1st insured person</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>2nd insured person</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>How much time off work have you taken in relation to this condition and when was this?</p>		
<p>If you've had time off work, have you now fully returned to work?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Are you fully recovered? This means no treatment, discharged from any further review and not under any follow up.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Medical condition 2</p>	<p>1st insured person</p>	<p>2nd insured person</p>
<p>Which question do the following answers relate to?</p>		
<p>What condition has been diagnosed?</p>		
<p>When did this condition first occur?</p>	<p>M M Y Y Y Y</p>	<p>M M Y Y Y Y</p>
<p>When did you last have symptoms?</p>	<p>M M Y Y Y Y</p>	<p>M M Y Y Y Y</p>
<p>Have symptoms been continuous? If No, how many episodes have you suffered?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Tell us what symptoms you're suffering or have suffered from, and the severity.</p>		
<p>Have you been told that this condition is due to another medical condition? If Yes, give full details.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Are you currently having treatment, for example any medication or specialist appointments? If Yes, tell us the type of treatment being received and the frequency.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you're claiming.

8. Supplementary medical history – continued

<p>If you've received treatment in the past, tell us the type, frequency and when this stopped.</p>	<input type="text"/>	<input type="text"/>
<p>Are you waiting for any investigations, operation or the results of any tests/ investigations? If Yes, give full details including date(s) and the results.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
<p>Have you had any tests or investigations? If Yes, give full details including date(s) and the results.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
<p>Have you been admitted to hospital with this condition? If Yes, give full details including the number of admissions and dates.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
<p>How much time off work have you taken in relation to this condition and when was this?</p>	<input type="text"/>	<input type="text"/>
<p>If you've had time off work, have you now fully returned to work?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Are you fully recovered? This means no treatment, discharged from any further review and not under any follow up.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

8. Supplementary medical history – continued

Medical condition 3	1st insured person	2nd insured person
Which question do the following answers relate to?	<input type="text"/>	<input type="text"/>
What condition has been diagnosed?	<input type="text"/>	<input type="text"/>
When did this condition first occur?	<input type="text" value="M M Y Y Y Y"/>	<input type="text" value="M M Y Y Y Y"/>
When did you last have symptoms?	<input type="text" value="M M Y Y Y Y"/>	<input type="text" value="M M Y Y Y Y"/>
Have symptoms been continuous? If No , how many episodes have you suffered?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
Tell us what symptoms you're suffering or have suffered from, and the severity.	<input type="text"/>	<input type="text"/>
Have you been told that this condition is due to another medical condition? If Yes , give full details.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
Are you currently having treatment, for example any medication or specialist appointments? If Yes , tell us the type of treatment being received and the frequency.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
If you've received treatment in the past, tell us the type, frequency and when this stopped.	<input type="text"/>	<input type="text"/>
Are you waiting for any investigations, operation or the results of any tests/ investigations? If Yes , give full details including date(s) and the results.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
Have you had any tests or investigations? If Yes , give full details including date(s) and the results.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
Have you been admitted to hospital with this condition? If Yes , give full details including the number of admissions and dates.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you're claiming.

8. Supplementary medical history – continued

	1st insured person – continued	2nd insured person – continued
How much time off work have you taken in relation to this condition and when was this?	<input type="text"/>	<input type="text"/>
If you've had time off work, have you now fully returned to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you fully recovered? This means no treatment, discharged from any further review and not under any follow up.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you want to give us more information regarding questions you answered 'Yes' to in section 7, please give us the additional details in the Extra notes section below. Or, you can write the details on a separate piece of paper, put your name and date of birth on it, then sign and date it and attach it securely to this form. ✉

Extra notes

9. How we use your information

Here at Aegon, we're committed to protecting and respecting your privacy. The personal information, including any special categories of personal information, for example medical data, we collect from you or others is required to enable us to verify your identity, assess your application for a policy, provide ongoing administration and assess any claims you make.

We need this information to carry out our obligations and provide you with the products and services under the terms of your contract with us. Without it, we wouldn't be able to provide you with a policy.

