Sharing the benefits of healthy living

VitalityLife supplementary health questionnaire and reinstatement application form.

IMPORTANT

Please use black ink, BLOCK LETTERS and tick or complete answers as appropriate. If you make a mistake please initial your correction.

VitalityLife plan number: ☐☐☐☐☐☐☐☐

Completed by:

Date: D D M M Y Y Y Y **Time:**

Notes to help you:

- If there is insufficient space on the form, please use the notes page at the end of this document or a separate sheet.
- Failure to disclose relevant information may result in non-payment of a claim.

Important information for the Planholder/Life(s) Assured

If completing this form in a printed format, please use black ink and BLOCK LETTERS. In all instances of completing this form, tick or complete answers as appropriate. Please help us by filling in the application form honestly and in full. If you miss any information out, or give us misleading information, this is likely to mean that a future claim will not be paid. In addition, this could also delay the processing of your application. If you are uncertain about whether any particular fact would influence our decision, you should include it. If you do not, it is likely that a claim in the future will not be paid. Please disclose all relevant information as we may not contact or obtain a GP report.

If someone else fills this form in for you (for example, your Financial Adviser or a Vitality Nurse), please check that all the details are correct before you sign the declaration. You are responsible for all the answers you or your Financial Adviser provide on this application. If a Vitality Nurse is completing this form on your behalf, please be aware that the calls will be recorded for training and monitoring purposes. If you make a mistake please cross it out, put in the correct word or words and initial next to the correction.

If you would prefer, you may complete the medical questions in private and return the Lifestyle details section direct to our Chief Medical Officer. Please indicate on this form if you have done so.

It is very important that you tell us if there is a change to any of the following between completion of this form and your application being accepted.

- your personal health
- your family history
- your occupation
- your participation in any hazardous leisure activities
- your travel or residence
- your lifestyle (smoking/alcohol consumption/etc)

If you do not, the plan may be cancelled and will result in non payment of a claim.

Information about genetic tests

If this application, taken together with any other insurance plans you already have, is for Life Cover up to a sum of £500,000, Serious Illness/Critical Illness Cover up to £300,000 or Income Protection Cover up to £30,000 per annum, you need not disclose any genetic test you may have had. You need not disclose the result of any genetic test undertaken in the context of research. Genetic test results need only be disclosed where the sum exceeds either £500,000 for Life Cover or £300,000 for Serious Illness/Critical Illness Cover, £30,000 per annum for Income Protection Cover and their use by insurers has been independently approved. You may, of course, disclose any genetic test result which is in your favour. If you either have a family history of, are experiencing symptoms of, or are having treatment for, a genetic condition, you must tell us.Further information is available on request which fully explains this plan and details those genetic tests approved for use by insurers.

Failure to disclose relevant information may result in non payment of a claim.

IMPORTANT INFORMATION:
If this is a joint application, the First Life Assured must be the person who has selected the highest level of Life Cover. If no Life Cover has been selected, then the First Life Assured is the person with the highest level of Serious Illness Cover. If there is no Life Cover and no Serious Illness Cover, then the First Life Assured is the person with the highest level of Income Protection Cover. If both lives have chosen the same level of cover, the First Life Assured will be the first person on the application.

Failure to disclose relevant information may result in non-payment of a claim.

A – Client information - first (or only) life assured

Are you a UK resident? (UK includes England, Scotland, Wales and Northern Ireland but EXCLUDES the Channel Islands, Isle of Man and Republic of Ireland)? Yes ☐ No ☐

For further guidance, please refer to the Eligibility Guidelines found on the Adviser Hub.

NB. We reserve the right to request additional information and documentation to verify the above.

If 'No', you will need to establish eligibility for a VitalityLife plan by discussing the residency status with our Financial Crime team - please see the Eligibility Guidelines on the Adviser Hub for contact details.

Title Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐ **Gender** Male ☐ Female ☐

First name _____ **Last name** _____

Date of birth D D M M Y Y Y Y

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Civil Partner

☐ Dissolved civil partnership ☐ Surviving partner of civil partnership

Please confirm your smoker status (includes cigarettes, cigars, pipe, loose tobacco, herbal cigarettes, any nicotine replacement therapy and electronic cigarettes) by selecting one of the following options:

☐ Occasional smoker ☐ Regular smoker ☐ Ex-smoker (stopped more than 12 months ago)

☐ Never smoked

We will carry out random tests to confirm non-smoker status.

How many cigarettes (include roll-ups) do you, or did you, smoke per day? _____

In an average week, how many alcoholic drinks do you have? (Examples of drink here include a pint of beer/cider, an average sized glass of wine or a single measure of spirits) _____

Occupation _____

Employment status ☐ Employed ☐ Self employed ☐ Unemployed ☐ Houseperson

Do you work on a zero hours contract basis? ☐ Yes ☐ No
(Unfortunately VitalityLife does not offer Income Protection Cover for zero contract hours applications)

Have you been self-employed for 2 years or more? (Complete only if self-employed is selected) Yes ☐ No ☐

Annual Personal Pre-Tax Income _____

Should our tele-underwriters/Vitality Nurses need to contact you, please choose the preferred contact times. We will contact you between Monday and Friday.

☐ No Preference 9am – 8pm ☐ Morning 9am – 12pm ☐ Afternoon 12pm – 4pm ☐ Evening 4pm – 8pm

Which telephone number should we use? ☐ Work ☐ Mobile ☐ Home

Please provide at least one contact number

Work _____ Mobile _____

Home _____ Email _____

Current Address _____

IMPORTANT INFORMATION:
If this is a joint application, the First Life Assured must be the person who has selected the highest level of Life Cover. If no Life Cover has been selected, then the First Life Assured is the person with the highest level of Serious Illness Cover. If there is no Life Cover and no Serious Illness Cover, then the First Life Assured is the person with the highest level of Income Protection Cover. If both lives have chosen the same level of cover, the First Life Assured will be the first person on the application.

Failure to disclose relevant information may result in non-payment of a claim.

A – client information - second life assured (if applicable)

Are you a UK resident? (UK includes England, Scotland, Wales and Northern Ireland but EXCLUDES the Channel Islands, Isle of Man and Republic of Ireland)? Yes ☐ No ☐

For further guidance, please refer to the Eligibility Guidelines found on the Adviser Hub.

NB. We reserve the right to request additional information and documentation to verify the above.

If 'No', you will need to establish eligibility for a VitalityLife plan by discussing the residency status with our Financial Crime team - please see the Eligibility Guidelines on the Adviser Hub for contact details.

Title Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐ **Gender** Male ☐ Female ☐

First name _____ **Last name** _____

Date of birth D D M M Y Y Y Y

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Civil Partner

☐ Dissolved civil partnership ☐ Surviving partner of civil partnership

Please confirm your smoker status (includes cigarettes, cigars, pipe, loose tobacco, herbal cigarettes, any nicotine replacement therapy and electronic cigarettes) by selecting one of the following options:

☐ Occasional smoker ☐ Regular smoker ☐ Ex-smoker (stopped more than 12 months ago)

☐ Never smoked

We will carry out random tests to confirm non-smoker status.

