

Application Number

Available once the application is entered on Adviser Hub. Please complete these for your records.

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VitalityLife application Personal Protection Plan application form with Standard Underwriting

This form is designed for Personal Protection Plan applications with Standard Underwriting.

VitalityLife offer two forms of underwriting for Personal Protection:

- 1) Standard Underwriting - **INCLUDED** in this form
- 2) Optimiser Underwriting - **NOT** included in this form.

Optimiser Underwriting is speedy and smooth, designed for certain applications that include Optimiser. It is NOT designed for applications including Income Protection Cover and eligibility is dependent on product selection and answers to a few upfront questions. If you would like to complete the Personal Protection Plan application form with Optimiser Underwriting adviser.vitality.co.uk/life/

Important information

This application form should be used with a financial adviser.

This form can be used for new applications for VitalityLife's personal protection products. It can also be used for data capture.

To enable us to quote, underwrite and administer your plan, we will collect, process, share and retain your personal, health and medical information, and that of any other members covered in your plan, as described in our Privacy Notice.

We will request a new application for any plans that are not in force within 6 months of submitting this application.

If you are reinstating an existing plan, please complete a Supplementary Health Questionnaire, available on adviser.vitality.co.uk/life/.

Contents

A - Your Details	3	H - Plan Owner Details	18
B - Your Core Cover	5	I - Plan Information	21
C - Your Additional Options and Benefits	8	J - Payment Details	23
D - Vitality Programme Option	9	K - Access to Medical Reports Act 1988	27
E - Existing Cover	10	L - Full Paper Application Client Declaration, Authority and Consent	29
F - Lifestyle and Health Details - Standard Underwriting	10	Medical Disclosure Questionnaires	33
G - Your Doctor's Details	17		

How to submit this application

a) Submit online in Adviser Hub to receive an immediate underwriting decision

- Complete all information up to the end of section H, along with payment details on page 23
- Submit the application online in Adviser Hub at adviser.vitality.co.uk/life/
- Receive an immediate underwriting decision or details of further information we require
- Your client(s) must sign the Access to Medical Reports Act 1988 Declaration on page 26. Please detach this declaration only and post it to FREEPOST VitalityLife, PO Box 619, Darlington, DL1 9FH.

b) Tele-underwriting submission

- Complete all information up to the end of section E, along with payment details on page 23
- Your client(s) must sign the Access to Medical Reports Act 1988 Declaration on page 26.
- Post this application form to FREEPOST VitalityLife, PO Box 619, Darlington, DL1 9FH.

c) Paper submission

- Complete all information, including payment details on page 23 and the client declaration, authority and consent starting on page 28
- Your client(s) must sign the Access to Medical Reports Act 1988 Declaration on page 26
- Post the paper application to FREEPOST VitalityLife, PO Box 619, Darlington, DL1 9FH.

Important information for the applicant(s)

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

Please take care to answer the questions on this form honestly and fully. If you miss any information out, or give us misleading information, this may mean that a future claim will not be paid. If you are applying for Income Protection Cover, giving us misleading information might mean the amount of the benefit will be reduced or not paid. In addition, this could also delay the processing of your application. Please enclose all relevant information as we may not contact your GP to obtain a GP report.

If someone else fills this form in for you, such as your financial adviser, 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 you prefer, you may complete the medical questions in private and return the Lifestyle and Health details in section G direct to our Chief Medical Officer. Please indicate on this form if you have done so.

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

- Your personal health
- Your family history
- Your occupation
- Your earnings
- Your participation in any hazardous leisure activities
- Your travel or residence
- Your lifestyle (such as smoking and alcohol consumption)

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, alongside any other insurance plans you have is over a total sum of £500,000 for Life Cover, you need to notify us if you have had a positive predictive genetic test for Huntington's disease.

If you have had any negative predictive genetic tests that you would like us to take into consideration, please include a copy of the results.

A. Your Details

IMPORTANT: If this is a joint application, Life 1 must be the person who has selected the highest level of Life Cover. If no Life Cover is selected, Life 1 must be the person who has selected the highest level of Serious Illness Cover or Income Protection. If Mortgage Serious Illness Cover is selected, the life assured must also have Life Cover.

Personal information	Life 1	Life 2 (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 <i>NB. We reserve the right to request additional information and documentation to verify this.</i>	Yes No
Have you been registered with a UK General Practitioner for the last 2 years or more? Only required if you're applying for Income Protection Cover.	Yes No <i>NB. VitalityLife does not offer Income Protection Cover for clients that have not been with a UK GP for at least 2 years.</i>	Yes No
IMPORTANT: If you select 'No', you'll need to establish eligibility for your plan by discussing your residency status with our Financial Crime team. Please read the Eligibility Guidelines on adviser.vitality.co.uk/life/ for contact details		
Title	Mr Mrs Miss Ms Other	Mr Mrs Miss Ms Other
First name(s)		
Surname		
Date of birth	<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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Medically Recognised Gender	Male Female	Male Female
Identified Gender	Male Female Non-binary	Male Female Non-binary
Please confirm your smoker status Includes cigarettes, cigars, pipe, loose tobacco, herbal cigarettes, any nicotine replacement therapy and electronic cigarettes.	Occasional smoker Regular smoker Ex-smoker (stopped more than 12 months ago) Never smoked <i>We will carry out random tests to confirm non-smoker status.</i>	Occasional smoker Regular smoker Ex-smoker (stopped more than 12 months ago) Never smoked
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 include a pint of beer/ cider, an average sized glass of wine or a single measure of spirits.		
Occupation		

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

More information if applicable		
Employment status	Employed Self-employed Unemployed Houseperson	Employed Self-employed Unemployed Houseperson
Do you work on a zero hour contract basis? Unfortunately VitalityLife does not offer Income Protection Cover for zero contract hours applications.	Yes No	Yes No
Annual Personal Pre-Tax Income	£	£

IMPORTANT: This is pre-tax income for the last 12 months. If you are employed this can be found on your P60 or pay slips. If you are self employed this is your share of the net profits (gross profit less expenses). If you are a director of your limited company this is the total of pre-tax income found on your P60 or payslips and your dividends taken from the company. If you are applying for Income Protection Cover please check the Plan Provisions for how we look at your earnings.

Contact information	Life 1	Life 2 (if applicable)
If our tele-underwriters and/or Vitality Nurses need to contact you, please choose your preferred contact time.	No Preference Mon - Fri 9am - 12pm Mon - Fri 12pm - 4pm Mon - Fri 4pm - 8pm	No Preference Mon - Fri 9am - 12pm Mon - Fri 12pm - 4pm Mon - Fri 4pm - 8pm
Contact telephone number(s)		
Email address		
Current address		

Client consent	Life 1	Life 2 (if applicable)
My client gives consent for their personal and medical information to be shared with the other life assured on the plan. Only applicable to a joint life plan.	Yes No	Yes No

IMPORTANT: If this is a joint life application and medical consent has not been provided to share medical and health information with both lives, please complete this application form for each Life Assured.