As part of our administration process, we work with carefully selected service providers (in other words suppliers) that carry out certain functions on our behalf. We only share the appropriate level of personal information necessary to enable our suppliers to carry out their services and they need to keep the information safe and protected at all times. Our suppliers must only act on our instructions and can't use your personal information for their own purposes.

The personal information we collect may be transferred to, and stored at a destination outside the European Economic Area (EEA). This could be to other companies within the Aegon Group or to our service providers. Where any such processing takes place, appropriate controls are in place to make sure that your information is protected.

We may disclose your information to licensed credit reference and/or fraud prevention agencies to help make financial or insurance proposals and claims decisions (this will be during the application or enrolment process and on an ongoing basis), for you and anyone you're linked with financially or other members of your household. Our enquiries or searches may be recorded.

As part of our underwriting process, we may use an automated decision-making tool. We've built rules into our underwriting engine which will either generate an automated decision or refer to one of our underwriters. We can review decisions if requested.

You can find more information on how we use and share your personal information, including how long we keep it and details of your rights at www.aegon.co.uk/protectinginformation or by contacting us to request a copy.

We'd like to keep you up-to-date with information about our news, products and services relating to our protection products by email, phone, SMS or mail. If you'd like to hear more from us, please select the relevant box(es) below.

Yes, I'm happy for you to contact me with information relating to your protection products.

Please tick below to indicate who this applies to:

1st insured person

2nd insured person

You can change your mind and unsubscribe at any time simply by contacting us. For more information on how to do this go to www.aegon.co.uk/protectinginformation

We won't pass your information to other companies outside of the Aegon Group for marketing purposes.

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you're claiming.

10. Access to medical reports – rights for the insured person(s)

In this part 'you' refers to the insured person(s) only (whether or not this is the policyholder(s))

10.1 We may need to get medical reports to support the application. Before we can ask any doctor that you've consulted to fill in a report, we need your permission under the Access to Medical Reports Act 1988 (or The Access to Personal Files and Medical Reports (Northern Ireland) Order 1991) (each referred to individually as the Act). Your rights under the Act are as follows:

- a. You don't need to give your permission, but if you don't, we may not be able to go ahead with the application. This doesn't prevent an application being made to other companies for insurance.
- b. You can ask to see the report before your doctor returns it to us. If this is the case, we'll tell your doctor to keep the report for 21 days so that you can arrange to see it. If you haven't made arrangements to see the report within this time, your doctor will send the report to us. Once you've seen the report, your consent is required before it can be passed to us.
- c. If you choose not to see the report at this stage, you may ask your doctor for a copy within six months of it being sent to us. We can send a copy of the report to your doctor if you ask to see it at a later date.
- d. If you indicate on this form that you don't want to see the report before it's sent to us, we can ask your doctor for a report without notifying you. However, you can still write to your doctor and ask to see the report before it's sent to us. You'll then have 21 days within which to make arrangements to see the report.
- e. If you think that any part of the report isn't correct or is misleading, you may ask your doctor to amend it. If your doctor refuses to make the amendments, you may ask them to attach a statement outlining your views, which will then accompany the report.
- f. Your doctor can withhold access to the report if:
 - they feel that it would cause physical or mental harm to you or others, or
 - it discloses information given by or about another person (apart from another doctor who has attended you), who doesn't want their identity or the information revealed. In these

circumstances, your doctor must notify you and you'll then be able to see only the non-confidential parts of the report. If the whole report is affected, your doctor must not send it to us unless you consent to this.

- g. If you ask for a copy of the report under any circumstances, your doctor can charge you a reasonable fee to cover the costs of supplying it.

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

- a. Your current health:
 - any care, medication or treatment you're currently receiving, and
 - the results of referrals or tests you're waiting for.
- b. Any time off work in the last three years.
- c. Your past health:
 - details of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your GP or any other medical adviser, therapist or counsellor.

In particular, whether you have a history of:

- malignancy (cancer), cardiovascular (heart) disease, diabetes and degenerative (gradually worsening) diseases;
- musculoskeletal disease or injury, for example arthritis, rheumatism, back problems or any other disorder of the joints or muscles;
- anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue;
- suicidal thoughts or attempts at suicide, or
- conditions related to drug or alcohol misuse or smoking or chewing tobacco;
- details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations, and
- any blood pressure readings in the last three years.