How many cigarettes (include roll-ups) do you, or did you, smoke per day? _____

In an average week, how many alcoholic drinks do you have? (Examples of drink here include a pint of beer/cider, an average sized glass of wine or a single measure of spirits.) _____

Occupation _____

Employment status ☐ Employed ☐ Self employed ☐ Unemployed ☐ Houseperson

Do you work on a zero hours contract basis? ☐ Yes ☐ No
(Unfortunately VitalityLife does not offer Income Protection Cover for zero contract hours applications)

Have you been self-employed for 2 years or more? (Complete only if self-employed is selected) Yes ☐ No ☐

Annual Personal Pre-Tax Income _____

Should our tele-underwriters/Vitality Nurses need to contact you, please choose the preferred contact times. We will contact you between Monday and Friday.

☐ No Preference 9am – 8pm ☐ Morning 9am – 12pm ☐ Afternoon 12pm – 4pm ☐ Evening 4pm – 8pm

Which telephone number should we use? ☐ Work ☐ Mobile ☐ Home

Please provide at least one contact number

Work _____ Mobile _____

Home _____ Email _____

Current Address _____

IMPORTANT: Failure to disclose relevant information may result in non-payment of a claim.

A – Clients information (additional details)

CLIENT INFORMATION	First (or only) life	Second life assured (if applicable)
1. Are you currently pregnant? (For females only) 1.1 What is the height and weight of the life assured?	Yes ☐ No ☐ Height Feet Height Inches Height cm Weight Stones Weight Pounds Weight Kg	Yes ☐ No ☐ Height Feet Height Inches Height cm Weight Stones Weight Pounds Weight Kg
2. Do you already have any Life Cover, Critical Illness/ Serious Illness or Income Protection Cover with VitalityLife (formerly known as PruProtect)?	Yes ☐ No ☐	Yes ☐ No ☐
2.1 Within the last 12 months have you applied for any other cover with VitalityLife, regardless of whether a plan has been issued or not? *If 'Yes' please provide full details of type of cover*	Yes ☐ No ☐ Yes	Yes ☐ No ☐ Yes
2.2 Including this application, will the total amount of Life cover you have for all purposes exceed £2 million or £800,000 for Serious Illness / Critical Illness cover? (ignore cover that will be cancelled and applications that are for comparative purposes only, but include any further cover you intend applying for in the next 6 months)	Yes ☐ No ☐	Yes ☐ No ☐
3. Do you have any Income Protection Cover with any other companies including any you are currently applying for? *If 'Yes' please provide the cover amounts*	Yes ☐ No ☐ £	Yes ☐ No ☐ £
4. Will you be cancelling any of the insurance cover outlined in questions 2 and 3 when your VitalityLife plan starts? Life Cover being cancelled Serious/Critical Illness cover being cancelled Income Protection Cover being cancelled	Yes ☐ No ☐ Cover Amount £ £ £	Yes ☐ No ☐ Cover Amount £ £ £

5. Who is the owner of the plan? (please tick one box)

- ☐ Life assured named on this form (Go to section B on page 5)
- ☐ Another life assured (Go to section B on page 5)
- ☐ Both lives (Complete the details below where appropriate)
- ☐ Trustees
- ☐ Company
- ☐ One or more individua

A – Clients information (additional details) - continued

5.1 Who is the owner of the plan? - continued

Trust(ee)

First name | Last name

Address for correspondence

Telephone number (home)

Telephone number (mobile)

Telephone number (work)

Relationship to life/lives assured

Reason for assurance

B – Lifestyle /health details

1. OCCUPATION	First (or only) life	Second life assured (if applicable)
1.1 What is your main occupation?		

IMPORTANT: Additional information may be required for specific occupations, such as percentage of time working at heights or whether working on oil rigs outside the North Sea or UK waters. Please capture these details if applicable.

1.2 Do you work in or with the armed forces or reserve forces? (Even if you have already selected an armed forces occupation title, you must answer 'yes' to this question if applicable)	Yes ☐ No ☐	Yes ☐ No ☐
1.3 Please indicate whether you work full time in the Armed Forces, are a Reservist or whether you work with or for the Armed Forces as a civilian: • Full time in the Armed Forces • As a civilian attached to the Armed Forces • As a Reservist If *'Yes'*, do you work with the Reservists on a full time basis?	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐

B – Lifestyle /health details (continued)

1. OCCUPATION	First (or only) life	Second life assured (if applicable)
1.4 Are you currently on, or have you received notification / confirmation (either written or verbal) that you will be deployed on an Operational Tour of Duty outside of the UK to a hazardous country within the next 12 months? This includes an Operational Tour of Duty with the United Nations. Hazardous countries include Afghanistan, Burundi, Central African Republic, Chad, Congo, Cote d'Ivoire, Guinea, Haiti, Iraq, Kyrgyzstan, Libya, Mali, Pakistan, Somalia, Sudan, South Sudan, Syria, Yemen and Zimbabwe.	Yes ☐ No ☐	Yes ☐ No ☐
If **'Yes',** what is the nature of the tour of duty e.g. combat, peace keeping, training and support (self and others), humanitarian etc? Please give details		
When will your posting start and how long do you expect it to last?		
What regions within this country or countries will you be posted to during your tour?		

i **IMPORTANT:** You do not need to complete the following questions if you work purely as a civilian attached to the Armed Forces.

1.5 Do you work in any branch of the Special Forces (e.g. SAS, SBS, SFSG, SRR)?	Yes ☐ No ☐	Yes ☐ No ☐
1.6 Do your normal duties involve bomb disposal, mine clearance, diving, flying in helicopters (as aircrew) or fast jets?	Yes ☐ No ☐	Yes ☐ No ☐
If **'Yes'**, please give a description of your duties		
If you have or you are applying for Life Cover only go to section B4.		

i **IMPORTANT:** If you have or you are applying for Life Cover only go to section B2 Travel / Residency

1.7 Do you work less than 16 hours per week? If you are unemployed, a student,a houseperson, retired or a pensioner then answer 'No' to this question.	Yes ☐ No ☐	Yes ☐ No ☐

1.8 Apart from commuting between your home and fixed place of work, does your job involve driving more than 25,000 miles per annum?	Yes ☐ No ☐	Yes ☐ No ☐
1.9 Since April 2020, have you been or are you currently furloughed? If 'Yes' please confirm if you have returned to work, if there has been any reduction in your hours or salary or are you aware of any pending changes to your employment such as redundancy or reduction in hours?	Yes ☐ No ☐	Yes ☐ No ☐
1.10 Since April 2020: Have you suffered an income drop of more than 10% from pre-coronavirus income? Have you become eligible for the Self Employed Income Support Scheme? Has your business / self-employment started within the last 12 months More than one of the above	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐

2. TRAVEL/RESIDENCY	**First (or only) life**	**Second life assured** (if applicable)
2.1 In the next 12 months, do you intend spending more than 4 weeks overall (i.e. in total across all of these areas) in the Middle East, Africa, Central or South America, Asia (ignore Japan, Hong Kong or Singapore), Ukraine, Russia or New Guinea? If **'Yes'** please provide details of country(s), whether currently living in that country, duration of stay (past and future), reason for stay, area (i.e. town/city)	Yes ☐ No ☐	Yes ☐ No ☐
2.2 In the last 5 years have you spent more than 3 consecutive months in Africa, India, Thailand or the Caribbean (Includes Antigua, Bahamas, Barbados, Bermuda, Cuba, Dominican Republic, Grenada, Haiti, Jamaica, Trinidad and Tobago)? If **'Yes'** please provide details of country(s), duration of stay, whether a UK citizen or have right to permanently stay in UK	Yes ☐ No ☐	Yes ☐ No ☐
3. HAZARDOUS PURSUITS/HOBBIES		