Marketing preferences

Keeping you up to date with our latest product offers

Be the first to hear about our new Vitality products and offers. You can opt-out at any time, and we'll never share your personal data with any other companies for marketing purposes.

Please tick below if you don't want to hear from us.

Life 1

No thanks, I don't want you to email me

No thanks, I don't want you to send text messages to me

Life 2

No thanks, I don't want you to email me

No thanks, I don't want you to send text messages to me

You can change your preferences at any time, and we'll never share your personal data with other companies for marketing purposes.

You'll still receive emails from us about your plan. That includes anniversary notifications, changes to any rewards or partners and plan updates.

We're committed to protecting your personal information. For details about how we manage your personal data, read our full Privacy Notice at vitality.co.uk/privacy.

More information	Life 1	Life 2 (if applicable)
Is this plan to be used in connection to a mortgage?	Yes No	Yes No
Is this plan to be used for Business Protection?	Yes No	Yes No
Height	Feet / inches Centimeters	Feet / inches Centimeters
Weight If you are currently pregnant, please tell us your pre-pregnancy weight.	Stone/pounds Kilograms	Stone/pounds Kilograms

B. Your Core Cover

Life Cover - section B1	
Would you like Life Cover?	Life 1 Life 2 Life 1 and 2 None, go to section B2
Cover amount	£
Cover term When selecting 'Fixed Term', please choose the term.	Whole of life years fixed term expiry age for Life 1 expiry age for Life 2
IMPORTANT: If Serious Illness Cover or Life with Serious Illness Cover is selected, the premium basis for Life Cover will have to be the same as these covers.	

Premium basis	Guaranteed Reviewable
IMPORTANT: If you choose the account basis to be indexed, the amount of cover will increase by Retail Prices Index (PRI) each year. Premiums will increase each year in line with RPI plus 1.5% to 3.5% up to the anniversary before your client's 80th birthday and RPI plus 5% after that. If this is a joint life plan, this will be based on the younger of the two lives covered.	
Cover basis	Indexed Level Decreasing (only available with Fixed Term)
If 'Decreasing', how would you like your cover to decrease? You can choose between 5-15% per year.	5% OR %
Payment options Only applicable for joint life Whole of Life cover chosen for both lives.	As a result of the first death As a result of the second death

Serious Illness Cover - section B2

IMPORTANT: If you have selected Life with Serious Illness Cover, then you cannot apply for Serious Illness Cover too.

Would you like Serious Illness Cover?	Yes No, go to section B3
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IMPORTANT: If Life Cover is selected, the amount of Serious Illness Cover cannot be higher than the amount of Life Cover.

Cover amount	£
Type of cover	Serious Illness Cover 1X Serious Illness Cover 2X Serious Illness Cover 3X

IMPORTANT: If Life Cover is selected, the premium basis for Serious Illness Cover must be the same as that for Life Cover.

Premium basis	Guaranteed Reviewable
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If you choose the account basis to be indexed, the amount of cover will increase by Retail Prices Index (PRI) each year. Premiums will increase each year in line with RPI plus 1.5% to 3.5% up to the anniversary before your client's 80th birthday and RPI plus 5% after that. If this is a joint life plan, this will be based on the younger of the two lives covered. If Life Cover is selected, the cover basis for Serious Illness Cover must be the same as that for Life Cover.

Cover basis	Indexed Level Decreasing
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IMPORTANT: If Life Cover is selected, the term for Serious Illness Cover must be the same as that for Life Cover.

Cover term	years
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Life with Serious Illness Cover - section B3

IMPORTANT: If you have selected Serious Illness Cover, then you cannot apply for Life with Serious Illness Cover too.

Would you like Serious Illness Cover?	Yes No, go to section B3
Cover amount	£
Type of cover	Serious Illness Cover 1X Serious Illness Cover 2X Serious Illness Cover 3X
Premium basis	Guaranteed Reviewable
<p>If you choose the account basis to be indexed, the amount of cover will increase by Retail Prices Index (PRI) each year. Premiums will increase each year in line with RPI plus 1.5% to 3.5% up to the anniversary before your client's 80th birthday and RPI plus 5% after that. If this is a joint life plan, this will be based on the younger of the two lives covered. If Life Cover is selected, the cover basis for Serious Illness Cover must be the same as that for Life Cover.</p>	
Cover basis	Indexed Level Decreasing
Cover term	years

Income Protection - section B3

	Life 1	Life 2 (if applicable)
Would you like Income Protection?	Yes No, go to section D.	Yes No, go to section C.
<p>IMPORTANT: The maximum amount of the benefit is the monthly equivalent of 60% of the first £60,000 per annum of your earnings and 50% of earnings in excess of £60,000 per annum. This is subject to an overall maximum benefit of £16,666.67 per month. If you have been self-employed for less than one year, your maximum benefit may be restricted.</p>		
Full term	1 year payment period 2 year payment period 5 year payment period Full term	1 year payment period 2 year payment period 5 year payment period Full term
Do you wish to split your cover over two deferred periods?	Yes No	Yes No
<p>What initial deferred period would you like?</p> <p>If you work as a teacher in the public sector, within the NHS, UK local councils or have a similar sick pay structure and would like the public sector deferred period, please select a 12 month deferred period.</p>	7 days (only for self-employed) 1 month 2 months 3 months 6 months 12 months 24 months 60 months	7 days (only for self-employed) 1 month 2 months 3 months 6 months 12 months 24 months 60 months

What amount of monthly benefit would you like after the initial deferred period?	£	£
What additional deferred period would you like? Please choose one option only.	7 days (only for self-employed) 1 month 2 months 3 months 6 months 12 months 24 months 60 months	7 days (only for self-employed) 1 month 2 months 3 months 6 months 12 months 24 months 60 months
What additional amount of monthly benefit would you like after the additional deferred period?	£	£
Cover term	years or expiry age	years or expiry age
Would you like your monthly benefit amount(s) selected above to increase in line with RPI (during a claim and when not claiming)?	Yes No	Yes No
Premium basis	Guaranteed	Reviewable
<p>IMPORTANT: If you receive any continuing income at the time of claim this may affect how much we will pay. Continuing income includes payments from another insurance policy for illness or incapacity. Please see the Plan Provisions for full details.</p>		

C. Your Additional Options and Benefits

Premium Step - section C1		
IMPORTANT: Available with Whole of Life Cover with Guaranteed premium benefits.		
Would you like to add Premium Step?	Yes	No
IMPORTANT: Premium Step will give you an upfront premium discount, compared to standard Whole of Life products. With Premium Step, your premium will increase at a fixed 2.5% annually.		
LifestyleCare Cover - section C2		
IMPORTANT: Available on Whole of Life Cover single life plans. Unavailable on Serious Illness Cover, Life with Serious Illness Cover and Income Protection.		
Would you like to include LifestyleCare Cover?	Yes	No, please go to section C3.
Cover amount This cannot exceed £250,000 and 100% of the Whole of Life Cover amount.	£	
Would you like LifestyleCare Cover Protector?	Level 1	Level 1 & 2 No

Child Serious Illness Cover - section C3

IMPORTANT: Available on all of our core covers.