10. Access to medical reports – rights for the insured person(s) – continued

- d. Any history of disease among your parents or brothers or sisters that you've told your doctor about.

10.3 If we ask your doctor for a report, we'll ask them not to reveal information about:

- a. negative tests for HIV, hepatitis B or C;
- b. any sexually transmitted diseases unless there could be long-term effects on your health, or
- c. predictive genetic test results, unless there's a favourable test result which shows that you haven't inherited a condition your family suffers from.

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

- a. refusing to provide insurance;
- b. increasing premiums above standard rates;
- c. excluding certain medical conditions, or
- d. setting premiums at standard rates.

10.5 Contact us

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

Protection Customer Service Centre
Aegon
Edinburgh Park
Edinburgh
EH12 9SE

10.6 Do you want to see the medical report before your doctor sends it to us?

Insured person 1

Yes – I **do** want to see the medical report before it's sent to you

No – I **don't** want to see the medical report before it's sent to you

Insured person 2

Yes – I **do** want to see the medical report before it's sent to you

No – I **don't** want to see the medical report before it's sent to you

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you're claiming.

11. Declaration and consent

Before signing this declaration, please read sections 9, 10 and 11 carefully.

Tick here if answers to some/all of the medical questions have been sent to our Chief Medical Officer.

11.1 Important notes for the policyholder(s) and the insured person(s)

The policy won't start until we've assessed and accepted the application and the first premium has been paid. If the insured person has a full or quarter birthday (quarter birthdays are at three, six and nine months after a birthday) while the application is being processed, the terms may differ from those originally illustrated. In most instances the premiums will be as originally illustrated. We may offer revised terms, but occasionally we may not be able to offer any terms.

We may ask you to contact your doctor if we're waiting for reports which we've asked for. If we ask you to attend a medical examination or we ask your doctor for a general practitioner's report, we may need to share the application information with another company we've authorised. They'll make the arrangements for the examination to take place and/or to obtain the general practitioner's report.

We may need to send the application and relevant medical reports to our reinsurers for their opinion or agreement to the terms offered, or we may need to send them at a later stage for purposes relating to managing the policy. Please ask us if you want details of any company we use to assess the application.

We have a confidentiality policy in place, which means we hold all medical information securely and access is limited to authorised individuals who need to see it. You're entitled to ask for a copy of our standard policy conditions and/or a copy of the application form at any time.

11.2 This declaration applies to both the policyholder(s) and the insured person(s), if different.

In this declaration 'I/me' means the policyholder(s) and/or the insured person(s) where appropriate in the context and 'you' means Aegon.

11.3 I've read sections 9, 10 and 11 of this form.

11.4 The information and statements I've made within this application, and within any additional documents you've asked for in connection with this application, are true and complete.

11.5 If I haven't received face-to-face advice from a financial adviser in connection with this application, I've received and had the opportunity to read the key features document, illustration and policy conditions that are relevant to this application.

11.6 I understand that it is my personal responsibility to:

- a. tell you, in writing, about any change to my health and/or circumstances which happen before this policy starts;
- b. fully and completely give all the facts required when answering the questions in this form. At no point will I assume that you'll write to my general practitioner for medical information, and
- c. comply with the points detailed above. If I fail to comply with the points above, then the protection cover may be altered or cancelled. If the cover is cancelled, no claim will be payable.

11.7 I agree:

- a. that if you need to accept my application on terms other than standard terms, you'll tell my financial adviser what those terms are;
- b. to you sharing the application information with another company you've authorised. This could include asking me to attend a medical examination or requesting a general practitioner's report. The authorised company will arrange for the examination to take place and/or to obtain the general practitioner's report;
- c. to you gathering relevant information from other insurers about any other applications for life, critical illness, sickness, disability, accident or private medical insurance that I've applied for, and
- d. that I'll sign any further consent to gather medical reports that you require, in the event that the current consent has expired.