3.1 Do you take part in or intend to take up any hazardous activities? Examples include but are not limited to aviation (except as a fare paying passenger or where it is your full time occupation), parachuting, skydiving, hang-gliding, water sports, diving, mountaineering, caving, bouldering, motor sports, extreme sports (such as bungee jumping, base jumping, canyoning) etc. One day experience or taster sessions can be ignored. If **'Yes'** please complete the following questionnaire: • Name of activity(s) - include names of ALL aspects of the activity you take part in. If activity is skiing or snowboarding, please advise whether you ever take part in speed skiing, or ski / snowboard in remote areas only accessible by helicopter or plane. • Please list any qualifications and state whether you participate in a professional or amateur capacity. • Where do you take part in this activity(s) i.e. venue type, area of the world etc? • How many times a year do you take part? • Do you ever take part alone? • If applicable, what heights/depths do you go to?	Yes ☐ No ☐ Yes ☐ No ☐ Height m Depth m	Yes ☐ No ☐ Yes ☐ No ☐ Height m Depth m

4. LIFESTYLE	**First (or only) life**	**Second life assured** (if applicable)
4.1 Have you ever been advised to reduce your alcohol intake because you were drinking too heavily? If **'Yes'** please provide full details of treatment or advice given.	Yes ☐ No ☐	Yes ☐ No ☐
4.2 In the last 10 years have you ever taken recreational drugs such as cannabis, ecstasy, cocaine, methadone, heroin, anabolic steroids or similar substances? If **'Yes'** please provide details including, type of drugs used, dates, how often (i.e. regularly or as an experiment) and circumstances (i.e. party, university etc).	Yes ☐ No ☐	Yes ☐ No ☐

IMPORTANT: This information may be sent in confidence to our chief medical officer.

5. FAMILY HISTORY	First (or only) life	Second life assured (if applicable)
5.1 Before the age of 60, have any members of your immediate family (natural parents, brothers or sisters) had any of the following medical conditions: Breast, Ovarian, Prostate, Colon or Bowel Cancer, Heart Attack, Angina, Cardiomyopathy, Diabetes, Multiple Sclerosis, Muscular Dystrophy, Parkinson's, Dementia / Alzheimer's Disease, Huntington's, Motor Neurone Disease or Polycystic Kidney Disease? If **'Yes'** please provide details of age of relative at the time they were diagnosed, relationship to you and whether you have had any screening or investigations for this condition yourself.	Yes ☐ No ☐	Yes ☐ No ☐
5.2 Are there any other conditions that run in your family that you have had, or been advised to have ongoing screening / monitoring for? (If you have already disclosed your family history in answer to the previous question please answer 'no') If 'Yes' please provide details of condition, age of relative at the time they were diagnosed, relationship to you and screening details including dates and results.	Yes ☐ No ☐	Yes ☐ No ☐

6. YOUR HEALTH	First (or only) life	Second life assured (if applicable)
Have you ever had or do you currently have any of the following: **(If 'Yes', please complete the relevant Medical Disclosure from page 13 for full details)**		
6.1 Cancer, leukaemia, Hodgkin's disease, lymphoma, brain or spinal tumour?	Yes ☐ No ☐	Yes ☐ No ☐
6.2 Heart disease or disorder, including heart attack, angina, cardiomyopathy, heart murmur, heart surgery or procedure, palpitations, irregular heart beat or chest pain?	Yes ☐ No ☐	Yes ☐ No ☐
	First (or only) life	**Second life assured** (if applicable)
6.3 Stroke, transient ischaemic attack (TIA), brain haemorrhage or permanent brain injury through an accident?	Yes ☐ No ☐	Yes ☐ No ☐
6.4 Multiple sclerosis, optic neuritis, epilepsy, paralysis, muscular dystrophy, Parkinson's disease, dementia or Alzheimer's disease, cerebral palsy, motor neurone disease or any disorders of the brain or nerves?	Yes ☐ No ☐	Yes ☐ No ☐
Have you ever had or do you currently have any of the following: **(If 'Yes', please complete the relevant Medical Disclosure from page 13)**		

B – Lifestyle /health details (continued)

6.5 Diabetes, sugar in the urine, low blood sugar, or thyroid problems?	Yes ☐ No ☐	Yes ☐ No ☐
6.6 Schizophrenia, bipolar disorder / manic depression or have you ever required hospital treatment as an inpatient for any mental illness?	Yes ☐ No ☐	Yes ☐ No ☐
6.7 Have you ever tested positive for HIV, Hepatitis B or Hepatitis C or are you awaiting the results of such a test? (Note: if the result is negative, the fact of having an HIV test will not, in itself, have any effect on your acceptance terms for insurance)	Yes ☐ No ☐	Yes ☐ No ☐

i **IMPORTANT:** Please complete the additional medical questionnaire(s) for each disclosure and provide as much information as possible.

7. YOUR HEALTH IN THE LAST 5 YEARS	**First (or only) life**	**Second life assured** (if applicable)
Apart from any condition you have already told us about, have you had any of the following in the last 5 years: (If yes, please complete the relevant Medical Disclosure form page 14)		
7.1 Lump, cyst, growth or skin lesion of any kind, or a mole or freckle that has bled, become painful, itchy, changed colour, increased in size or that you have been advised to monitor (including photographic surveillance)?	Yes ☐ No ☐	Yes ☐ No ☐
7.2 Raised blood pressure or raised cholesterol, Deep Vein Thrombosis, disease or disorder of the blood vessels including the aorta and arteries of the leg or neck or any condition affecting the blood such as anaemia or thalassaemia?	Yes ☐ No ☐	Yes ☐ No ☐
7.3 Numbness, tremor, tingling, pins and needles, dizziness facial pain or visual disturbance including blurred or double vision?	Yes ☐ No ☐	Yes ☐ No ☐
7.4 Seizures, fits, fainting, blackouts or memory loss?	Yes ☐ No ☐	Yes ☐ No ☐
7.5 Any disorder of the digestive system, liver, stomach, oesophagus, pancreas, colon or bowel, hepatitis, colitis or Crohn's disease? Please ignore minor indigestion, heartburn, appendicitis (operated and fully recovered) or irritable bowel syndrome (IBS) that only cause occasional mild discomfort and for which you have not required investigation or hospital referral and none are planned.	Yes ☐ No ☐	Yes ☐ No ☐