Would you like to add Child Serious Illness Cover?

Yes No, please go to section C4

Cover amount (across all children)
This cannot exceed the greater of your Life Cover, Serious Illness Cover or Life with Serious Illness Cover amounts.

£

IMPORTANT: Child Serious Illness Cover will apply to all children. If the adult(s) assured do not have Serious Illness Cover, or if the adult(s) assured has Serious Illness Cover 1X, then cover for all children will be Child Serious Illness Cover 1x. If adult(s) assured has Serious Illness Cover 2X, then cover for all children will be Child Serious Illness Cover 2x. If adult(s) assured has Serious Illness Cover 3X, then cover for all children will be Child Serious Illness Cover 3x.

All current and future children are covered through Child Serious Illness Cover. If you want access to Vitality benefits, please provide details of your children.

If you would like to add details for more than four children, please continue on a separate sheet.

Child	First name(s)	Surname	Gender	Date of Birth
1			<input type="checkbox"/> M <input type="checkbox"/> F	<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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2			<input type="checkbox"/> M <input type="checkbox"/> F	<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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3			<input type="checkbox"/> M <input type="checkbox"/> F	<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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4			<input type="checkbox"/> M <input type="checkbox"/> F	<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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Waiver of Premium options - section C4

Life 1

Life 2 (if applicable)

IMPORTANT: In the event of a claim, the benefits we pay under any of the Waiver of Premium options will cover all premiums for Life 1 and Life 2 (if applicable).

Would you like Waiver of Premium on Incapacity?

Yes No

Yes No

What deferred period would you like for Waiver of Premium for Incapacity?
Choose one option only.

7 days
(only for self-employed)
1 month
2 months
3 months
6 months
12 months

7 days
(only for self-employed)
1 month
2 months
3 months
6 months
12 months

D. Vitality Programme Option

Optimiser - section D1

Life 1

Would you like to add Optimiser?

Yes No

E. Existing Cover

Existing cover	Life 1	Life 2 (if applicable)
Do you already have any Life Cover, Critical Illness / Serious Illness or Income Protection Cover with VitalityLife (formerly known as PruProtect)?	Yes No Plan number	Yes No Plan number
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 the cover and reason declined.	Yes No	Yes No
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 to apply for in the next 6 months)	Yes No	Yes No

F. Lifestyle and Health Details - Standard Underwriting

Occupation - section F1	Life 1	Life 2 (if applicable)
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
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: <ul style="list-style-type: none"> • 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

<p>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.</p> <p>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, Zimbabwe and Europe (excluding Cyprus).</p> <p>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</p> <p>When will your posting start and how long do you expect it to last?</p> <p>What regions within this country or countries will you be posted to during your tour?</p>	<p>Yes No</p>	<p>Yes No</p>
<p>IMPORTANT: You do not need to complete the following two questions if you work purely as a civilian attached to the Armed Forces.</p>		
<p>Do you work in any branch of the Special Forces (e.g. SAS, SBS, SFSG, SRR) or in the Army Rangers (Ranger Regiment)?</p>	<p>Yes No</p>	<p>Yes No</p>
<p>Do your normal duties involve bomb disposal, mine clearance, diving, flying in helicopters (as aircrew) or fast jets? If 'Yes', please give a description of your duties.</p>	<p>Yes No</p>	<p>Yes No</p>
<p>IMPORTANT: If you have or you are applying for Life Cover only, please go to section F2 - Travel and Residency</p>		
<p>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.</p>	<p>Yes No</p>	<p>Yes No</p>
<p>Apart from commuting between your home and fixed place of work, does your job involve driving more than 25,000 miles per year? Only required if you're applying for Income Protection Cover.</p>	<p>Yes No</p>	<p>Yes No</p>
<p>Have you been self-employed for 2 years or more? Complete only if self-employed is selected. Only required if you're applying for Income Protection Cover.</p>	<p>Yes No</p>	<p>Yes No</p>

Travel and residency - section F2	Life 1	Life 2 (if applicable)
<p>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 and Singapore), Ukraine, Russia or New Guinea?</p> <p>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).</p>	<p>Yes No</p>	<p>Yes No</p>
<p>In the last 3 years have you spent more than 3 consecutive months in Africa, Thailand or the Caribbean (includes Antigua, Bahamas, Barbados, Bermuda, Cuba, Dominican Republic, Grenada, Haiti, Jamaica, Trinidad and Tobago)?</p> <p>If 'Yes', please provide details of country(s), duration of stay, whether a UK citizen or have right to permanently stay in UK</p>	<p>Yes No</p>	<p>Yes No</p>
Hazardous pursuits/hobbies - section F3	Life 1	Life 2 (if applicable)
<p>Do you take part in or intend to take up any hazardous activities?</p> <p>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.</p> <p>If 'Yes' please complete the following questionnaire:</p> <ul style="list-style-type: none"> 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? 	<p>Yes No</p> <p>Yes No</p> <p>height depth</p>	<p>Yes No</p> <p>Yes No</p> <p>height depth</p>

Lifestyle - section F4	Life 1		Life 2 (if applicable)	
<p>6. Alcohol and Drugs</p> <p>Have any of the following ever applied to you in relation to your alcohol consumption?</p> <p>I have been advised to reduce my alcohol intake because I was drinking too heavily</p>	Yes	No	Yes	No
<p>I have attended or been advised to attend a hospital or a medical facility due to an injury, illness or incapacity whilst under the influence of alcohol</p>	Yes	No	Yes	No
<p>I have used or been referred to a specialist support service or counsellor e.g. Alcoholics Anonymous or Community Alcohol Team</p>	Yes	No	Yes	No
<p>I have been advised to have or have had a scan, biopsy, blood test or other investigations to check my liver is functioning correctly</p>	Yes	No	Yes	No
<p>If you have answered "Yes" to any of the above, please provide full details</p>				
<p>In the last 10 years have any of the following applied to you in relation to drug use</p> <p>I have used recreational drugs (Examples of recreational drugs - cannabis, amphetamines, cocaine, ecstasy, hallucinogens, opiates (such as heroin, methadone or buprenorphine), solvents or anabolic steroids)</p>	Yes	No	Yes	No
<p>I have attended or been advised to attend a hospital or a medical facility due to an injury, illness or incapacity whilst under the influence of drugs</p>	Yes	No	Yes	No
<p>I have used or been referred to a specialist support service or counsellor in relation to my drug intake e.g. Narcotics Anonymous or Community Drugs Team</p>	Yes	No	Yes	No
<p>I have misused, over used or been addicted to any medication (whether prescribed by a doctor or not)</p>	Yes	No	Yes	No
<p>If you have answered "Yes" to any of the above, please provide full details</p>				
<p>In the last 5 years, have any of the following applied to you?</p> <p>I have received a penalty due to drink driving (a penalty can be a fine, a driving ban or imprisonment)</p>	Yes	No	Yes	No
<p>I have received a penalty due to drug driving (a penalty can be a fine, a driving ban or imprisonment)</p>	Yes	No	Yes	No