11. Declaration and consent – continued

11.8 I give you permission to:

- a. request medical information at any time, before or after my death, about any matter which relates to my physical or mental health, from any doctor who has attended me. I also agree to you passing the results from any independent medical examination to my own doctor;
- b. share medical evidence with any other company within the Aegon UK plc group or to get any evidence held by any other company within the group;
- c. share any medical information with another insurer if they ask for such information, and
- d. ask for the relevant financial information, if needed, to assess this application.

11.9 I authorise those asked to provide medical information when they see a copy of this declaration and consent. It allows you to gather medical reports within 12 months of the date I signed it, at any time in the event that I'm ill, or after my death to support any claim made on the policy.

You can use this information to maintain management information for business analysis.

11.10 Terms of contract

In this section, 'I' means the policyholder(s) and the insured person(s) (if different), and 'you' means Aegon.

- a. I agree that the contract will be governed by the following documents:
 - this declaration and consent;
 - this application record, and
 - the Aegon policy schedule and the accompanying policy conditions.
- b. By signing this declaration, I am allowing you to process my application using the information that I have given. You may also use this information to process any claim made on this policy.
- c. I have read the declaration, important notes and information relating to my/our rights under the Act in section 11.

Please remember that if you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you're claiming.

11. Declaration and consent – continued

Signature(s) of the insured person(s)

1st insured person

Date

D	D	M	M	2	0	Y	Y
---	---	---	---	---	---	---	---

Print name

X	X
---	---

2nd insured person

Date

D	D	M	M	2	0	Y	Y
---	---	---	---	---	---	---	---

Print name

X	X
---	---

Signature(s) of policyholder(s) (if different to the insured person(s))

1st policyholder

Date

D	D	M	M	2	0	Y	Y
---	---	---	---	---	---	---	---

If a company, please give the position/authority of signatory

Print name

X	X
---	---

2nd policyholder

Date

D	D	M	M	2	0	Y	Y
---	---	---	---	---	---	---	---

If a company, please give the position/authority of signatory

Print name

X	X
---	---

12. Agency details

To be filled in by the financial adviser

Your name and company name

Phone number

Email address

Your principal Financial Services Register reference number

Your appointed rep Financial Services Register reference number

If you're a member of a support services company, please give your reference

Commission details

Please tick one box only:

- Initial plus renewal (Indemnity)
Lump sum paid then renewal commission paid after the indemnity period.
- Initial plus renewal (Non-indemnity)
Paid in regular instalments over the initial period then renewal commission paid after the initial period.
- Level
Paid in regular instalments throughout the life of the policy.

Would you like to give up any commission?

- Yes No

If 'Yes', what percentage do you want to give up?

 %

Is this application being provided for the adviser's own use, for example the intermediary or their appointed representative, employee, relative, or a relative of an employee of the intermediary?

- Yes No

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

Please fill in the whole form using a ballpoint pen and send it to: Aegon, Edinburgh Park, Edinburgh EH12 9SE

Name(s) of account holder(s)

Bank/Building society account number

Branch sort code

Name and full postal address of your bank or building society

To: The Manager	Bank/Building society
Address	
Postcode	

Reference

Service user number

PLEASE COMPLETE

This isn't part of the instruction to your bank or building society.

Policy number/online application reference

Insured person(s)

Direct Debits should normally be paid from the policyholder's own bank or building society account. If this isn't the case, please tell us the reason and the name and address of the person making the policy payments in section 3.

Instruction to your bank or building society

Please pay Scottish Equitable plc Direct Debits from the account detailed in this Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand this Instruction may remain with Scottish Equitable plc and, if so, details will be passed electronically to my bank/building society.

Signature(s)

X	X
X	X

Date

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

This guarantee should be detached and retained by the payer.

The Direct Debit Guarantee

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits.
- If there are any changes to the amount, date or frequency of your Direct Debit, Scottish Equitable plc will notify you three working days in advance of your account being debited or as otherwise agreed. If you request Scottish Equitable plc 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 Scottish Equitable plc 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 Scottish Equitable plc 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.



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