7.6 Any disorder of the kidneys, bladder or prostate, including blood or protein in the urine or urinary tract infection?	Yes ☐ No ☐	Yes ☐ No ☐
7.7 Any mental disorder, including stress, anxiety, panic attacks, depression or continuous fatigue, tiredness, fibromyalgia or eating disorders?	Yes ☐ No ☐	Yes ☐ No ☐
7.8 Any respiratory or lung disorder, including asthma, bronchitis, COPD (COAD), emphysema or sleep apnoea?	Yes ☐ No ☐	Yes ☐ No ☐
7.9.1 Any pain or other problems relating to your back, neck, joints, bones or muscles, including arthritis, ankylosing spondylitis, rheumatism or gout. Simple muscle strain, sprains or fractures of limbs that you have fully recovered from can be ignored. There is no need to answer this question if the application is life cover only.	Yes ☐ No ☐	Yes ☐ No ☐
7.9.2 Any disorder of the eyes or ears, including blindness or deafness, or problems with your sight or difficulty hearing? (conjunctivitis, sight problems fully corrected by glasses, contact lenses or laser eye treatment for short/long sight or cosmetic reasons, or simple earache or ear infections that have cleared up with no ongoing hearing loss can be ignored)	Yes ☐ No ☐	Yes ☐ No ☐
7.9.3 Any gynaecological disorder including abnormal cervical smears or breast conditions which have required investigations, referral to a specialist or treatment (Infertility treatment, miscarriage/termination, uncomplicated pregnancy/caesarean section, thrush, routine scan/blood test for pregnancy, routine cervical smear (normal result), HRT(no investigations involved) can be ignored. Only applicable where the life assured is Female.	Yes ☐ No ☐	Yes ☐ No ☐
7.9.4 In the last 5 years have you required more than 2 weeks off work for any medical condition, illness or injury not already mentioned. Please ignore flu or colds from which you've fully recovered and pregnancy where no complications were present.	Yes ☐ No ☐	Yes ☐ No ☐

B – Lifestyle /health details (continued)

IMPORTANT: If answered 'Yes' to any of these questions please complete the additional medical questionnaire(s) for each disclosure and provide as much information as possible.

IMPORTANT: You do not need to tell us about any of the following minor conditions or treatments:

Acne	Haemorrhoids/piles	Routine wellman/woman check (normal results)
Appendicitis (operated and fully recovered)	Hay fever	Shingles
Athletes foot	HRT (no investigations involved)	Simple fracture of limbs (fully recovered)
Bunion	Indigestion/heartburn/IBS (no investigations required)	Sprains (fully recovered)
Cold Sore	Infertility treatment	Thrush
Colds/flu	Ingrowing toe nail	Tonsillitis
Common childhood diseases (fully recovered)	Miscarriage/termination	Uncomplicated pregnancy/ caesarean
Conjunctivitis	Muscle strain (fully recovered)	Vasectomy
Ear syringing	Routine cervical smear (normal result)	Verruca
Food poisoning (fully recovered)	Routine scan/blood test for pregnancy	Wisdom teeth removed

8. RECENT AND CURRENT HEALTH	**First (or only) life**	**Second life assured** (if applicable)
IMPORTANT: For the remaining questions please see the list of minor conditions and treatments that can be ignored above.		
8.1 In the last 6 months have you experienced any unintentional or unexplained weight loss?	Yes ☐ No ☐	Yes ☐ No ☐
8.2 Apart from anything you have already told us about in this form, within the last 2 years have you had any medical condition, illness or injury that you have received treatment for over a continuous period of 2 weeks or more?	Yes ☐ No ☐	Yes ☐ No ☐
8.3 Apart from anything you have already told us about in this form, within the last 2 years have you been advised to have or undergone any investigation such as blood tests, scans or biopsies? If so, for what condition (or suspected condition)?	Yes ☐ No ☐	Yes ☐ No ☐
8.4 Apart from anything you have already told us about in this form, do you have any impairment or medical complaints that you intend seeking medical advice for, or are you currently awaiting the results of any investigations? If **"Yes"** please provide as much information as possible.	Yes ☐ No ☐	Yes ☐ No ☐

8. RECENT AND CURRENT HEALTH	First (or only) life	Second life assured (if applicable)
i **IMPORTANT:** For the remaining questions please see the list of minor conditions and treatments that can be ignored above.		
8.5 Have you ever tested positive for COVID-19 (Coronavirus) ?	Yes ☐ No ☐	Yes ☐ No ☐
If **"Yes"**, please answer the questions below:		
Have you made a full recovery?	Yes ☐ No ☐	Yes ☐ No ☐
Did you require hospital admission to treat the virus?	Yes ☐ No ☐	Yes ☐ No ☐
Did you require admission to any of the following: Intensive Care Unit (ICU), Intensive Treatment Unit (ITU), High Dependency Unit (HDU) or Critical Care Unit (CCU)?	Yes ☐ No ☐	Yes ☐ No ☐
Did you require mechanical ventilation to help you breathe?	Yes ☐ No ☐	Yes ☐ No ☐
What date did you make a full recovery and return to your usual daily activities?		
8.6. In the last month have you been personally advised to self-isolate by a medical professional or the NHS 111 but have not been diagnosed with Coronavirus, had a new continuous cough and / or high temperature, or had direct contact with someone who's been confirmed or suspected to have Coronavirus? (Please answer No if the only contact is related to working as a medical professional or this relates to a Coronavirus infection already disclosed)	Yes ☐ No ☐	Yes ☐ No ☐

Medical Questionnaires

Medical questionnaire – FOR Diabetes ONLY

PLEASE COMPLETE THE FOLLOWING QUESTIONS

	First (or only) life	**Second life assured** (if applicable)
1. What type of diabetes do you have?		
2. When was your diabetes first diagnosed?		
3. Have you ever had a heart attack, angina, stroke, blood vessel disease, circulation problems in your legs or feet, or kidney problems? If **'Yes'** please provide as much information as possible.	Yes ☐ No ☐	Yes ☐ No ☐
4. Have you been admitted to hospital with hyperglycaemia, hypoglycaemia, diabetic coma or any other reason related to your diabetes? If **'Yes'** please provide as much information as possible, including date(s).	Yes ☐ No ☐	Yes ☐ No ☐
5. When was your last diabetic review, either with your GP or clinic/hospital?		
6. If known, what was the result of your last HbA1c?		
7. If known, what was the result of your last blood pressure reading?		
8. Are you on medication to either treat high blood pressure, or as a preventative measure to maintain your blood pressure at acceptable levels?		
9. If known, what was the result of your last cholesterol level?		
10. Are you on medication to either treat raised cholesterol, or as a preventative measure to maintain your cholesterol at acceptable levels?		
11. Have you ever had any ulcers, numbness, tingling or loss of sensation in your fingers, toes, feet or legs? If **'Yes'** please provide as much information as possible.	Yes ☐ No ☐	Yes ☐ No ☐
12. Have you ever had protein in your urine?		
13. Have you ever had any diabetic eye problems? If **'Yes'** please provide as much information as possible, including nature of any treatment received or planned.	Yes ☐ No ☐	Yes ☐ No ☐

If you need to advise us of any other disclosures please do so below.

MEDICAL QUESTIONNAIRE – FOR HIGH BLOOD PRESSURE AND RAISED CHOLESTEROL ONLY

PLEASE COMPLETE THE FOLLOWING QUESTIONS

	First (or only) life	**Second life assured** (if applicable)
1. Please confirm whether you have been diagnosed with high blood pressure, raised cholesterol or both.		
2. Apart from routine follow up appointments, are you awaiting medical tests or investigations, test results, referral to a specialist, clinic or hospital for high blood pressure and/or raised cholesterol? If **'Yes'** please provide details including when you were first diagnosed with your condition, any consultations or treatment you've had to date and when your next appointment or test results are due.	Yes ☐ No ☐	Yes ☐ No ☐
3. If you are taking medication, has this changed or increased to improve control of your condition within the last 6 months? If you are not on medication for either blood pressure or cholesterol, please select **No.**	Yes ☐ No ☐	Yes ☐ No ☐
4. For the following questions, please answer those which are relevant to your condition(s) as disclosed above:		
4.1 When did you last have your blood pressure checked by a medical professional?		