If you have answered "Yes" to any of the above, please provide full details		
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IMPORTANT: This information may be sent in confidence to our Chief Medical Officer

Family medical history - section F5	Life 1	Life 2 (if applicable)
<p>Before the age of 60, have any members of your immediate family (natural parents, brothers or sisters) had any of the following medical conditions:</p> <p>Breast, Ovarian, Prostate, Colon or Bowel Cancer, Heart Attack, Angina, Stroke, Cardiomyopathy, Diabetes, Multiple Sclerosis, Muscular Dystrophy, Parkinson's, Dementia / Alzheimer's Disease, Huntington's, Motor Neurone Disease or Polycystic Kidney Disease?</p> <p>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.</p>	<p>Yes No</p>	<p>Yes No</p>
<p>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')</p> <p>If "Yes" please provide details of the condition, age of the relative(s) at the time they were diagnosed, relationship to the relative(s) and details of any screenings including dates and results.</p>	<p>Yes No</p>	<p>Yes No</p>

Your health - section F6	Life 1	Life 2 (if applicable)
<p>Have you ever had or do you currently have any of the following: If 'Yes', please complete the relevant Medical Disclosure questionnaire with full details on page 32.</p>		
Cancer, leukaemia, Hodgkin's disease, lymphoma, brain or spinal tumour?	<p>Yes No</p>	<p>Yes No</p>
Heart disease or disorder, including heart attack, angina, cardiomyopathy, heart murmur, heart surgery or procedure, palpitations, irregular heart beat or chest pain?	<p>Yes No</p>	<p>Yes No</p>
Stroke, transient ischaemic attack (TIA), brain haemorrhage or permanent brain injury through an accident?	<p>Yes No</p>	<p>Yes No</p>
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?	<p>Yes No</p>	<p>Yes No</p>

Mental health problem where hospital treatment or a referral to a psychiatrist or hospital clinic has been advised?	Yes	No	Yes	No
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
IMPORTANT: Please complete the additional medical questionnaire(s) for each disclosure and provide as much information as possible.				

Your health in the last 5 years - section F7	Life 1		Life 2 (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 questionnaire with full details on page 32.				
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
Diabetes, raised blood sugar, pre-diabetes or Impaired Glucose Tolerance (IGT).	Yes	No	Yes	No
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
Numbness, tremor, tingling, pins and needles, dizziness, facial pain or visual disturbance including blurred or double vision?	Yes	No	Yes	No
Seizures, fits, fainting, blackouts or memory loss?	Yes	No	Yes	No
Any disorder of the digestive system, liver, stomach, oesophagus, pancreas, colon or bowel, including hepatitis, colitis, Crohn's disease, Irritable Bowel Syndrome (IBS), bleeding or stomach ulcers?	Yes	No	Yes	No
Any disorder of the kidneys, bladder or prostate, including blood or protein in the urine or urinary tract infection?	Yes	No	Yes	No
Any mental health problem including depression, stress, anxiety, panic attacks or eating disorder that has required treatment, consultation with a health professional or time off work?	Yes	No	Yes	No

Post viral syndrome, continuous fatigue, tiredness, long/chronic covid, ME (Myalgia encephalo-myelitis) or fibromyalgia?	Yes No	Yes No
Any respiratory or lung disorder, including asthma, bronchitis, COPD (COAD), emphysema or sleep apnoea?	Yes No	Yes No
Any gynaecological disorder which has required regular follow up or referral to a specialist including abnormal cervical screening (smear tests), abnormal menstrual bleeding or breast conditions. Infertility treatment, miscarriage/termination, uncomplicated pregnancy/caesarean section, thrush, routine scan/blood test for pregnancy, routine cervical screening/smear test (normal result), HRT (no investigations involved) can be ignored. Only applicable where the life assured is Female.	Yes No	Yes No
Any pain or other problems relating to your back, neck, joints, bones or muscles, including arthritis, ankylosing spondylitis, rheumatism or gout. There is no need to answer this question if the application is life cover only.	Yes No	Yes No
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. There is no need to answer this question if the application is life cover only.	Yes No	Yes No
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
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.		

Recent and current health - section F8	Life 1	Life 2 (if applicable)
Apart from anything you have already told us about on this application, in the last 3 years have you: If 'Yes', please complete the relevant Medical Disclosure questionnaire with full details on page 32.		
Been referred to a specialist (including if you are still on the waiting list) or been advised to have any medical investigations (for example blood tests, x-rays, urine tests, scans, biopsies or internal camera investigations) in connection with a medical condition or symptom, even if you are awaiting the results?	Yes No	Yes No
Been prescribed any medication, treatment or counselling for two weeks or more in connection with any medical condition or symptom?	Yes No	Yes No
Been admitted to hospital overnight.	Yes No	Yes No
Apart from anything you have already told us about on this application, have you had any of the following in the last 3 months:		
A lump, growth, cyst or lesion that has grown or changed in appearance?	Yes No	Yes No
Blood in your urine?	Yes No	Yes No
Bleeding from the bowel or a change in bowel habit?	Yes No	Yes No
Unexplained weight loss?	Yes No	Yes No
Any other symptom you are planning to consult a medical professional or therapist about?	Yes No	Yes No

G. Your Doctor's Details

Doctor's details	Life 1	Life 2 (if applicable)
IMPORTANT: If applicable, please tick here if the Life 1 and Life 2 have the same doctor.		
Doctor's name		
Clinic/surgery address		
Telephone number		
I give permission for VitalityLife to share my personal and medical information with my named GP for the purpose of this application	Yes No	Yes No

H. Plan Owner Details

Plan owner details - section H1	Plan owner								
Plan owner's name									
Plan owner type	<table> <tr> <td>Life Assured</td> <td>Company</td> </tr> <tr> <td>Individual</td> <td>Other e.g. group of individuals</td> </tr> </table>	Life Assured	Company	Individual	Other e.g. group of individuals				
Life Assured	Company								
Individual	Other e.g. group of individuals								
<p>IMPORTANT: If you have selected Individual/Other as the plan owner type, please complete section H2, section H3 and section H4 (if applicable).</p> <p>If you have selected Life Assured, please complete section H3.</p> <p>If you have selected Company, please complete the information in section H5.</p>									
<p>IMPORTANT: If you have selected Individual/Other as the plan owner type, please complete the information below.</p>									
Individual/other plan owner details - section H2									
Title	Mr Mrs Miss Ms Other								
First name(s)									
Surname									
Date of birth	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
Contact telephone number(s)									
Email address									
Address for correspondence									
Postcode									
Relationship to the life(s) assured									