	First (or only) life	Second life assured (if applicable)
4.2 Do you know your most recent blood pressure reading?	Yes ☐ No ☐	Yes ☐ No ☐
If **'Yes'** please provide your most recent reading.		
If **'No'**, how was your latest blood pressure reading described by your doctor or nurse?		
- High or resistant to control	Yes ☐ No ☐	Yes ☐ No ☐
- Fluctuating / variable blood pressure	Yes ☐ No ☐	Yes ☐ No ☐
- Slightly higher than normal	Yes ☐ No ☐	Yes ☐ No ☐
- Normal	Yes ☐ No ☐	Yes ☐ No ☐
- None of the above	Yes ☐ No ☐	Yes ☐ No ☐
4.3 Have you had any complications of raised blood pressure, such as eye or kidney problems, or abnormal urine test results (e.g. protein or blood in the urine)?	Yes ☐ No ☐	Yes ☐ No ☐
4.4 When did you last have your cholesterol checked by a medical professional?		
4.5 Do you know your most recent cholesterol reading?	Yes ☐ No ☐	Yes ☐ No ☐
If **'Yes'** please provide your most recent reading.		
If **'No'**, how was your latest cholesterol reading described by your doctor or nurse?		
- Raised or resistant to control	Yes ☐ No ☐	Yes ☐ No ☐
- Fluctuating / variable cholesterol	Yes ☐ No ☐	Yes ☐ No ☐
- Slightly higher than normal	Yes ☐ No ☐	Yes ☐ No ☐
- Normal	Yes ☐ No ☐	Yes ☐ No ☐
- None of the above		

If you need to advise us of any other disclosures please do so below.

MEDICAL QUESTIONNAIRE – FOR MENTAL HEALTH ONLY

PLEASE COMPLETE THE FOLLOWING QUESTIONS

	First (or only) life	**Second life assured** (if applicable)
1. What symptoms did you experience and when did they start?		
2. Did your condition start in reaction to a major life event such as pregnancy, bereavement, unemployment or divorce?	Yes ☐ No ☐	Yes ☐ No ☐
3. Have you had more than one distinct episode of this condition (i.e. recurrent episodes)?	Yes ☐ No ☐	Yes ☐ No ☐
4. What diagnosis was given?		
5. Within the last 3 years, what is the longest duration that your daily activities been restricted due to this condition (e.g. causing time off work, confinement to the house, bed rest etc)? Please answer in total days.		
6. Please give details of medication and/or treatment taken past and present, including dates and dosage.		
7. Have you required any of the following to treat this condition: hospital admission, referral to a psychiatrist, Lithium medication or ECT (electroconvulsive therapy)?		
8. Have you ever attempted: suicide, overdose, self-harm or had suicidal thoughts? If **'Yes'** please provide number of occasions and when last did this occur?		

9. Do you have any current symptoms? If **'Yes'** please provide details? If **'No'** please advise when last did you experience symptoms?	Yes ☐ No ☐	Yes ☐ No ☐

If you need to advise us of any other disclosures please do so below.

MEDICAL QUESTIONNAIRE – FOR MOLES, LUMPS, CYSTS AND SKIN LESIONS ONLY

PLEASE COMPLETE THE FOLLOWING QUESTIONS

	First (or only) life	**Second life assured** (if applicable)
1. What type of lesion does this disclosure relate to (for example, mole, freckle, cyst, lump, lipoma, growth etc)?		
2. Does your disclosure relate to a single occurrence or multiple occurrences?		
3. Please describe the area(s) of the body this disclosure relates to.		
4. Have you consulted your doctor about this condition?	Yes ☐ No ☐	Yes ☐ No ☐
5. Are you awaiting any medical tests or investigations, test results, referral to hospital or surgery for this disclosure? If **'Yes'** please provide details including all investigations performed so far, dates, results and further appointments due	Yes ☐ No ☐	Yes ☐ No ☐

	First (or only) life	Second life assured (if applicable)
6. Have you ever been told any mole, growth, lump, cyst or other lesion was any of the following: cancerous, pre-cancerous, malignant, pre-malignant, BCC (Basal Cell Carcinoma) or SCC (Squamous Cell Carcinoma)? If **'Yes'** please provide details of the diagnosis including when and where this was given.	Yes ☐ No ☐	Yes ☐ No ☐
7. Have you had any treatment (surgery, radiotherapy, chemotherapy, hormone therapy or tablets (other than painkillers)) for this condition? If **'Yes'**please provide details, including type of treatment, whether any follow up checks were required (except to remove stitches or check wound healing following any surgery) and relevant dates.	Yes ☐ No ☐	Yes ☐ No ☐
8. Do you have any moles, cysts, lumps, growths or lesions still present?	Yes ☐ No ☐	Yes ☐ No ☐
9. Have you now been discharged from follow up, with no further consultations, investigations, treatment or monitoring due? If **'No'**please provide details of all planned tests, investigations or appointments, along with all relevant dates	Yes ☐ No ☐	Yes ☐ No ☐

If you need to advise us of any other disclosures please do so below.

MEDICAL QUESTIONNAIRE – ADDITIONAL DISCLOSURE 1

ONLY COMPLETE IF YOU HAVE ANSWERED 'YES' TO ANY PARTS OF QUESTIONS 6.1 TO 8.4 IN SECTION B

	First (or only) life	**Second life assured** (if applicable)
1. What is the medical condition?		
2. Has the diagnosis been confirmed?	Yes ☐ No ☐	Yes ☐ No ☐
3. Are you having any investigations into the cause of your symptoms? (i) When did symptoms of this condition first occur? (ii) When did you last have symptoms?	Yes ☐ No ☐	Yes ☐ No ☐
4. Do you have recurrent symptoms? (i) If **'Yes'**, please give details of how many episodes or attacks of symptoms you have had since onset of condition and describe the nature and severity of the symptoms	Yes ☐ No ☐	Yes ☐ No ☐
5. Do they restrict you in any way? (i) If **'Yes'**, please give details of the problems experienced	Yes ☐ No ☐	Yes ☐ No ☐
6. Have you seen a specialist for the condition? (i) If **'Yes'**, please give their name and address, the last date you attended and whether you are still attending them or not.	Yes ☐ No ☐	Yes ☐ No ☐
7. What medical investigations have been performed?		
8. What were the results (if known) and the dates they were done?		
9. Have all investigations now been completed?		
10. Are you waiting for any follow-ups or reviews? . (i) When did you last see your GP with this condition?	Yes ☐ No ☐	Yes ☐ No ☐
11. How many times have you been admitted to hospital for this condition and when was the last time?		

	First (or only) life	Second life assured (if applicable)
12. When was the last time you went to hospital as an outpatient for investigations or check-ups for this condition?		
13. What treatment has been prescribed? (This should include details of all oral steroid prescriptions, e.g. prednisolone.) Please continue on a separate sheet if necessary (i) Is the treatment continuing? (ii) If **'No'**, when did it stop?	Yes ☐ No ☐	Yes ☐ No ☐
14. Has any operation been performed or is any planned? (i) What type of operation? (ii) If **'Yes'**, when is it planned?	Yes ☐ No ☐	Yes ☐ No ☐
15. Have you required time off work? (i) If **'Yes'**, please give the date you were first absent from work. (ii) The date you returned to work.	Yes ☐ No ☐	Yes ☐ No ☐

If you need to advise us of any other disclosures please do so below.

MEDICAL QUESTIONNAIRE – ADDITIONAL DISCLOSURE 2

ONLY COMPLETE IF YOU HAVE ANSWERED 'YES' TO ANY PARTS OF QUESTIONS 6.1 TO 8.4 IN SECTION B

	First (or only) life	**Second life assured** (if applicable)
1. What is the medical condition?		
2. Has the diagnosis been confirmed?	Yes ☐ No ☐	Yes ☐ No ☐
3. Are you having any investigations into the cause of your symptoms? (i) When did symptoms of this condition first occur? (ii) When did you last have symptoms?	Yes ☐ No ☐	Yes ☐ No ☐
4. Do you have recurrent symptoms? (i) If **'Yes'**, please give details of how many episodes or attacks of symptoms you have had since onset of condition and describe the nature and severity of the symptoms	Yes ☐ No ☐	Yes ☐ No ☐
5. Do they restrict you in any way? (i) If **'Yes'**, please give details of the problems experienced	Yes ☐ No ☐	Yes ☐ No ☐
6. Have you seen a specialist for the condition? (i) If **'Yes'**, please give their name and address, the last date you attended and whether you are still attending them or not.	Yes ☐ No ☐	Yes ☐ No ☐
7. What medical investigations have been performed?		
8. What were the results (if known) and the dates they were done?		
9. Have all investigations now been completed?		
10. Are you waiting for any follow-ups or reviews? . (i) When did you last see your GP with this condition?	Yes ☐ No ☐	Yes ☐ No ☐
11. How many times have you been admitted to hospital for this condition and when was the last time?		

	First (or only) life	**Second life assured** (if applicable)
12. When was the last time you went to hospital as an outpatient for investigations or check-ups for this condition?		
13. What treatment has been prescribed? (This should include details of all oral steroid prescriptions, e.g. prednisolone.) Please continue on a separate sheet if necessary (i) Is the treatment continuing? (ii) If **'No'**, when did it stop?	Yes ☐ No ☐	Yes ☐ No ☐
14. Has any operation been performed or is any planned? (i) What type of operation? (ii) If **'Yes'**, when is it planned?	Yes ☐ No ☐	Yes ☐ No ☐
15. Have you required time off work? (i) If **'Yes'**, please give the date you were first absent from work. (ii) The date you returned to work.	Yes ☐ No ☐	Yes ☐ No ☐

If you need to advise us of any other disclosures please do so below.

MEDICAL QUESTIONNAIRE – ADDITIONAL DISCLOSURE 3

ONLY COMPLETE IF YOU HAVE ANSWERED 'YES' TO ANY PARTS OF QUESTIONS 6.1 TO 8.4 IN SECTION B

	First (or only) life	**Second life assured** (if applicable)
1. What is the medical condition?		
2. Has the diagnosis been confirmed?	Yes ☐ No ☐	Yes ☐ No ☐
3. Are you having any investigations into the cause of your symptoms? (i) When did symptoms of this condition first occur? (ii) When did you last have symptoms?	Yes ☐ No ☐	Yes ☐ No ☐
4. Do you have recurrent symptoms? (i) If **'Yes'**, please give details of how many episodes or attacks of symptoms you have had since onset of condition and describe the nature and severity of the symptoms	Yes ☐ No ☐	Yes ☐ No ☐
5. Do they restrict you in any way? (i) If **'Yes'**, please give details of the problems experienced	Yes ☐ No ☐	Yes ☐ No ☐
6. Have you seen a specialist for the condition? (i) If **'Yes'**, please give their name and address, the last date you attended and whether you are still attending them or not.	Yes ☐ No ☐	Yes ☐ No ☐
7. What medical investigations have been performed?		
8. What were the results (if known) and the dates they were done?		
9. Have all investigations now been completed?		
10. Are you waiting for any follow-ups or reviews? . (i) When did you last see your GP with this condition?	Yes ☐ No ☐	Yes ☐ No ☐
11. How many times have you been admitted to hospital for this condition and when was the last time?		

	First (or only) life	Second life assured (if applicable)
12. When was the last time you went to hospital as an outpatient for investigations or check-ups for this condition?		
13. What treatment has been prescribed? (This should include details of all oral steroid prescriptions, e.g. prednisolone.) Please continue on a separate sheet if necessary (i) Is the treatment continuing? (ii) If **'No'**, when did it stop?	Yes ☐ No ☐	Yes ☐ No ☐
14. Has any operation been performed or is any planned? (i) What type of operation? (ii) If **'Yes'**, when is it planned?	Yes ☐ No ☐	Yes ☐ No ☐
15. Have you required time off work? (i) If **'Yes'**, please give the date you were first absent from work. (ii) The date you returned to work.	Yes ☐ No ☐	Yes ☐ No ☐

If you need to advise us of any other disclosures please do so below.

Changing this data protection notice

This Data Protection Notice may change from time to time and you should review the contents regularly. We will notify you of any changes where we are required to do so by law.

IMPORTANT: Please complete this section with your client(s) if you are using this document as a full paper application form

C. Full paper application client declaration, authority and consent

Declaration

How we use your personal data

I/We the applicant(s) declare that, to the best of my/our knowledge and belief, the information on this form is true and complete and agree that the terms of this application and declaration and any statements made by the life or lives to be assured to VitalityLife's medical examiner together with VitalityLife's letter of acceptance will be deemed to form part of any resultant contracts.

I/We will inform you immediately of any changes that occur before the application is accepted. I/We understand that failure to do so may result in the contract being declared void, and that a claim for the proceeds may not be paid.

*I/We authorise my/our financial adviser to act on my/our behalf to amend the sum(s) to be assured or term of the assurance applied for to correspond with any alteration in detail of the mortgage from that set out in this application and to agree the commencement date of the plan with VitalityLife.

☐ *** Tick this box if you do NOT wish your Financial Adviser to act on your behalf to make changes or start the Plan**

I/We consent to VitalityLife seeking details of the mortgage from the lender.

I/We am/are aware that the income benefits I/we receive could affect the amount of any income support/income based Jobseekers Allowance, should I/We be eligible for state help.

General information

1. By returning this form to us you consent to our processing sensitive personal data about you where this is necessary.
2. Copies of the plan provisions, and the completed application form are available on request.
3. If anyone else fills in this Application on your behalf, He/She does so as your agent and not as an agent of VitalityLife. He/She does not have the authority to accept this Application on behalf of VitalityLife.
4. Completion of the direct debit instruction does NOT imply commencement of your plan assurance risk. VitalityLife's letter of acceptance will indicate when the plan will commence. In most instances your payments will be as originally quoted.

   Revised terms may be offered to you, for example if you have a birthday while your application is being processed but occasionally we may be unable to offer any terms.
5. The direct debit instruction attached is designed to enable you to pay premiums to VitalityLife with the minimum of inconvenience as and when they fall due. If the amount payable under your instruction is due to be altered, VitalityLife will advise you of details of the new amount shortly before your account is due for debiting.

   Direct debits under this Instruction will be originated only in respect of premiums payable in accordance with the terms of the plan for which it is drawn.
6. If the Applicant is not the life or lives to be assured, you must have sufficient insurable interest to be able to apply for the plan on this basis. If in doubt, please check with your financial adviser that sufficient insurable interest exists.