Would you like us to correspond with this plan owner in relation to the plan?	Yes	No	
	Life 1		Life 2 (if applicable)
I confirm that consent has been given by the life assured to share the medical information and plan documents with the plan owner(s) in relation to this plan	Yes	No	Yes No
Plan information further details - section H3			
Do you have a Property and Financial Affairs Lasting Power of Attorney (LPA) or an Enduring Power of Attorney (EPA)?	Yes	No	If 'Yes', you can send us a certified true copy of the registered LPA or EPA and we can keep a copy on file to expedite the process in the event of your attorney(s) needing to correspond with us on your behalf.
IMPORTANT: For more information about LPAs, please visit https://www.gov.uk/power-of-attorney . For more information about EPAs please visit https://www.gov.uk/use-or-cancel-an-enduring-power-of-attorney .			
Marketing preferences			
Keeping you up to date with our latest product offers			
Be the first to hear about our new Vitality products and offers. You can opt-out at any time, and we'll never share your personal data with any other companies for marketing purposes.			
Please tick below if you don't want to hear from us.			
No thanks, I don't want you to email me			
No thanks, I don't want you to send text messages to me			
You can change your preferences at any time, and we'll never share your personal data with other companies for marketing purposes.			
You'll still receive emails from us about your plan. That includes anniversary notifications, changes to any rewards or partners and plan updates.			
We're committed to protecting your personal information. For details about how we manage your personal data, read our full Privacy Notice at vitality.co.uk/privacy .			
IMPORTANT: If you have selected Individual/Other as the plan owner type and there is more than one plan owner please also complete the information below.			
Individual/other plan owner details - section H4			
Title	Mr	Mrs	Miss Ms Other
First name(s)			
Surname			
Date of birth	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
Contact telephone number(s)			
Email address			

Address for correspondence		
Postcode		
Relationship to the life(s) assured		
Would you like us to correspond with this plan owner in relation to the plan?	Yes	No
	Life 1	Life 2 (if applicable)
I confirm that consent has been given by the life assured to share the medical information and plan documents with the plan owner(s) in relation to this plan	Yes	No
Do you have a Property and Financial Affairs Lasting Power of Attorney (LPA) or an Enduring Power of Attorney (EPA)?	Yes	No
	If 'Yes', you can send us a certified true copy of the registered LPA or EPA and we can keep a copy on file to expedite the process in the event of your attorney(s) needing to correspond with us on your behalf.	
IMPORTANT: For more information about LPAs, please visit https://www.gov.uk/power-of-attorney . For more information about EPAs please visit https://www.gov.uk/use-or-cancel-an-enduring-power-of-attorney .		
<p>Marketing preferences</p> <p>Keeping you up to date with our latest product offers</p> <p>Be the first to hear about our new Vitality products and offers. You can opt-out at any time, and we'll never share your personal data with any other companies for marketing purposes.</p> <p>Please tick below if you don't want to hear from us.</p> <p>No thanks, I don't want you to email me</p> <p>No thanks, I don't want you to send text messages to me</p> <p>You can change your preferences at any time, and we'll never share your personal data with other companies for marketing purposes.</p> <p>You'll still receive emails from us about your plan. That includes anniversary notifications, changes to any rewards or partners and plan updates.</p> <p>We're committed to protecting your personal information. For details about how we manage your personal data, read our full Privacy Notice at vitality.co.uk/privacy.</p>		
Company details - section H5		
Address for correspondence		
Postcode		
Relationship to the life assured e.g. employer		

Company contact details		
IMPORTANT: We will correspond with the person named below in relation to the plan.		
Title	Mr	Mrs Miss Ms Other
First name		
Surname		
Date of birth	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Job title		
Contact telephone number(s)		
Email address		
Address for correspondence		
Postcode		
	Life 1	Life 2 (if applicable)
I confirm that consent has been given by the life assured to share the medical information and plan documents with the plan owner(s) in relation to this plan	Yes No	Yes No
Do you have a Property and Financial Affairs Lasting Power of Attorney (LPA) or an Enduring Power of Attorney (EPA)?	Yes No If 'Yes', you can send us a certified true copy of the registered LPA or EPA and we can keep a copy on file to expedite the process in the event of your attorney(s) needing to correspond with us on your behalf.	
IMPORTANT: For more information about LPAs, please visit https://www.gov.uk/power-of-attorney . For more information about EPAs please visit https://www.gov.uk/use-or-cancel-an-enduring-power-of-attorney .		

I. Plan Information

IMPORTANT: This section is for the Financial Adviser, please ensure all questions are completed.	
Adviser details - section I1	
FCA Regulatory Number	
Adviser's first name(s)	
Adviser's surname	
Agency details - VitalityLife Agency Number	

IMPORTANT: Advisers that only have permissions to carry out insurance mediation on non-investment insurance contracts (i.e. pure protection business under the Insurance Conduct of Business “ICOBS” regime) will only be able to answer question 1 as ‘No’, since they will not have regulatory permissions to advise or arrange investment business. Advisers who hold permissions to advise or arrange investment business as well as non-investment insurance contracts will need to consider whether this quote/application for VitalityLife is associated with advice on investment business and answer question 1 as ‘Yes’ or ‘No’ as appropriate.

1. Is the protection sale associated with advice on investment business as per the FCA Retail Distribution Review?	Yes No
2. How would you like to be remunerated on this VitalityLife business?	Commission Fee or other adviser charge Mix of commission and fee or other adviser charge
3. If you are being remunerated by commission (whether in full or in part), are you intending to rebate/sacrifice a proportion of commission? If so, what percentage of commission is to be discounted (rebated)?	Yes No %
IMPORTANT: Advisers who answered question 1 as ‘Yes’ and are being remunerated for any subsequent VitalityLife plan by commission in question 2 are required under FCA rules to disclose the commission on the illustration. Therefore, in this circumstance question 4 should be answered as “Yes”.	
4. Do you want to disclose the commission on the illustration?	Yes No

Plan correspondence and options - section I2

Please submit your client’s email address. This is important for them to receive their key plan documents via email and be notified of plan correspondence in their Member Zone inbox. Does they wish to receive plan correspondence via post only?	First (or only) life email address: Second life (if applicable) email address: Only by post
Who shall we send the acceptance letter to?	Direct to the plan owner, with copy to you Both to you
Who shall we send the plan documents to?	Direct to the plan owner, with copy to you Both to you

J. Payment Details

<p>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 or Electronic Fund Transfer (EFT). Electronic Fund Transfers (EFT) must be made into the following account. Please ensure you include the plan number as the reference to avoid delays in allocating the payment to the plan.</p> <p>Bank account name: VitalityLife Bank: HSBC Sort Code: 400250 Bank account number: 81359118 Reference number: Your plan number followed by AB</p>	
How does your client wish to pay their premiums?	<input type="checkbox"/> Monthly <input type="checkbox"/> Annually
<p>IMPORTANT: Please only complete the following information if your clients are paying by Direct Debit.</p>	
How does your client wish to complete their direct debit instruction?	<input type="checkbox"/> Paperless <input type="checkbox"/> Paper with client signature
I have chosen to obtain client signatures on direct debit:	<input type="checkbox"/> Yes <input type="checkbox"/> No
First (or only) life assured name or payer name To be completed by the Financial Adviser.	
Date of Birth To be completed by the Financial Adviser.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
On what date of the month would you like us to collect the premiums? This must be between the 1 st and 28 th of the month.	<input type="text"/> of the month
<p>IMPORTANT: If your client has elected to pay via Direct Debit, please complete the Direct Debit form on page 24.</p>	

Instruction to your Bank or Building Society to pay by Direct Debit



i NOTE: Please fill in the form and send to: **FREEPOST VitalityLife, PO Box 619, Darlington, DL1 9FH.**

Name(s) of account holder(s)

Reference number (please complete)																				
<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>																				

Bank/Building Society account number																				
<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>																				

Service user number						
<table border="1"> <tr> <td>2</td><td>9</td><td>8</td><td>4</td><td>9</td><td>7</td> </tr> </table>	2	9	8	4	9	7
2	9	8	4	9	7	

Branch Sort Code											
<table border="1"> <tr> <td> </td><td> </td><td> </td> <td>-</td> <td> </td><td> </td><td> </td> <td>-</td> <td> </td><td> </td><td> </td> </tr> </table>				-				-			
			-				-				

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

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

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.

VitalityLife is a trading name of Vitality Corporate Services Limited. Vitality Life Limited, registration number 03319079 is the insurer that underwrites the VitalityLife plan. Vitality Corporate Services Limited, registration number 05933141 arranges and administers VitalityLife plans. Registered offices at 3 More London Riverside, London, SE1 2AQ. Registered in England and Wales. Vitality Corporate Services Limited is authorised and regulated by the Financial Conduct Authority. Vitality Life Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.

The Direct Debit Guarantee

K. Access to Medical Reports Act 1988

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

We may need to get medical reports to support your claim, 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 claim.

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.

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;
- 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, PO Box 619, Darlington, DL1 9FH.

Important notes

Claim payments will not start until we have assessed and accepted your claim. During this period, premiums must be kept up to date.

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 claim form and relevant medical reports and financial information to our reinsurers for their opinion. Or, we may need to send them at a later stage for purposes relating to managing the claim. You can get details of general reassurance principles and details of any company we use to assess your claim, from our head office:

VitalityLife Customer Services, VitalityLife, PO Box 619, Darlington, DL1 9FH.

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.

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 1988 remain the same. In the event that the medical report shows that you failed to disclose a fact that it would be reasonable to expect you to disclose, we reserve the right to reconsider the terms offered to you or cancel the policy.

Please refer to page 28 for the data protection notice. If you have any questions about this please write to:

Group Head of Data Protection, Vitality, 5th Floor East, Eighty Strand, London, WC2R 0DT

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 information.

- 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 1988.

Signature of First (or only) Life Assured	
Full name	Date of birth <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="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 <input type="text" value="X"/>	Date <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>

Signature of Second Life Assured (if applicable)	
Full name	Date of birth <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="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 <input type="text" value="X"/>	Date <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>

To be completed by the Financial Adviser
If you are submitting this application online in Adviser Hub, please record the application number below.
Application number:

Please fax this completed form to VitalityLife at **0870 240 0937** or post to **VitalityLife, New Business, PO Box 619, Darlington, DL1 9FH.**

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.

L. Full paper application client declaration, authority and consent

How we use your personal data

I/We hereby certify that the answers given have been accurately re-produced, that I/we have disclosed all material facts and I/We verify the truth of the answers. Moreover, I/we authorise that they form the basis of the contract applied for. I/We understand that the nurse is bound by and will adhere to the NMC Code of Conduct at all times. In accordance with applicable Data Protection Laws (including, but not limited to all laws and regulations in the United Kingdom including the General Data Protection Regulation and the Data Protection Act 2018 and laws and regulations of the European Union, the European Economic Area and their member states, applicable to the processing of personal data and the interception of communications in place from time to time), the medical collections agent will hold information about me on their computer systems.

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

Why should you read this notice?

We think it is important for all of our members to be made aware of what information Vitality holds about them and to have the reassurance of knowing that we comply with the data protection legislations. The following is a summary of our Privacy Notice. For details of the full Privacy Notice (latest full Privacy Notice) please visit vitality.co.uk/privacy.

Who Vitality are?

Vitality is part of the Discovery Group of companies and is owned by Discovery Limited, a financial services firm based in South Africa.

Vitality Corporate Services Limited is an authorised intermediary of Vitality Health Limited ("VitalityHealth"), Vitality Life Limited ("VitalityLife") and ("VitalityInvest"). Together Vitality arranges and administers products provided by VitalityHealth, VitalityLife and VitalityInvest. Vitality Corporate Services Limited is the data controller for the management of interactions between us and you; VitalityHealth and VitalityLife and VitalityInvest respectively are the data controllers for the personal data and special category data that you or your representative provide to us.

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

Sharing your personal data

We may need to share your personal data for legal or regulatory purposes, with your authorised representative where you have appointed an insurance or financial adviser or with other companies in order to provide our products and services.

Processing claims

In the event of a claim we may require a medical report from your GP. Such a report will only be requested with your consent and will be in compliance with the Access to Medical Reports Act 1988 ('AMRA'). The information requested from your GP will be limited to only the information relevant to your claim. You have the right to request to see the GP's report and to request any amendments be made by the GP where you consider the data to be inaccurate. The GP may agree to this at his/her discretion. You will be informed about the AMRA process at the time we request your consent to enable us to ask your GP for a report.

We may have to give some information about your plan and about your health or medical status to those involved in your treatment or care, (and/or your representative if you have consented to us doing this). Any such disclosure will be done confidentially unless you specifically instruct us otherwise.

If the claimant is aged 13 or over we will address any correspondence to the claimant in order to protect their right to confidentiality. The planholder will be informed only that a claim has been made and the value of the payment we have made; no details about the medical condition or treatment provided will be disclosed to them. If the claimant wishes to waive their right to confidentiality they should inform us at the time the claim is made.

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 data to that other insurer so that we can ensure we only pay our proportion of the claim.

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.

Marketing

Vitality Corporate Services Limited would like to send you information about our products and future products, which currently include health and life insurance and general insurance. We are focused on bringing exciting new products to you and to enhance those already available by offering improved services and benefits as a Vitality member.

When you purchase a product from Vitality you will be provided with access to the Member Zone where you can manage your marketing preferences and choose your preferred method of receiving information about our products, services and the benefits at any time.

You can manage your marketing preferences and choose your preferred method of receiving information about our products, services and the benefits at any time by calling our customer services team.

Data protection complaints

We want all of our members to be happy with the way their personal data, health data and medical information has been processed by us. If you are unhappy about the way we have managed your personal data we would like to know about it as we are constantly striving to ensure we do the right thing and we would like to be able to put things right.

You'll find the contact details for our complaints teams at: vitality.co.uk/legal/complaints

However, if you are still dissatisfied you have the right to contact the Information Commissioner, who regulates compliance with data protection regulation and laws at: ico.org.uk

You can also call the ICO on 0303 123 1113 or 01625 545 745, or write to them at:

Information Commissioner's Office

**Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF**

If you have any queries in respect of your data protection rights or the way your personal data is processed by Vitality, please call us on 0207 133 8600, or write to us at:

Data Protection Officer

**Vitality
5th Floor East
Eighty Strand
London
WC2R 0DT**

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

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 General Data Protection Regulation and the Data Protection Act 2018, the declaration, important notes and general information.