Data Protection Notice

Privacy Policy

For the purpose of the Data Protection Act 2018 (the *"Act"*), the data controller is Vitality Corporate Services Limited (trading as Vitality Health, Vitality Life, and Vitality Healthy Workplace) of 3 More London Riverside, London SE1 2AQ.

Vitality Health, Vitality Life, and Vitality Healthy Workplace (*"the Vitality Group", "we", "us" or "our")* are health and life insurers that offer their members a range of incentives and benefits for being healthy.
This privacy policy applies to our non-investment private medical insurance plans, life insurance and protection plans, our range of incentives and benefits, our website located at www.vitality.co.uk (*"our site"*) and our Vitality mobile applications for iPhone OS and Android OS (collectively referred to in this privacy policy as the *"Services"*).

Please read the following carefully to understand our views and practices regarding your personal data and how we will treat it. By using the Services you are accepting and consenting to the practices described in this privacy policy.

What type of data will be collected?

We may collect and process the following data about you:

(i) Information you give us

You may give us information about you when you use the Services, by filling in forms on our site or by corresponding with us by phone, e-mail, post or otherwise. This includes information you provide when you register to use the Vitality Member Zone, enter into a competition, promotion or survey and when you report a problem with our site. We may also need to collect sensitive personal data which could include details around your physical and mental health. You can choose whether to supply or withhold any sensitive personal data. However, withholding this information may restrict the Services we are able to offer you.

(ii) Information we receive from other sources

We may receive information about you from third parties who assist in the provision of the Services (including but not limited to, service providers and prospective new Vitality partners, sub-contractors in technical payment and delivery services, advertising networks, analytics providers, search information providers, and credit reference agencies). We will always ensure that any data we receive has been collected lawfully and fairly in accordance with your rights under the Act.

How we use personal data

We will only collect personal data which is necessary to provide you with the Services or an associated or required service. We may process your personal data and sensitive personal data for the following reasons:

- administration and management of our Services;
- as part of our business processes and relevant activities including auditing, business planning, accounting and transactions;
- compliance with legal and regulatory obligations;
- for research, statistical purposes or to improve our Services, including developing new wellness or reward partnerships;
- to generate and administer the weekly or monthly rewards earned as a result of you getting active in accordance with the Services;
- to award Vitality points;
- to notify you about changes to our Services;
- to improve our site to ensure content is presented in the most effective manner for your computer;
- as part of our efforts to keep our site safe and secure;
- to measure or understand the effectiveness of the advertising we serve to you and others, and to deliver relevant advertising to you; and
- to make suggestions and recommendations to you and other users of our site about goods or services that may interest you or them.

This is not an exhaustive list and is subject to change where business, legal or regulatory requirements may dictate. We may combine information received from other sources with information we collect about you for the purposes set out above.

Processing claims

In the event of a claim, we may have to give some information to those involved in your treatment or care and/or your representative (if you have chosen one). This will be done confidentially.

An insured dependant aged 16 or over has the right to confidentiality in relation to their claims and information. In order for them to exercise this right the insured dependant should contact customer services.

If you have another insurance plan that covers the same costs that you are claiming from us, then we may also disclose your relevant personal information to that other insurer so that we can ensure we only pay our proportion of the claim.

How we may keep, store and dispose of data

We hold data in various forms including electronic databases, computerised files and paper files. Data will be held for a reasonable period of time, which may include a period of time after a plan ends. Data will be disposed of in line with approved company processes to ensure all reasonable efforts and precautions are taken to protect the confidentiality of the data. We may continue to keep non-personally identifiable data for the research and statistical purposes to improve our Services.

Who we may share data with

We may disclose data to selected third parties for the purpose of administering the services, including the following:

- service providers;
- sub-contractors in technical payment and delivery services;
- analytics providers and search information providers;
- credit reference agencies for the purposes of assessing your credit score where this is a condition of us entering into a contract with you; and
- any legal or regulatory organisation provided that we are under a duty to disclose or share your personal data in order to comply with any legal obligation. This includes exchanging information with other companies and organisations for the purposes of fraud protection and credit risk reduction.

If you have appointed an insurance adviser we will send them copies of correspondence relating to the plan and any renewal documentation. We may disclose information about a claim to them, although no medical information will be provided without your consent. Your information, and that of others also covered by the plan, may be disclosed to other parties (for example other insurance companies) with a view to preventing fraudulent or improper claims.

In order to help you maximize the benefits of Vitality, we will disclose limited data to:

- brokers regarding your engagement with the Services, as they are well-placed to promote the benefits of the Services and ensure you receive the most from your plan;
- prospective new Vitality partners in order for us to develop and improve the Services; and
- where your insurance is paid for by an employer, we may provide non-personally identifiable data to the employer to allow them to assess the impact of Vitality on their workforce.

In all cases we adopt privacy enhancing technologies as promoted by the ICO and in accordance with EU guidance.

Where we store your personal data

The data that we collect from you may be transferred to, and stored at, a destination outside the European Economic Area (*"EEA"*). It may also be processed by staff operating outside the EEA who work for us or for one of our suppliers. Such staff maybe engaged in, among other things, the fulfilment of the Services, the processing of your payment details and the provision of support services. By submitting your personal data, you agree to this transfer, storing or processing. We will take all steps reasonably necessary to ensure that your data is treated securely and in accordance with this privacy policy.

C. Full paper application client declaration, authority and consent - continued

Marketing

You have the right to ask us not to process your personal data for marketing purposes. We will usually inform you (before collecting your data) if we intend to use your data for such purposes. You can exercise your right to prevent such processing by checking certain boxes on the forms we use to collect your data. You can also exercise the right at any time by logging into the Member Zone and sending us a secure message, by contacting our customer services department or by sending us an email at **marketingchoices@vitality.co.uk**.

Your rights to request, review and amend personal data

You have the right to request a copy of the data we hold about you and to have any inaccurate data corrected. Your right of access can be exercised in accordance with the Act. If you wish to request this data, please contact the Subject Access Request team:

Email: **dsar@vitality.co.uk**

Post: DSAR Team, St Christopher House, 217 Wellington Road South, Stockport SK2 6NG

IMPORTANT: Please complete this section with your client(s) if you are using this document as a full paper application form

Declaration

I/We have read the information relating to My/Our rights under the Data Protection Act, the declaration, important notes and general information.

Signature of Life Assured	
Signature	Date ☐☐☐☐☐☐☐☐

Signature of applicant if different	
Signature	Date ☐☐☐☐☐☐☐☐

FOR INTERNAL USE ONLY: If this form is completed as a tele-interview the Vitality Nurse should confirm the following declaration on behalf of the Life Assured on the recorded call.

☐ **The Life assured declares that the information supplied on this call is true and correct.**

D. Access to Medical Reports

Please tick if Life 1 and Life 2 have the same doctor.	**First (or only) life assured**	**Second life assured** (if applicable)
Name of doctor		
Clinic/surgery address		
	Postcode	Postcode
Telephone number		

IMPORTANT: Please read and sign this declaration relating to your medical records.

D. Access to Medical Reports Act 1988

We may need to get medical reports to support your application. Before we can ask any doctor that you have consulted to fill in a report,we need your permission under the Access to Medical Reports Act 1988. Your rights under the act are as follows.

You do not need to give your permission, but if you do not, we may not be able to go ahead with your application. This does not prevent you from applying to other companies for insurance.

You can ask to see the report before the doctor returns it to us. If this is the case, we will tell the doctor to keep the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.