I/We hereby certify that the answers given have been accurately re-produced, that I/We have disclosed all material facts and I/We verify the truth of the answers. Moreover, I/We authorise that they form the basis of the contract applied for. In accordance with applicable Data Protection Laws (including, but not limited to all laws and regulations in the United Kingdom including the General Data Protection Regulation and the Data Protection Act 2018 and laws and regulations of the European Union, the European Economic Area and their member states, applicable to the processing of personal data and the interception of communications in place from time to time), the medical collections agent will hold information about me on their computer systems.

Signature of first (or only) Life Assured

Signature

X

Date

D D M M Y Y Y Y

Signature of applicant if different

Signature

X

Date

D D M M Y Y Y Y

What are the next steps in the application process?

IMPORTANT: Please follow this information if you are submitting this application online in Adviser Hub at adviser.vitality.co.uk/life/.

- 1) Many applications can be approved without further underwriting. However if further underwriting is required, your client will be issued a letter keeping them informed.
- 2) Send us the appropriate documents
 - a) Detach the Access to Medical Reports Act 1988 form on pages 26-27 and return to us as indicated
 - b) If you are not completing the Direct Debit instruction online, please complete the paper version and obtain your client's signature. Please post the form to VitalityLife, PO Box 619, Darlington, DL1 9FH.
- 3) If you find any errors or omissions, please call us and let us know on 0345 601 0072. You can notify us in writing on the form at the end of the confirmation schedule. If you are happy that the information in the confirmation schedule is complete and correct, you do not need to do anything further.
- 4) Once we have reached our underwriting decision your client will receive an acceptance letter. In some instances where special terms have been offered, we will need the client's signature before we can proceed.
- 5) Your client will receive their Welcome Pack including a plan schedule, plan summary and plan provisions, plus details about Vitality and how they can log into their Member Zone.

USEFUL TIP: As advisers, you can choose to receive your correspondence about the application from VitalityLife electronically via a secure inbox. In order to do so, you can update your settings in Adviser Hub. Simply click on Account Settings and update your answer for the question 'You can be kept informed of each application as it progresses through email alerts'.

Medical Disclosure Questionnaires

IMPORTANT: If you provided a disclosure earlier in this form, please complete the relevant medical questionnaire and give us as much information as possible.

Diabetes:	Page 35
High blood pressure and raised cholesterol:	Page 36
Mental health:	Page 38
Moles, lumps, cysts and skin lesions:	Page 39
Additional disclosure 1:	Page 41
Additional disclosure 2:	Page 43
Additional disclosure 3:	Page 45

Medical questionnaire - For diabetes ONLY
Please complete the following questions

Diabetes only	Life 1	Life 2 (if applicable)
What type of diabetes do you have?	Type 1 Type 2	Type 1 Type 2
When was your diabetes first diagnosed?	<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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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
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
When was your last diabetic review, either with your GP or clinic/hospital?	<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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
If known, what was the result of your last HbA1c?		
If known, what was the result of your last blood pressure reading?		
Are you on medication to either treat high blood pressure, or as a preventative measure to maintain your blood pressure at acceptable levels?		
If known, what was the result of your last cholesterol level?		
Are you on medication to either treat raised cholesterol, or as a preventative measure to maintain your cholesterol at acceptable levels?		
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
Have you ever had protein in your urine?		
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**

High blood pressure and raised cholesterol only	Life 1	Life 2 (if applicable)
Please confirm whether you have been diagnosed with high blood pressure, raised cholesterol or both.		
<p>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?</p> <p>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.</p>	<p>Yes No</p>	<p>Yes No</p>
<p>If you are taking medication, has this changed or increased to improve control of your condition within the last 6 months?</p> <p>If you are not on medication for either blood pressure or cholesterol, please select No.</p>	<p>Yes No</p>	<p>Yes No</p>
For the following questions, please answer those which are relevant to your condition(s) as disclosed above:		
When did you last have your blood pressure checked by a medical professional?	<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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

High blood pressure and raised cholesterol only	Life 1	Life 2 (if applicable)
<p>Do you know your most recent blood pressure reading? If 'Yes' please provide your most recent reading.</p> <p>If 'No', how was your latest blood pressure reading described by your doctor or nurse?</p> <ul style="list-style-type: none"> · High or resistant to control · Fluctuating / variable blood pressure · Slightly higher than normal · Normal · None of the above 	<p>Yes No</p> <p>Yes No</p> <p>Yes No</p> <p>Yes No</p> <p>Yes No</p>	<p>Yes No</p> <p>Yes No</p> <p>Yes No</p> <p>Yes No</p> <p>Yes No</p>
<p>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)?</p>	<p>Yes No</p>	<p>Yes No</p>
<p>When did you last have your cholesterol checked by a medical professional?</p>	<p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>
<p>Do you know your most recent cholesterol reading? If 'Yes' please provide your most recent reading.</p> <p>If 'No', how was your latest cholesterol reading described by your doctor or nurse?</p> <ul style="list-style-type: none"> · Raised or resistant to control · Fluctuating / variable cholesterol · Slightly higher than normal · Normal · None of the above 	<p>Yes No</p> <p>Yes No</p> <p>Yes No</p> <p>Yes No</p> <p>Yes No</p> <p>Yes No</p>	<p>Yes No</p> <p>Yes No</p> <p>Yes No</p> <p>Yes No</p> <p>Yes No</p>

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

Mental health only	Life 1	Life 2 (if applicable)
<p>What symptoms did you experience and when did they start?</p>	<div style="display: flex; justify-content: space-around; border: 1px solid black; padding: 2px;"> DDMMYYYY </div>	<div style="display: flex; justify-content: space-around; border: 1px solid black; padding: 2px;"> DDMMYYYY </div>
<p>Have you had more than one distinct episode of this condition (i.e. recurrent episodes)?</p>	<p>Yes No</p>	<p>Yes No</p>
<p>What diagnosis was given?</p>		
<p>Over the last 12 months, for how many days has this condition restricted your ability to perform your usual daily activities such as work attendance, household chores etc?</p>	<div style="display: flex; justify-content: space-around; border: 1px solid black; padding: 2px;"> DDD </div>	<div style="display: flex; justify-content: space-around; border: 1px solid black; padding: 2px;"> DDD </div>
<p>Please give details of medication and/or treatment taken in the past and present. If you are taking medication, has this changed or increased to improve control of your condition within the last 6 months</p>		
<p>Have you ever been advised to have any of the following to treat this condition: hospital treatment, treatment with Lithium medication or referral to psychiatrist or hospital clinic?</p>		
<p>Have you ever attempted suicide, overdose or self harm?</p> <p>If 'Yes' please confirm how many times this has happened and when was the last time?</p>	<div style="display: flex; justify-content: space-around; border: 1px solid black; padding: 2px;"> DDMMYYYY </div>	<div style="display: flex; justify-content: space-around; border: 1px solid black; padding: 2px;"> DDMMYYYY </div>
<p>Have you ever needed to seek help due to thoughts of suicide or self harm?</p> <p>If 'Yes' please confirm how many times this has happened and when was the last time.</p>	<div style="display: flex; justify-content: space-around; border: 1px solid black; padding: 2px;"> DDMMYYYY </div>	<div style="display: flex; justify-content: space-around; border: 1px solid black; padding: 2px;"> DDMMYYYY </div>
<p>Do you have any current symptoms? If 'Yes' please provide details?</p> <p>If 'No' please advise when last did you experience symptoms?</p>	<p>Yes No</p> <div style="display: flex; justify-content: space-around; border: 1px solid black; padding: 2px; margin-top: 10px;"> DDMMYYYY </div>	<p>Yes No</p> <div style="display: flex; justify-content: space-around; border: 1px solid black; padding: 2px; margin-top: 10px;"> DDMMYYYY </div>

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

Moles, lumps, cysts and skin lesions only	Life 1	Life 2 (if applicable)
What type of lesion does this disclosure relate to (for example, mole, freckle, cyst, lump, lipoma, growth etc)?		
Does your disclosure relate to a single occurrence or multiple occurrences?		
Please describe the area(s) of the body this disclosure relates to.		
Have you consulted your doctor about this condition?	Yes No	Yes No
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
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

<p>Have you had any treatment (surgery, radiotherapy, chemotherapy, hormone therapy or tablets (other than painkillers)) for this condition?</p> <p>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.</p>	<p>Yes No</p>	<p>Yes No</p>
<p>Do you have any moles, cysts, lumps, growths or lesions still present?</p>	<p>Yes No</p>	<p>Yes No</p>
<p>Have you now been discharged from follow up, with no further consultations, investigations, treatment or monitoring due?</p> <p>If 'No' please provide details of all planned tests, investigations or appointments, along with all relevant dates</p>	<p>Yes No</p>	<p>Yes No</p>

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

Medical questionnaire - additional disclosure 1

Additional disclosure 1	Life 1	Life 2 (if applicable)
What is the medical condition?		
Has the diagnosis been confirmed?	Yes No	Yes No
Are you having any investigations into the cause of your symptoms? When did symptoms of this condition first occur? When did you last have symptoms?	Yes No <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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Yes No <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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Do you have recurrent symptoms? 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
Do they restrict you in any way? If 'Yes', please give details of the problems experienced	Yes No	Yes No
Have you seen a specialist for the condition? 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
What medical investigations have been performed?		
What were the results (if known) and the dates they were done?		
Have all investigations now been completed?		
Are you waiting for any follow-ups or reviews? When did you last see your GP with this condition?	Yes No <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Yes No <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 have you been admitted to hospital for this condition and when was the last time?	<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"/> <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 was the last time you went to hospital as an outpatient for investigations or check-ups for this condition?	<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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Additional disclosure 1	Life 1	Life 2 (if applicable)
<p>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</p> <p>Is the treatment continuing?</p> <p>If 'No', when did it stop?</p>	<p>Yes No</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>Yes No</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>
<p>Is any operation planned or being considered?</p> <p>What type of operation?</p> <p>If 'Yes', when is it planned?</p>	<p>Yes No</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>Yes No</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>
<p>Have you required time off work?</p> <p>If 'Yes', please give the date you were first absent from work.</p> <p>The date you returned to work.</p>	<p>Yes No</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>Yes No</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>

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

Medical questionnaire - additional disclosure 2

Additional disclosure 2	Life 1	Life 2 (if applicable)
What is the medical condition?		
Has the diagnosis been confirmed?	Yes No	Yes No
Are you having any investigations into the cause of your symptoms? When did symptoms of this condition first occur? When did you last have symptoms?	Yes No DDMMYYYY DDMMYYYY	Yes No DDMMYYYY DDMMYYYY
Do you have recurrent symptoms? 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
Do they restrict you in any way? If 'Yes', please give details of the problems experienced	Yes No	Yes No
Have you seen a specialist for the condition? 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
What medical investigations have been performed?		
What were the results (if known) and the dates they were done?		
Have all investigations now been completed?		
Are you waiting for any follow-ups or reviews? When did you last see your GP with this condition?	Yes No DDMMYYYY	Yes No DDMMYYYY
How many times have you been admitted to hospital for this condition and when was the last time?	NNN DDMMYYYY	NNN DDMMYYYY
When was the last time you went to hospital as an outpatient for investigations or check-ups for this condition?	DDMMYYYY	DDMMYYYY

Additional disclosure 2	Life 1	Life 2 (if applicable)
<p>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</p> <p>Is the treatment continuing? If 'No', when did it stop?</p>	<p>Yes No</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>Yes No</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>
<p>Is any operation planned or being considered? What type of operation? If 'Yes', when is it planned?</p>	<p>Yes No</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>Yes No</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>
<p>Have you required time off work? If 'Yes', please give the date you were first absent from work. The date you returned to work.</p>	<p>Yes No</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>Yes No</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>

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

Medical questionnaire - additional disclosure 3

Additional disclosure 3	Life 1	Life 2 (if applicable)
What is the medical condition?		
Has the diagnosis been confirmed?	Yes No	Yes No
Are you having any investigations into the cause of your symptoms? When did symptoms of this condition first occur? When did you last have symptoms?	Yes No DDMMYYYY DDMMYYYY	Yes No DDMMYYYY DDMMYYYY
Do you have recurrent symptoms? 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
Do they restrict you in any way? If 'Yes', please give details of the problems experienced	Yes No	Yes No
Have you seen a specialist for the condition? 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
What medical investigations have been performed?		
What were the results (if known) and the dates they were done?		
Have all investigations now been completed?		
Are you waiting for any follow-ups or reviews? When did you last see your GP with this condition?	Yes No DDMMYYYY	Yes No DDMMYYYY
How many times have you been admitted to hospital for this condition and when was the last time?	NNN DDMMYYYY	NNN DDMMYYYY
When was the last time you went to hospital as an outpatient for investigations or check-ups for this condition?	DDMMYYYY	DDMMYYYY

Additional disclosure 3	Life 1	Life 2 (if applicable)
<p>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</p> <p>Is the treatment continuing? If 'No', when did it stop?</p>	<p>Yes No</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>Yes No</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>
<p>Is any operation planned or being considered? What type of operation? If 'Yes', when is it planned?</p>	<p>Yes No</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>Yes No</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>
<p>Have you required time off work? If 'Yes', please give the date you were first absent from work. The date you returned to work.</p>	<p>Yes No</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>Yes No</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>

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

VitalityLife is a trading name of Vitality Corporate Services Limited. Vitality Life Limited (registration number 03319079) is the insurer that underwrites the VitalityLife plan. Vitality Corporate Services Limited (registration number 05933141) arranges and administers VitalityLife plans.

Registered offices at 3 More London Riverside, London, SE1 2AQ. Registered in England and Wales.

Vitality Corporate Services Limited is authorised and regulated by the Financial Conduct Authority. Vitality Life Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.

Calls may be recorded/monitored to help improve customer service.