If you choose not to see the report at this stage, you may ask the 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.

If you think that any part of the report is not correct or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him or her to attach a statement outlining your views, which will then accompany the report.

Your doctor can withhold access to the report if he or she feels that it would cause physical or mental harm to you or others.

Please note that VitalityLife may use a third party agency to obtain your medical report.

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

- Your current health
- Any care, medication or treatment you are currently receiving
- The results of referrals or tests you are waiting for
- Any time off work in the last three years
- Your past health
- Details of any relevant illness, trauma or referrals for specialist advice or treatment, hospital admissions, 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;
  - musculo-skeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles;
  - anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue;
  - suicidal thoughts or attempts at suicide; or
  - conditions related to drug or alcohol misuse or smoking or chewing tobacco
- Details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations
- Any blood pressure readings in the last three years
- Any history of disease among your parents or brothers or sisters that you have told your doctor about

We have asked your doctor not to reveal information about:

- Negative tests for HIV, hepatitis B or C;
- Any sexually-transmitted diseases unless there could be
  long-term effects on your health; or
- Predictive genetic test results unless there is a favourable
  test result which shows that you have not inherited a condition your family suffers from

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

- Refusing to provide insurance;
- Increasing premiums above standard rates; or
- Setting premiums at standard rates

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

Chief Medical Officer, VitalityLife, Sheffield, S95 1BW.

Important notes

The plan will not start until we have assessed and accepted your application, and we have been advised of the start date. If you have a birthday while your application is being processed, the terms may differ from those originally quoted.

In most instances your payments will be as originally quoted. We may offer you revised terms, but occasionally we may not be able to offer any terms.

We may ask you to contact your doctor if we are waiting for reports which we have asked for.

If we ask you to come for a medical examination, we will need to share the application information with another company we have authorised. They will make the arrangements for the examination to take place.

We may need to send your application and relevant medical reports to our reassurers for their opinion or agreement

of the terms offered. Or, we may need to send them at a later stage for purposes relating to managing the policy.

You can get details of general reassurance principles and details of any company we use to assess your application, from our head office.

We have a confidentiality policy in place which means we hold your medical information securely and access is limited to authorised individuals who need to see it.

IMPORTANT: Please read and sign this declaration relating to your medical records.

D. Access to Medical Reports Act 1988 - continued

Declaration

How we use your personal data

You are entitled to ask for a copy of our standard terms and conditions and a copy of your application form at any time.

It is our policy to obtain a random sample of medical reports shortly after acceptance of insurance contracts to monitor the accuracy and completeness of the information given. By signing this declaration you will be giving us the right to request a medical report. We will write to tell you if we require such a report. Your rights under the Access to Medical Reports Act remain the same. In the event that the medical report highlights a material fact that you have knowingly failed to disclose, we reserve the right to reconsider the terms offered to you or cancel the policy. For a copy of your Data Protection Notice please refer to your original application form. If you have any questions about this please write to:

The Data Protection Officer, VitalityLife, 4th Floor, 70 Gracechurch Street, London, EC3V 0XL.

For certain products we will need to process sensitive personal information such as health information. By signing and returning this form, you consent to us processing your sensitive data.

- I/ We agree to you asking any doctor I /we have consulted about my/our physical or mental health to provide medical information so you may assess my/our proposal. You may gather relevant information from other insurers about any other applications for life, critical illness, sickness, disability, accident or private medical insurance that I/we have applied for. I/We authorise those asked to provide medical information when they see a copy of this consent form. This form allows you to gather medical reports within six months of the start of the plan, or after my/our death, to support any claim made on the plan proceeds.
- This information can also be used to maintain management information for business analysis.

I/We have read the declaration, important notes and information relating to my rights under the Access to Medical Reports Act.

Signature of first (or only) life assured

Full name

Date of birth D D M M Y Y Y Y

I **do not** want to see the report before it is sent to the company. ☐

I **do** want to see the report before it is sent to the company. ☐

Signature

Date D D M M Y Y Y Y

Signature of second life assured (if applicable)

Full name

Date of birth D D M M Y Y Y Y

I **do not** want to see the report before it is sent to the company. ☐

I **do** want to see the report before it is sent to the company. ☐

Signature

Date D D M M Y Y Y Y

To be completed by the Financial Adviser

If you are applying online, please record the application reference number in the box below, as shown on the Intermediary Zone **vitalitylife.co.uk**

Application reference number:

Please fax this completed form to VitalityLife at **0870 240 0937** or post to **VitalityLife, Sheffield, S95 1BW.**

FOR INTERNAL USE ONLY: If this form is completed as a tele-interview the Vitality Nurse should confirm the following declaration on behalf of the Life Assured on the recorded call.

☐ **The Life assured declares that the information supplied on this call is true and correct.**

E. Payment details

1. How does your client wish to pay their premiums?	Monthly ☐ Annually ☐

IMPORTANT: If your client has selected monthly, premiums must be paid by direct debit. If your client has selected annual, the plan premium can be paid for by either direct debit, Electronic Fund Transfer (EFT). Electronic Fund Transfers (EFT) must be made into the following account. Please ensure you include the policy number as the reference to avoid delays in allocating the payment to the policy.

Bank account name:	VitalityLife
Bank:	HSBC
Sort Code:	400250
Bank account number:	81359118
Reference number:	Your policy number followed by AB

2. Complete for clients paying by direct debit.	
2.1 How does your client wish to complete their direct debit instruction?	Paperless ☐ Paper with client signature ☐
2.2 I have chosen to obtain client signatures on direct debit:	Yes ☐ No ☐
2.3 First (or only) life assured name, or payer name (To be completed by the financial adviser.)	
2.4 Date of birth (To be completed by the financial adviser.)	D D M M Y Y Y Y
2.5 On what date of the month do you want us to collect your premiums? (This must be between the 1st and 28th of the month.)	☐ of the month

IMPORTANT: If your client has elected to pay via Direct Debit please complete the Direct Debit form on page 37

FOR REINSTATEMENT POLICIES ONLY

Payment arrangement options (please tick the applicable one):

Collect the outstanding premium/s via Direct Debit in 7 working days	☐
Collect the outstanding premium/s via Direct Debit on the next preferred payment date	☐
Collect two premiums via Direct Debit on your preferred payment date until arrears are cleared	☐
Make a once off deposit into our bank account (see above for bank details)	☐

Alternatively, contact our Retentions department to discuss other acceptable payment options on **0800 030 4903**.

INSTRUCTION TO YOUR BANK OR BUILDING SOCIETY TO PAY BY DIRECT DEBIT

i NOTE: Please fill in the form and send to: **FREEPOST VitalityLife, Sheffield, S95 1BW.**

Name(s) of account holder(s)

Reference number (please complete)

Bank/Building Society account number

Service user number

2	9	8	4	9	7

Branch Sort Code

Instruction to your Bank or Building Society

Please pay VitalityLife 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 VitalityLife and, if so, details will be passed electronically to my Bank/Building Society.

Name and full postal address of your Bank or Building Society

To: The manager

Bank/Building Society

Bank or Building Society address

Postcode

Signature(s)

Date D D M M Y Y Y Y

Banks and Building Societies may not accept Direct Debit Instructions from 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 VitalityLife will notify you at least 5 working days in advance of your account being debited or as otherwise agreed. If you request VitalityLife 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 VitalityLife 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 VitalityLife 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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